Evaluation of Dutch Humanitarian Assistance in the Great Lakes region
2000 - 2005

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Acronyms

ADOSAGO	Association des Donneurs de Sang de Goma
AMI-Kivu	Appui Médical Integré – Kivu
ASRAMES	Association Régionale d'Approvisionnement en Médicaments Essentiels
AU	African Union
BAD	Banque Africaine de Développement
BDOM-Goma	Bureau Diocèses Oeuvres Medical
CAP	Consolidated Appeal Process
CCA	Committee for Agricultural Coordination
CEMUBAC	Centre Scientifique et Médical de l'Université Libre de Bruxelles pour ses Activités de Coopération
CIF-Santé	Conseil, Information, Formation -Santé
CHAP	Consolidated Humanitarian Action Plan
CNDD-FDD	Conseil National Pour la Défense de la Démocratie–Forces pour la Défense de la Démocratie
COCA	Checklist for Organisational Capacity Assessment
COMESA	Commonwealth Secretariat
DAC	Development Assistance Committee
DDR	Disarmament, Demobilisation, Reintegration
DGIS	Directorate-General for International Cooperation
DDR-CONADER	Convention Nationale de Démobilisation et Réintégration
DMV	Human Rights and Peacebuilding Department
DMV/HH	Humanitarian Aid Division (of the Human Rights and Peacebuilding Department)
DRA	Dutch Relief and Rehabilitation Agency
DRC	Democratic Republic of Congo
EC	European Commission
ECC	Eglise du Christ au Congo
ECHO	European Commission Humanitarian Aid Office
EDF	European Development Fund
E-DRC	Eastern Democratic Republic of Congo
EPI	Extended Programme of Immunisation
FAB	Burundi Army
FAO	Food and Agriculture Organisation
FAO-TCOR	Food and Agriculture Organisation- Special Relief Operations Service
FDD	Forces pour la Défense de la Démocratie
FED	Fond Européen de Développement – European Development Fund
FLEC	Front de Libération de l'Est du Congo
FNL	Front de Libération Nationale
FRODEBU	Front for Democracy in Burundi
GAM	Global Acute Malnutrition
GHD	Good Humanitarian Donorship
GTZ	Gesellschaft für Technische Zusammenarbeit (German Agency for Development)
HMA	Heads of Medicines Agencies
HNI	HealthNet International
HQ	Head Quarters
ICRC	International Committee of the Red Cross

IDA	International Development Association
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
INGO	International Non Governmental Organisation
LNGO	Local Non Governmental Organisation
IOB	Policy and Operations Evaluation Department of the Netherlands Ministry of Foreign Affairs
IPS	Inspection Provincial de Santé
LRRD	Linking Relief Rehabilitation and Development
MDF-ESA	Management for Development Foundation
MFA	Ministry of Foreign Affairs
MINUAR	Mission des Nations Unies pour l'Assistance au Rwanda
MONUC	United Nations Military Observer Mission in the Congo
MDRP	Multi Country Demobilization and Reintegration Program
MDTF	Multi-Donor Trust Fund
MSF	Médecins Sans Frontières
MSF-H	Médecins Sans Frontières-Holland
NCDRR	National Commission for Demobilization, Reinsertion and Reintegration
NGO	Non Governmental Organisation
NL	Netherlands
NNGO	National Non Governmental Organisation
NOVIB	Oxfam NL
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Co-operation and Development
OFDA	US-AID- Office of Disaster Assistance
ONUB	United Nations Operation in Burundi
PALIPEHUTU-FNL	Front National de Libération
PCAC	Programme Cadre d'Appui aux Communautés du Burundi
PRA	Participatory Rapid Appraisal
RCD	Rassemblement Congolais pour la Democratie
RET	Refugee Education Trust
SAEU	Southern Africa Extension Unit
SAM	Severe Acute Malnutrition
SC	Save the Children
SC-F	Save the Children-France
SC-UK	Save the Children-UK
SFC	Supplementary Feeding Centre
TFC	Therapeutic Feeding Centre
TMF	Theme-based Co-financing
TNF	Transnational Fund of Security Sector Actions
TOR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNPROFOR	United Nation Coordinator for Security
UNSECOORD	United Nations Security Coordinator Office
WFP	United Nations World Food Programme
WHO	World Health Organization
WV	World Vision
WVI	World Vision International

1 SUMMARY AND KEY ISSUES

1.1 Introduction

Over the period 2000-2004 the Netherlands Ministry of Foreign Affairs allocated €53 million to the humanitarian operations in Tanzania, Burundi and Democratic Republic of Congo. These operations were part of the international response to a notorious complex of local wars, caused by related factors of an ethnic and economic nature. The humanitarian operations were coordinated with peacekeeping and peace-building initiatives, also supported by the Netherlands, but the management was essentially handed over to independent UN agencies, Dutch NGOs, and their local partners.

From 1998 the violence claimed an estimated 3 million lives in the DRC, up to 300.000 in Burundi, and caused the flight of up to 600,000 Burundi refugees into Tanzania. In 2005 many of these operations are shifting to a recovery mode, in the context of broad political change. This offers key lessons about emergency assistance and rehabilitation in fragile and hostile environments.

The Policy and Operations Evaluation Department (IOB) of the Netherlands Ministry of Foreign Affairs (MFA) commissioned Channel Research to conduct an empirical study of Dutch supported humanitarian actions in the Great Lakes region over the period May to November 2005. This case study forms part of a larger evaluation conducted by IOB on Dutch humanitarian assistance.

The assessment focused on activities funded from the emergency aid articles of the humanitarian assistance budget vote. It reviewed linkages to the relevant aspects of Dutch foreign policy in the region.

The sample of the evaluation included five projects or programmes implemented by five agencies in Burundi and Tanzania (UNDP, FAO, OCHA, Cordaid in Burundi, and CARE in Tanzania), and four projects or programmes in the eastern part of the Democratic Republic of Congo –DRC (WFP in North Katanga and South Kivu, Save the Children, World Vision and ASRAMES in North Kivu). The evaluation will focus on the implementation and results of these interventions and will as well review Dutch humanitarian policy and administrative procedures for the implementation of humanitarian assistance.

The evaluation is based on a review of documentation held by the Ministry of Foreign Affairs, on a review of literature and internet resources, and on information communicated by the agencies to the team through text and interviews. It is also based on field visits to six project sites in the three countries concerned, where the team observed the delivery of outputs, and the general condition of the population: in the areas of Kibondo (western Tanzania), Makamba (southern Burundi), Uvira and Bukavu (South Kivu, DRC), Kalemie (North Katanga, DRC), Goma (North Kivu, DRC). The field visit took place between 6 and 24 August 2005. It started and ended with meetings in the Dutch embassy in Kigali, Rwanda, which is responsible for Burundi. In addition, the

Team Leader visited the Dutch embassy in Kinshasa on 11 November 2005.

The evaluation analysed the quality and the results of the projects at different levels of the aid management chain:

1 Population: relevance to needs (in terms of health, human rights, and livelihoods), relevance to social structures and coping, and wider effects;
2 Delivery mechanisms: in terms of information flow, resource cycles, management of assistance;
3 Agency: targeting, coordination, and capacity and;
4 Policy level: links to peace processes, institutional linkages, addressing situational as well as chronic vulnerability.

The report applies set evaluation criteria (effectiveness, efficiency, relevance, sustainability, connectedness, impact). It covers the projects and programmes funded by Dutch humanitarian assistance, but does not distinguish activities within these projects and programmes which received funding from other sources than the Dutch government.

1.2 Population

The needs of all categories of people have been addressed, whether displaced or not, and the outcomes (defined as changes foreseen in the specific objectives) of the projects responding to them have been tangible and positive. The wider impacts, for example in the health sector in Congo, can be verified through small surveys which are carried out by the agencies.

However, the evaluation finds two weaknesses which reduce effectiveness. First there is a pattern of neglect of particular population pockets which do not pertain to population categories recognised in agency planning, which limits the relevance of the aid. This is particularly to do with gender differentiation, and with ethnic groups. For example a particularly significant problem exists for women who have been victims of rape (which has reached epidemic proportions), and for forest-based ethnic groups (such as the Twa in Burundi). Their needs are not well addressed.

This occasional neglect is because the agencies are not equipped to correct biases which exist in society. This occurs when these categories of people are not recognised in agency policies, or when assessments are not able to identify them. Poor assessments occur because of the limited interaction between the agencies and the population –this interaction does not take place in a direct way, but through management committees, local partners, short field visits. These intermediaries are often treated in a relatively superficial manner as they do not feature highly in Dutch funding guidelines, and because of the long management chains which separate the donor and the actual delivery of aid. The succession of contracts and sub-contracts creates rigidities in the design of the activities, and a lack of security about the long-term nature of funding at field level. This creates a preference for short-term approaches and very conventional programming.

The second weakness is particularly evident in the context of Congo and Burundi, where the state is not functioning. The projects tend to treat structural

vulnerability as though it were situational, meaning short-term and temporary. There is an absence of instruments (no strategic vision, no long-term funding) in the emergency phase to deal with connectedness (short-term assistance addressing structural causes).

As a consequence vulnerability is not fully addressed, particularly in protection, discrimination in access to services, and chronic food and health insecurity. There is even a tendency among some donors (not the Netherlands) to phase out when an emergency is considered "over" and/or it is time to handover to development – but the needs are still there, unaddressed (this refers to Congo in particular).

Vulnerability is linked to displacement, gender and age. We find that the specific needs and conditions of women and children are not well covered. They differ from those of adult men, as a result of the effects of war on social structure and culture. The focus on basic needs (food and physical health) leads to a neglect of trauma, gender based violence, and cultural understandings of the crisis by the population. This is seen by the evaluation team as sowing the seeds of future societal instability, in the form of disenfranchised groups and continued patterns of abuse.

It should be mentioned that the agencies encounter severe constraints in this region of the world, particularly Congo. Insecurity prevails, and transport is expensive, dangerous and long. The agencies are confronted with prevailing structural factors, in particular the continued absence or even deterioration of the state, the prevalence of an unregulated, understaffed and poor health service, and, above all, chronic poverty.

1.3 Delivery

This level of analysis shows strong performance. Technical standards are generally well implemented. The context has played a significant role in determining what happens on the ground, but the agencies selected for funding by the Ministry of Foreign Affairs have done their best in very difficult circumstances, and reflect relevant choices.

Logistic bottlenecks have been addressed and comparative strengths have been exploited, as well as processes of consultation which have been established with authorities where appropriate. Performance in delivery in the visited projects has been generally good, except for the case of medical supplies where gaps frequently appear (the supply of medicines has been implemented better in Congo than in Burundi).

This good performance is however based on external agencies receiving support from the international aid community. Those agencies are about to go through a difficult funding transition in the process of shift from emergency to reconstruction. They and the overall aid system in place will require careful revision to adapt to the changing circumstances, and require continued funding from the highly useful "gap" funding instruments created by the Ministry of Foreign Affairs.

Another risk requires continued attention from agencies and from the Ministry. The evaluation has observed an extensive use of local NGOs and user committees

that are directly servicing the target groups, such as the "Maison de la Femme" in Kalemie (through Caritas), or ASRAMES in Goma. Although the agencies rely on the good performance of these local partners the need for long-term institutional capacity building is often neglected –not recognized or not reinforced– by the humanitarian aid agencies, and this has been detrimental to the effectiveness of aid in all sites visited.

Some agencies, such as WFP, have made themselves operationally dependent on the last link in the chain (whether they be international or local NGOs). This is because they hand over all control over resources at a delivery point, beyond which beneficiary listing, distribution and monitoring of the use of the aid are delegated to local partners. The latter are often not equipped to address problems when these are identified, for lack of human resources. In other cases the agencies are developing monitoring mechanisms (indicators) and contractual agreements with their implementing partners, but this is still limited to some individual initiatives. A lack of follow-up and proper monitoring considerably reduces efficiency.

1.4 Agency

This is the level at which the evaluation is more critical. There is a diffuse sense that nowhere is there an agency with direct responsibility for an operation. Projects tend to start and end through a logic of their own with only a loose connection to the evolution of needs. In this dynamic the local actors are neglected, or there are simply not enough resources in the budgets or in international personnel to take them into account.

A consequence is that the flow of information may be insufficient, or the information is not regularly updated –or both. This affects decision-making and thereby effectiveness. Poor communications infrastructure has played a role in reducing quality, as well as a confused understanding of what counts as important in monitoring.

More importantly, the strategic analysis of this information is missing at the upper agency levels (headquarters and country offices in capitals) where the larger amounts of resources are managed (for example UN agencies handling many contracts). This is due to the fragmentation of ownership along the aid management chain. International agencies usually work with local partners and their partners and sub-contractors so that long chains for information flow occur. Different sectors are handled by different agencies, and there are multiple levels of sub-contracting within each sector.

The report is critical of the information content of the Consolidated Appeals, which does not allow monitoring based on performance. There is no overall monitoring of results achieved, based on a systematic use of indicators, for projects and programmes which have been funded. We find a notable exception to these findings for two NGOs, for which evidence is reflected in the text (planning reviewed in reporting, evaluations and analysis of weaknesses). Agencies in general do not plan according to the (changing) needs of the population because of operational risks (such as security and access) that require continual adaptation, and because the priorities of donors are –although clearly communicated– not always clearly perceived. There is only limited real planning on the basis of the local capacity available and on the basis of the experiences

learnt from programmes.

The evaluation team notes that when access becomes possible, thorough and timely needs assessments are not always carried out. Technical indicators are scarce, whether they be quantitative or qualitative. Some agencies do stand out again as exceptions, but the application of technical indicators is not used at the inter-agency level.

There has not been a clear flow of information from the population, through the aid agency structures, to the Ministry. In most agencies information flow tends to be bottom up, and overburdened with general un-prioritised indicators. There is a lack of comparability over time and considerable impressionism in the analysis of situations and impact. Furthermore there is often no distinction between indicators or output, outcomes and impact, nor of the factors influencing them over and beyond the sole project reported on.

Knowledge management (particularly about needs), and international and national human resource management, are affected by turnover and a drain of qualified personnel from the agencies. There are some exceptions such as FAO in Burundi that show that this is not unavoidable, as it has built a cadre of personnel that will be deployed to emerging public structures.

The mobilisation of resources, particularly in the case of partnerships for the UN, has led to delays in implementation and loss of effectiveness and impact. The delays in financing have led to delays in implementation, and shortages in drug supply. In the case of SAEU, who is the local implementing partner of CARE in the refugee camps in Tanzania, delays in the delivery of training and other activities have affected the beneficiaries.

The ability to coordinate in terms of information exchange, and address gaps in delivery, has been good at the level of humanitarian assistance. It is when one moves beyond short-term humanitarian operations that performance deteriorates considerably. The more long-term structural issues, particularly capacity building of local partners and structures, which would help address long-term structural issues, are neglected.

This is due to a restrictive application of the notion of humanitarian assistance by donors and agencies, and the limited availability of Dutch transition assistance (mostly aimed at the security sector) does not counterbalance the overall effect. It has not been for example possible to continue funding to the ASRAMES' spin off CIF (*Centre d'Information et de Formation)* because a component of the proposal did not fit in the Subsidy Policy Framework and also appeared to be beyond the core business of humanitarian assistance in the Ministry of Foreign Affairs.

There is considerable policy coherence between the different arms of international policies in Burundi and Congo, focusing simultaneously on the alleviation of suffering, and the achievement of stable political transitions which have a direct impact on the well-being of the population. The Netherlands has played a very constructive role in this respect. This is due to the combination of funding of humanitarian aid, demobilisation and peacekeeping with diplomatic action.

The instruments available in the emergency response sector (significant logistics, short-term projects, outcomes designed in a return to "status quo ante") are of low relevance to mitigate structural vulnerability. The question of how to better deal with this situation is effectively postponed to a later date, when public governance and development aid will resume.

There is only a gradually emerging awareness in the humanitarian aid system for a two track approach (situational and structural) and the possibility of passing from one to the other. Linking Relief, Rehabilitation and Development, which is considered good practice in humanitarian aid, is still not secured for lack of general (all donor) funding. Linking Development, Rehabilitation to Relief (in other words a shift back from development to relief) is not foreseen by donors such as ECHO and OFDA, yet the shift from stability to crisis occurs frequently on the ground because some structural issues go unaddressed. Since the Netherlands co-funds some projects with these donors, it finds itself caught in the general weakness of the system even though it has developed more flexible funding.

There is no incoherence but yet a small gap between institutions dealing with peacekeeping, political mediation, and humanitarian aid. The connections take place through work in the security sector, but not at the level of management of transition. The aid community lags behind the political dynamics such as the demobilisation process, because of the absence of coordination fora (absent for rehabilitation in Burundi for example).

However the peacekeeping missions in Burundi and DRC have had a globally positive effect on the sense of stability among the population, with the exception of Ituri Province, Congo since 2004 where evidence collected in interviews points to the fact that the peacekeeping mission is one of the forces engaged in military action. Humanitarian space is often very limited by insecurity, but well negotiated through a structured process. The UN has drawn the lessons from integrated missions of the past, with improvement in coordination. The peacekeepers are able to expand the humanitarian space of the agencies, rather than increasing the constraints as has been the case frequently in the nineties.

Regional planning for programmes takes place only to a limited extent at the embassies and the Ministry in The Hague and even less so among the agencies. The evaluation team found that UNHCR's recent activities in relation to repatriation in Burundi is an exception.[1] The reduction in food rations in Tanzania, for example, is acting as an encouragement to repatriation even though there is at the moment of the evaluation no official policy of the UN of encouragement of repatriation.

1.5 Conclusions and Recommendations

A number of conclusions follow from the above findings. The first is that Dutch humanitarian assistance to Burundi and the DRC has been relevant and effective, in terms of Dutch policy as well as the (general) needs on the ground. Through an integrated approach it combines the funding of life-saving humanitarian activities

[1] This view is not shared by DMV/HH, which sees WFP with its Protracted Relief and Rehanilitation Operation for the Great Lakes region as one of the rare examples of regional planning.

with support for peace negotiations and support to create stability through Security Council mandated peacekeeping forces in the region. There is a strong connectedness between humanitarian aid and conflict resolution.

Second although not all humanitarian activities succeeded in achieving all their objectives, they have been able to meet most of the needs of the people reached and have saved lives. Overall, Dutch-supported humanitarian activities have succeeded in narrowing the gap between relief, and rehabilitation and development. The evaluation team established that many of the interventions it scrutinised were able to pursue activities that take the longer-term issues into account. Examples are the gradual phasing-out of food relief in favour of support to foster food security, and health programmes and projects that also focus on building the capacity of local health structures. In sum, the 'humanitarian plus' approach has combined the provision of immediate relief and the contribution to initial rehabilitation.

The third conclusion relates to the longer-term outlook. It may be assumed that normal and stable conditions may return in Burundi and the DRC in due course. However, this may take a considerable time in Burundi and even longer in the DRC, which implies that humanitarian assistance will be required for some time, although its nature and direction will progressively change from relief to rehabilitation. Besides humanitarian assistance, the Netherlands is also providing support for reconstruction in both countries. The reconstruction activities are not financed from the humanitarian aid budget but from the Stability Fund and the Theme-based Co-financing Fund for rehabilitation (TMF). Both funds have until now mainly been used to finance activities promoting security sector reform and the disarmament and demobilisation of former combatants and their reintegration in society. Since the Netherlands has no structural bilateral development relations with Burundi or the DRC, no other major funding mechanisms are available to support economic recovery in either country. As a consequence, Dutch policy and modes of financing for Burundi and the DRC do not offer sufficient prospects for the provision of long-term economic assistance to populations which have been caught up in prolonged conflict and face largely collapsed public services. On the one hand, this may be considered a missed opportunity. On the other, it may be argued that other donors who have traditionally had a bilateral relationship with Burundi and the DRC may be better placed to provide such assistance.

The fourth conclusion is that the regional approach envisaged for the Great Lakes Region (Dutch assistance to Burundi and DRC that focuses mainly on resolving and preventing conflict and restoring governance – and debt relief in the case of the DRC) should resolve the crisis in the long-term. Humanitarian assistance does not feature very prominently in the regional approach, as witnessed by the lack of attention given to humanitarian aid in the policy note for the Great Lakes Region of 2004 and during the regional conference of the Dutch ambassadors and the Director of the Africa Department held in Kampala in September 2005. That conference, in which the Humanitarian Aid Division did not participate, was specifically organised to strengthen the regional approach and regional coordination. Its outcome has not yet resulted in creating a basis for a comprehensive approach that could bring about a better linkage between humanitarian assistance and assistance for reconstruction and longer-term development.

Finally, it is concluded that decision-making and monitoring of aid implementation are constrained by the limited staff capacity of the Humanitarian Aid Division and of the embassies in the region. The capacity is not sufficient to conduct the necessary analytical work needed as a basis to achieve fully informed decisions on future interventions. As a result of its limited staff resources, the Humanitarian Aid Division has only one person covering humanitarian issues and activities in Burundi, the DRC and Uganda. Due to the limited resources, the staff at the embassy in Kigali (which also has to cover Burundi) and the staff at the embassy in Kinshasa seem to be involved more deeply in policy matters other than humanitarian aid. The embassies monitor the humanitarian situation in Burundi and in the DRC largely via a wide variety of contacts with other donors, agencies and the government. In contrast to this type of situational monitoring, results monitoring at the implementation level has been weak because of time constraints and the sheer distance between these embassies and the localities where the various interventions are being implemented. This is particularly the case for the embassy in Kinshasa. The embassy in Kigali, which mainly deals with the Dutch development programme in Rwanda, has experienced problems in covering humanitarian activities in Burundi; these were solved in mid-2005 by posting a member of staff to Bujumbura.

The evaluation makes four recommendations. The Netherlands will remain involved in providing a mix of humanitarian and transitional assistance to Burundi and the DRC in the foreseeable future. Depending on how the political stability in both countries progresses, the nature of the support to be provided will gradually change from relief and early rehabilitation, to reconstruction.

- The Netherlands must explore possibilities to improve the management of knowledge of the humanitarian situation at the country level. The Humanitarian Aid Division and the embassies should invest in strengthening their analytical capabilities in order to align these with the ambitions defined by Dutch humanitarian assistance policy. Strengthening their analytical capabilities may enable the Humanitarian Aid Division and the embassies to better integrate information provided by third parties, such as ECHO's network of technical experts in the country, other humanitarian agencies, and donors. In the event that staff resources cannot be expanded sufficiently, the alternative might be to join forces with other donors in order to create a separate capacity to conduct situational monitoring and to monitor the performance of humanitarian interventions.

- Second, in view of the improbability that the Netherlands will enter into a fully fledged bilateral aid relationship with Burundi and the DRC in the foreseeable future, there should be an increase in the funding of rehabilitation and reconstruction activities from the current Stability Fund and the Theme-based Co-financing Fund for rehabilitation (TMF) could be considered. Alternatively, the parameters defining which types of interventions are to be financed from the humanitarian aid budget may be reconsidered, in order to allow the funding of activities that focus on capacity building, structural support to health and social services, and psycho-social needs of a protracted nature.

- Third, the Netherlands should intensify the efforts to strengthen the regional and integrated approach to the Great Lakes Region by better linking humanitarian assistance to simultaneous support for peace building and stabilisation, nation building, reconstruction and economic development. Such an approach would entail designing a comprehensive and flexible package of support consisting of humanitarian and other types of assistance in order to avoid gaps in programming for emergency relief, rehabilitation and development.

- Finally, population-based rather than sector-based approaches currently applied in the needs assessments underlying the CAPs could be encouraged. Such population-based approaches would include all population groups located in a certain area, or particularly vulnerable groups, and would be based on accurate and manageable indicators of key conditions. The different needs of these beneficiaries would need to be taken into account in order to provide them with support in an integrated manner instead of addressing each different need by sectoral projects and programmes.

2 INTRODUCTION TO THE EVALUATION

2.1 Mandate

The Policy and Operations Evaluation Department (IOB) of the Netherlands Ministry of Foreign Affairs (MFA) commissioned Channel Research to implement this empirical evaluation of Dutch supported humanitarian actions in the Great Lakes region, specifically taking place in Burundi as a whole, the Burundian refugee camps in the Kibondo district in Tanzania, and the Eastern provinces of the Democratic Republic of Congo (excluding Ituri).

The evaluation focuses on the Netherlands' humanitarian assistance policy and analyses only activities funded from the emergency aid articles of the humanitarian assistance budget. This is done by looking at a sample of completed and ongoing humanitarian assistance programmes in the three countries.

The study is part of a broader exercise, which as well includes the evaluation of the humanitarian assistance activities funded in Sudan, Afghanistan and Somalia. All studies will flow into a report of the overall evaluation of Dutch humanitarian assistance in the period 2000-2004. The study will contribute to the lessons learning process within the Ministry and provide field level evidence to further develop the Dutch humanitarian assistance policy.

Other activities of the Netherlands, such as the support to peacekeeping operations or diplomatic interventions have not been evaluated. However they have been taken into account as much as they are relevant in the humanitarian context of the crisis in the Great Lakes region.

2.2 Methodology

IOB has provided the evaluation team with a set of sample projects from the three countries concerned (four from Burundi, one from Tanzania, and four from Eastern DRC). According to the Terms of Reference (ToR) these activities have been selected on the basis of an inventory[2]: "The selection represents a cross section of sectors and organisations involved in implementation (UN, ICRC/Red Cross, international NGOs, national NGOs and where appropriate local NGOs). It is not statistically representative, but provides a sufficiently illustrative sample of humanitarian activities supported by the Netherlands."

The sample included four programmes implemented by the UN (OCHA, FAO and UNDP in Burundi, and WFP in Congo), four projects implemented by Dutch NGOs (Cordaid in Burundi, Care Netherlands in Tanzania, World Vision Netherlands, and Save the Children Netherlands in Congo), and one project implemented by a local NGO (ASRAMES in Congo)[3]:

[2] See Annex 2.

[3] Details of the Programme matrix are available from Channel Research.

Programme/project title	Sector	Agency	Country
Community Assistance Umbrella Programme (Socio economic rehabilitation and income generating activities)	Multi sector	UNDP	Burundi
Emergency supply of essential agricultural inputs to rural households affected by displacement, climatic hazards and precarious living conditions	Agriculture	FAO	Burundi
Coordination of Humanitarian Assistance	Coordination	OCHA	Burundi
Basic health care programme supporting health centres in Burundi (medicine supply, training)	Health	Cordaid	Burundi
Community services and education	Multi sector	Care NL	Tanzania
Drug distribution Programme	Health	ASRAMES	DRC
Emergency Health Programme	Health	Save the Children	DRC
Kirotshe Health and Nutrition Programme	Health	World Vision	DRC
Protracted relief and recovery operation for war-affected victims and vulnerable groups	Food	World Food Programme	DRC

These sample projects were analysed in detail according to the ToR with regard to the OECD-DAC evaluation criteria:

Relevance

Was the humanitarian assistance provided to Burundi and the Eastern DRC in line with the humanitarian policy and procedures of the Netherlands, as well as the needs, priorities and rights of the affected populations?

Effectiveness

To what extent did the humanitarian assistance provided to Burundi and the Eastern DRC achieve its purpose?
What have been the wider effects of the Dutch humanitarian interventions in Burundi and the Eastern DRC?

Efficiency

Were the financial resources and other inputs efficiently used to achieve results?

Connectedness

To what extent have the humanitarian activities taken into account the specific context in Burundi and the Eastern DRC with its longer-term and interconnected problems?

Coherence

Are humanitarian policy and programming at field level in Burundi and the Eastern DRC coherent with those of other actors?

Co-ordination

How effective has co-ordination at policy, strategic and implementation levels been?

The analysis of each programme was done on the four analytical levels of the evaluation: policy level, agency level, delivery level, and population level. The fundamental premise of the team is that the support provided by the Ministry may contribute to a variety of positive outcomes, for the beneficiary population, naturally, but also in terms of facilitating delivery, strengthening the agencies, and increasing policy effectiveness:

- **Population level**: the evaluation team collected verifiable empirical evidence of conditions of the population directly affected by the programmes supported, through five area-based assessments. These locations were selected according to the sample and included: Makamba province in Burundi, refugee camps in Kibondo district in Tanzania, and then Uvira (South Kivu), Kalemie (North Katanga) and the Goma (North Kivu) areas in Eastern DRC.

- **Delivery level**: the team reviewed the specifics of delivery in the four areas, extending from the entry point (national capital or regional city) to the population itself. This review took into account the technical standards (appropriateness and timeliness of supplies, quality of targeting, risks and opportunities of beneficiary participation as they are assessed and developed by the agencies whose activities were included in the evaluation), and the information flow from the field upwards. Logistic bottlenecks or strengths were also reviewed. Again, the starting point for the assessment were the activities funded by the Dutch government through its partners (UN and NGOs) represented by the sample projects provided by IOB.

- **Agency level**: the evaluation analysed the central tenets of the aid management chain, which is where there is a centralisation and synthesis of the needs assessments in the field, and international capacity is gathered and developed over time. The team in particular analysed the degree to which the agencies were able to target the specific needs of the population in fast changing and complex situations. Special attention was given to the assessment of a possible value added by the often long management chain.

- **Policy level**: the evaluation analyses the policy approach of the Dutch MFA and the appropriateness of the humanitarian aid policy. It examined the so-called policy and interface issue between humanitarian aid and other instruments deployed or supported by the MFA, including peacekeeping, mediation, and multilateral bodies such as the largely Dutch funded Multi Country Demobilisation and Reintegration Programme.

Additionally the following special issues were taken into consideration and are dealt with in the above mentioned sections:

- Security, protection and humanitarian access
- The gap-issue: Linking relief, rehabilitation and development
- Co-ordination and coherence of humanitarian assistance
- Quality, Accountability and Good Humanitarian Donorship

2.3 Execution

Channel Research's evaluation team included nine evaluators with the following specifications:

- Expertise in humanitarian aid, UN coordination, rural development, psycho-social assistance, and of course evaluations.
- Three women (the senior experts) and six men (team leader and support personnel).
- Eight different nationalities (Burundian, Congolese, Togolese, Dutch, French, Swiss, British, German).

The evaluation was divided into three main phases:

1. Inception Phase (June-July 2005)

During the Inception Phase the team undertook a comprehensive desk study, prepared a detailed matrix for each of the sample programmes, did first interviews (in the Netherlands and by telephone), and specified the evaluation scope and questions.[4] The desk study was used to carry out a comprehensive survey of the files of the sample projects and programmes obtained from the MFA and from the NGOs. The sample projects and programmes were analysed in terms of objectives and sub-objectives, target group, locations, sources of funding and amounts, and achievements as these have been recorded. This initial analysis served as a basis for the subsequent field work. The output of this phase was an Inception Report (dated 15 July 2005), which has been sent to IOB and to the agencies involved in the evaluation prior to the field work.

In-depth interviews have been carried out with key MFA personnel in The Hague, Kigali, and Kinshasa In spite of repeated efforts it was not possible to make contact with the Embassy in Dar es Salaam.

2. Field Mission (6-24 August 2005)

The field mission started with a briefing at the Netherlands Embassy in Kigali, continued in Burundi and Tanzania and ended in Eastern DRC.[5] Due to time constraints and logistics the team split up during the field mission. To ensure a common approach and constant sharing of information the team met regularly for joint sessions (in Kigali, Bujumbura, Bukavu and Goma).

Locations of joint and separated team visits:

<table>
<tr><td colspan="3">Kigali/Bujumbura</td></tr>
<tr><td>Kibondo (Tanzania)</td><td>Makamba (Burundi)</td><td>Bujumbura (Burundi)</td></tr>
<tr><td colspan="3">Uvira, Fizi, Bukavu (DRC)</td></tr>
<tr><td colspan="2">Kalemie (DRC)</td><td>Goma (DRC)</td></tr>
<tr><td colspan="3">Goma/Kigali</td></tr>
</table>

joint visits separated visits

[4] See detailed list of interviews and locations in Annex 2
[5] Ibid.

Methods of data and information gathering were mainly semi-structured interviews and other relevant PRA methods when in the field, direct observation, and the review of formal reports, texts, and internal memoranda, provided to the team either directly by IOB, by other staff of the Ministry or by the agencies.

The team conducted about 115 interviews with aid officials and the population, and visited 24 project sites. Out of the 115 interviews 30 were done in with groups with a group size of 3-18 (average 5).[6] Some of the interviews were carried out by telephone. Interviews were either conducted in French, English, or in one of the local languages, occasionally in the presence of the operational agencies. Where translation was necessary either the local team members translated directly or staff of agencies or representatives of the beneficiaries provided translation services to the team.

In July 2005 an independent evaluation was commissioned by World Vision international (WVI) to assess its North Kivu assistance programme over the past two years. WVI made available the draft evaluation report to the Channel Research evaluators and indicated that, further to consultations with the Foreign Ministry of the Netherlands, the latter were of the opinion that no further evaluation of the same activities would be necessary by the Channel Research team. In light of this new information, the Channel Research evaluators decided to limit their evaluation of WVI to a few of the essential points emanating from the WVI evaluation and to pay attention to an in-depth examination to the strategic value of the intervention covering the past four and a half years of MFA funding. The current evaluation focuses on feeding/nutritional programmes strategy and impact, food security and phasing-out strategies employed by WVI, and has not examined the health (EPI) aspects of the programme.

At the end of the mission a debriefing was held for IOB and the staff of HMA in Kigali.

The output of this phase in an Aide Mémoire, dated 23 August 2005, destined for the Ministry of Foreign Affairs.

The main constraints faced by the team were in the number of locations selected in the ToR. As a result some programmes which occupy a minor position (for example SAEU: 3 % of the total expenditure for Burundi[7]) absorbed a significant number of person days (14 for SAEU) due to the time taken by logistics. The time spent travelling (in difficult conditions) limited the interaction with the population.

Another constraint in the sample selected for the evaluation is the fact that activities focusing on human rights protection and protection under international humanitarian law were not included. In fact none of the agencies covered by the evaluation, with the exception of Save the Children, integrated

[6] See detailed list of interviews and locations in Annex 2.
[7] See ToR in Annex 1.

this work in their mandate. Protection, however, is a significant dimension of humanitarian action in the Great Lakes region.[8]

3. Synthesis Phase (September-October 2005)

During the Synthesis Phase the team undertook additional desk research, prepared the draft Final Report, and undertook further interviews (in Kinshasa and by telephone). The agencies whose activities were evaluated were given the opportunity to comment on the draft report. Comments were received from Cordaid, ASRAMES, World Vision, FAO, OCHA, Care, and Save the Children.

For each sample programme one lead writer within the team was nominated together with one co-writer. The programme related sections serve as the basis for the chapters about the four evaluation levels, which are written by the Team Leader who also has the overall responsibility of the report. A senior expert was responsible for quality assurance, which took place during the reporting phase of the study.

3 CRISIS IN THE GREAT LAKES REGION

The instability which occurred from 1993 till today in the Great Lakes regions led to the most severe humanitarian crises of the period 2000-2005. The starting point goes back into the history of the formation of states, access to natural resources, and imbalances in ethnic relations. It has been amply described in other fora, so will be given only limited space here.

3.1 Burundi

In the last ten years, two political processes have run in parallel in the country: the violent struggle for power between leadership and ethnic groups that started in 1993 with the assassination of the first democratically elected Hutu president (with a strong element of intimidation of the population or forced movements), and the peace process, which began officially in Arusha in June 1998. The Arusha process, which came after the failure of several internally negotiated power sharing agreements, has lasted seven years. The former AU – now ONUB – peacekeeping mission is providing the guarantee for the implementation of these agreements, and leading the international involvement in the crisis.

On November 16, 2003, the government led by President Buyoya signed a ceasefire agreement with the party of Jean-Pierre Nkurunziza. This complemented the ceasefire reached earlier in 2002 with two minor rebel groups (the CNDD-FDD faction led by Jean-Bosco Ndayikengurukiye and the PALIPEHUTU-FNL faction led by Alain Mugabarabona). Following the signing, an African Union force was deployed in the spring 2003, and replaced a year later by a UN peacekeeping force.

[8] The issue of protection will be dealt with in chapters 4.2 and 5.3.1.

Since the signing of the comprehensive ceasefire agreement both sides have demonstrated total respect for the cessation of hostilities. The only rebel movement still in activity is the FNL, located around Bujumbura. The communal elections on 3 June 2005, which led into the presidential elections on 19 August 2005 have been peaceful, and observers are more optimistic now than they have been for the past 15 years.

Yet the social indicators provided by international bodies as the World Bank[9] for Burundi are disquieting. With annual population growth above 1.9 %, Burundi is Africa's second most densely populated country. At the same time the economy has shrunk dramatically (GDP growth is nil, after a rate of 30 % in 1997), over 50,000 people visit nutrition centres every day and over 600,000 people are displaced.[10] The Bank estimates that rural poverty grew by 80 % since 1993. School attendance dropped from 70 % to 44 % over six years. The rates of HIV infection are known to be increasing, although the difficulty of obtaining a reliable diagnosis, particularly in the countryside, means that the level of prevalence is not known.[11] Salaries for civil servants are still being paid by the central government, but the coverage of services has withdrawn from remote rural areas. Private clinics and pharmacies, in addition to INGOs, have effectively replaced the Ministry of Health in many locations. This leads to a sense of gloom and social regression, even of discrimination, making the population more prone to the appeal of militants to resolve the situation by violent means.

Data on humanitarian needs are difficult to generalize, as they change rapidly with the evolution of conflict over the evaluated period, and their empirical basis is weak. A simple but relatively weak indicator of vulnerability is provided by the numbers of internally displaced persons. OCHA provides evidence of a gradual drop in the totals, from 281,000 in 2002 (when fighting was at its worst in the country) to 145,000 in 2004, and dropping since.

The humanitarian aid community in Burundi is now long established, and is composed of a core group of UN agencies carrying out humanitarian and reconstruction work (UNHCR, UNICEF, WFP, FAO, UNDP, OCHA), a large number of international NGOs and Red Cross Movement entities. Logistics and coordination activities are run out of Bujumbura, helped by ease of access to the entire country, which can be crossed by car from one end to the other in half a day. The reviews and evaluations carried out however show a low level of cooperation amongst the UN agencies, and even amongst the donors (see for example the review of the GHD pilot in Burundi conducted in 2004). Many of the donor agencies are operating from outside the country, and are hence dependent on the aid agencies for information and strategic direction.

[9] *Burundi: An Interim Strategy 1999-2001*, Report No 19592-Bu, Macroeconomics Unit 3, Africa Region.
[10] Some reports from NGOs involved in the project refer to higher figures – for example Action Aid Burundi states that 12% of the total population is displaced (report from June 2000).
[11] Rwanda, with a comparable social makeup has 10.8% of the rural and 11.6% of the urban population aged 12 and above as being seropositive, according to DFID statistics (Rwanda Country Strategy Paper, 1999).

3.2 Burundi Refugees

About 240,000 Burundian refugees are currently living in Tanzanian camps along the Burundian border. Another estimated 200,000 live among the local population.[12] Burundian refugees are hosted in western Tanzania in refugee camps, including three near Kibondo. Kibondo District is not a favourable area for self-reliance, as it is one of the least developed of the country. It has a local population officially estimated at 233,000. A Danida report[13] describes the population as 38 % living below the poverty line, with 82 % engaged in subsistence farming. There are practically no tarmac roads in the District, although with an expansion in economic activity (popularly attributed to the refugee presence) there are increasing bus services to Mwanza and Kigoma.

In 2002 UNHCR began a voluntary repatriation programme for Burundian refugees living in the camps in western Tanzanian. Since then more than 200,000 (UNHCR, September 2005) refugees have returned with the assistance of UNHCR. In a tripartite agreement with UNHCR, Burundi and Tanzania it has been decided to close all camps with a refugee population under 10,000 refugees. At the time of the evaluation, the first refugee camp for Burundians, Karago camp was closed; its 5,500 inhabitants were moved to Mtendeli camp.

Despite the assistance in repatriation there is still a high concern among refugees about availability of basic social services in their home country, but most particularly about security and the future of the peace process. Land ownership issues feature highly in discussions.

Increasing evidence tends to show that people in western Tanzania have benefited from the continued presence of refugees, and that environmental degradation, although much feared, has not been extensive. This is however combined with limited investment by the Government, and the continued isolation of western Tanzania.

The foreseeable disappointment of a large number of refugees who will be unable to recover their property in Burundi offers ideal political opportunities for the opponents of the process, and could place the entire transition in jeopardy. The urgent requirement in this situation is to defuse the land conflict trigger through the creation of an innovative transitional judicial process designed exclusively for land management.

3.3 Democratic Republic of Congo

Stability began to replace war at the signature of a ceasefire agreement in Lusaka, Zambia, in July 1999. In 2000 the UN Security Council sent a peacekeeping mission to the Congo (MONUC), with a mandate to use all necessary means to fulfil its mission (Chapter 7 of the Charter). This force has been gradually increased to 15,000, which underscores the degree to which the national government has difficulties exerting its authority over the entire

[12] UNHCR Briefing Note 5 April 2005

[13] "Programme for Refugee Host Areas: Kagera and Kigoma Regions: Final Concept Note, January 2003", PEM Consult for Danida.

country, which is the size of half the EU. The evaluation found evidence of fragmenting military hierarchies in the east, as well as the continued presence of armed groups originating in neighbouring countries.

Congo's transitional government has begun the disarmament, demobilisation and reintegration process for former combatants. Future stability – especially in the Eastern parts of DRC – will highly depend on the willingness of local and national leaders to commit to this process and on the capacity of the public authorities to implement it. Insecurity remains extremely high in the east, both for humanitarian aid agencies and the civilian population, and the evaluation team observed evidence of continued foreign military presence in the area of Goma.

Humanitarian aid agencies have been present in Congo for many years because of the collapse of the health infrastructure and general poverty, but their operations were stepped up in 1993 due to an ethnic conflict in the Masisi plateau (North Kivu), and subsequently by the influx of some two million Rwandan refugees in July 1994. This was followed by international war from December 1996 and the overthrow of the Mobutu regime in early 1997, followed by renewed war affecting mostly the eastern half of the country in 1998. This structured the aid effort into two, reflecting in part the modalities of the Sudan operations, one hub located in Kinshasa, and one in Kigali-Goma. These were often connected to separate regional offices, reflecting two trading and communication routes (one connecting to the outside world through Kampala, Nairobi or Dar es Salaam in the case of WFP, the other through Kinshasa), and to a certain extent reflecting a linguistic cleavage even in the organisations involved.

The resource levels in DRC have been maintained more through political will than international interest. The studies released by NGOs and human rights groups on conditions in eastern Congo, denouncing deaths of up to three million individuals, an epidemic of rape, and the looting of economic assets by criminal organisations, never managed to arouse the sort of attention bestowed to Darfur or to Aceh. The most salient feature of the crisis in international analyses is the UN peacekeeping mission, increasingly considered to be a success. Precise data on the living conditions of the population remains elusive.

The Democratic Republic of Congo (DRC) has had large-scale food insecurity since armed conflicts began in 1996. Conflict involves the non-combatants directly as various armed factions fight for influence and territory. Most of the difficulties of access are in the eastern part of the country where other nations are providing support to some of the armed factions. The resulting insecurity and degraded development infrastructure has had a major impact on malnutrition rates and on school attendance.

According to a national survey by UNICEF, chronic malnutrition rates are 10-15 % in relatively peaceful areas like Kinshasa, and as high as 25 % in eastern areas with high insecurity like the provinces of North Kivu and South Kivu and the Ituri District of Province Orientale.

Gross enrolment rate of school-age children (6 to 11 years) decreases constantly from 117.6 % in 1978/79 to 98.2 % in 1985/86 (of which 70.1 % were boys and 57.8 % girls), then to 56 % in 1995. Note that in 2001, this rate was 52 % (55 % boys and 49 % girls). This average covers significant gaps. For example, between areas under government control (Kinshasa: 77 %) and areas under rebel control (North Kivu 34 %) for); and, between well-to-do households (81 %) and poor households (39 %).[14] The activities related to the improvement of nutritional status and the prevention of epidemics and HIV/AIDS have been reported in the documentation provided to the evaluation team as very successful. On the other hand the activities related to the strengthening of the health structures, which fall into the 'grey' area of rehabilitation assistance, progressed more slowly because of periods of high instability and security problems.

4 DUTCH RESPONSE TO THE CRISIS

4.1 Dutch Humanitarian Aid Policy

The objective of Dutch humanitarian assistance is to "contribute to the relief of life-threatening human needs, in particular those of women and children".[15] The Ministry of Foreign Affairs through its Humanitarian Aid Division (DMV/HH) is responsible for the Dutch official response to humanitarian disasters, either man-made disasters (war, attacks, explosions) or natural (earthquakes, hurricanes, and floods). The Ministry differentiates between two forms of crisis, the one being long-lasting or protracted crisis and the second being acute emergency situations.

The following **international humanitarian aid principles** are applied[16]:

- "the humanitarian response to crises is exclusively motivated by a desire to alleviate the suffering of the most vulnerable in the affected zone (the humanitarian imperative);
- humanitarian aid should always be adapted and tailored to local circumstances and customs, in order to build existing capacity and self-sufficiency and prevent donor dependency;
- humanitarian aid should be impartial: it should not be used to promote political or other external agendas, and should be provided without discrimination on the grounds of race, religion, political conviction, gender, etc;
- humanitarian aid should be free of political influence (from the Netherlands or the country concerned);
- in a conflict situation, the sovereignty of the country concerned should be subordinate to the need for providing unhampered and impartial humanitarian aid, which relies on free access to the affected population;
- humanitarian aid should be demand driven, not supply driven."

[14] *UNICEF/USAID/DRC government, Enquête nationale sur la situation des enfants et des femmes , MICS2/2001*

[15] Subsidie kader Humanitaire Hulp en annexen, MFA, 2004

[16] Grant policy framework for humanitarian aid 2005

The Dutch humanitarian aid policy states a coordinated approach and foresees close cooperation with the UN agencies, which means that funding goes through the CAP. To promote the coordination of international aid activities, the Ministry urges implementing organisations to actively participate in de UN coordination structure (and funds the UN coordination body OCHA) and coordinate their activities with other NGOs.

In practice, the Ministry follows a responsive approach, which takes place under a number of guidelines. The desk officer receives funding proposals for humanitarian aid programmes and decides about the funding on the basis of his own knowledge of the crisis and on advice from the embassy responsible for the concerned country. The embassy in Kigali, Rwanda is responsible for the assistance to Burundi but not for the Burundian refugee camps in Tanzania, which fall under the responsibility of the embassy in Dar es Salaam, and not for eastern DRC, which falls under the responsibility of the embassy in Kinshasa.

A number of decision criteria apply, of which some are:

- Proposals should contain a detailed investigation of needs and a clearly defined target group. The Ministry does not finance the costs of identification missions to investigate needs which are intended to test the capacity of the organisations.
- Long-term projects are not funded but it is in principle possible to submit proposals with a maximum duration of 24 months (this is possible in the cases of Burundi and DRC). This "streamlining" is supposed to reduce the work load of MFA staff. In 2006 there will be an evaluation of this practice.
- In protracted crises, priority is given to continuing relevant activities rather than funding new ones. The nine sample projects, which were analysed in detail in this evaluation, were funded for at least the last two years. In the case of the project implemented by ASRAMES and the refugee camps in Tanzania the funding goes back to 1998.
- Clearly defined activities should be matched with expected results, aims, instruments and indicators.
- Attention should be paid to the gap between humanitarian aid and rehabilitation; special attention should be paid to the gap problem in countries that qualify for Theme-based Co-financing (TMF) rehabilitation and in areas where TMF activities are carried out.
- The project proposal should contain an exit strategy.

According to the Kigali embassy the time and staff resources at the embassies are not sufficient to perform proper monitoring of projects. The embassy's role is limited with regard to influencing humanitarian aid flows. The embassy's staff does not have neither the time, nor the expert knowledge to advice on programme details or sector specific issues.

The headquarters in The Hague are also staffed with only one desk officer responsible for the Humanitarian Assistance to the Great Lakes region. There are no formal coordination mechanisms such as regular coordination meetings between the different departments in the MFA (humanitarian aid, peace-building and development, policy advice) although there is an informal

information exchange on ad hoc basis. Desk officers from different units call each other or ask for a meeting in case they see a need for coordination or information exchange. Parties wish for a more structured and formalized coordination, which is part of the working procedures of the Ministry.

Until 2003 NGOs could send requests for funding at any time of the year. In 2004 the procedure has been changed and NGOs now send their proposals in November/December so that the projects can start in following January. This goes in line with the GHD initiative, where donors are asked to spend their funds in the first part of the year.

Emergency food aid is mainly (and in Burundi and Eastern DRC exclusively) channelled through multilateral organisations.

The Netherlands seeks to apply a regional approach in the Great Lakes region.[17] The aim is to contribute to conflict resolution, conflict prevention, and good governance. The focus lies on the promotion of security and stability. The Dutch government supports peacekeeping and reconciliation initiatives and engages in political dialogue with governments, at national and regional level. A key element in this process is the support to demobilisation, disarmament, reintegration and security sector reform. These activities fall under the responsibility of the MFA staff dealing with policy and development and the regional approach does not include humanitarian assistance. As stated above there is not enough coordination with DMV/HH, which also contributes to the fact that this regional approach is fewer reflected in the activities funded by DMV/HH.

However only with Uganda and Rwanda are there bilateral relations that allow structured cooperation on a long-term basis. In Burundi and in DRC, the Netherlands is limited to the support of the peace process, to provide humanitarian assistance and contributing to demobilisation and reintegration. Due to the expectations that arise from entering into bi-lateral relations MFA is reluctant to formulate any policy, event short-term for these countries.

The Netherlands is, according to the UN financial tracking system, one of the biggest providers of humanitarian aid to Burundi, (together with the European Commission, the United States, Sweden and the United Kingdom), and to the Democratic Republic of the Congo (together with the EU, the United States, Belgium and the United Kingdom) – see Consolidated Appeal 2005 below.

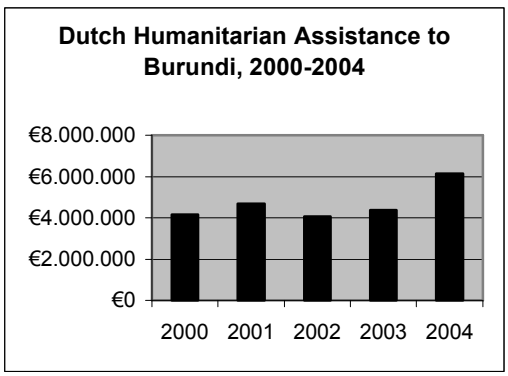
[17] Grant Policy Framework for humanitarian aid 2005; Region Annex 2005: Great Lakes (Burundi, Democratic Republic of Congo).

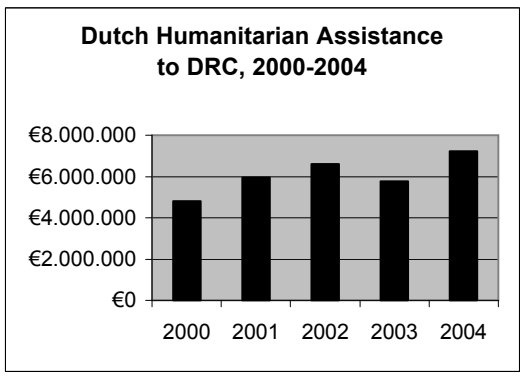
Donor – as of Sept 2005[18] BURUNDI	Commitments/ Contributions US$	% of Grand Total
United States	11,801,855	21.4 %
ECHO (European Commission)	11,128,024	20.2 %
Allocations of unearmarked funds by UN	7,144,414	13.0 %
Netherlands	**4,034,000**	**7.3 %**
Sweden	3,768,691	6.8 %
United Kingdom	3,701,273	6.7 %
Belgium	3,652,190	6.6 %
Norway	3,588,495	6.5 %
Canada	1,440,986	2.6 %
Japan	1,000,000	1.8 %
Finland	882,040	1.6 %
Germany	757,799	1.4 %
Italy	736,981	1.3 %
Private	523,613	0.9 %
Switzerland	416,667	0.8 %
Luxembourg	265,252	0.5 %
Ireland	124,378	0.2 %
France	100,000	0.2 %
Austria	67,592	0.1 %
Grand Total:	**55,134,250**	

[18] Total Contributions per Donor (to projects listed in the Consolidated Appeal for 2005) (carry over not included) as of 13-September-2005; http://www.reliefweb.int/fts.

Donor-as of September 2005[19] DRC	Commitments/ Contributions US$	% of Grand Total
United States	32,416,908	27.3 %
Allocations of unearmarked funds by UN	15,944,839	13.4 %
United Kingdom	12,934,218	10.9 %
ECHO (European Commission)	10,945,726	9.2 %
Belgium	9,744,981	8.2 %
Canada	8,552,931	7.2 %
Japan	5,623,005	4.7 %
Netherlands	**4,482,122**	**3.8 %**
Sweden	4,087,026	3.4 %
Norway	2,904,892	2.4 %
Italy	2,864,805	2.4 %
Finland	1,636,388	1.4 %
Private	1,381,749	1.2 %
France	1,358,701	1.1 %
Germany	1,319,512	1.1 %
Denmark	818,350	0.7 %
Ireland	738,755	0.6 %
Luxembourg	530,504	0.4 %
Switzerland	397,000	0.3 %
South Africa	59,271	0.0 %
New Zealand	53,856	0.0 %
Saudi Arabia	15,945	0.0 %
Grand Total:	**118,811,484**	

Dutch Humanitarian Assistance to Burundi and DRC per year, 2000-2004[20]





[19] Total contributions per donor (to projects listed in the Consolidated Appeal) (carry over not included) as per 13 September, 2005; http://www.reliefweb.int/fts.

[20] Source: Terms of Reference for the evaluation.

During 2005, the Netherlands funds generally the same sectors and themes in Burundi and DRC as in 2000-2004 (see section 4.2). Unless mass repatriations of Burundian refugees in Tanzania make another form of support necessary aid to the refugees in the camps will continue.

Geographically Dutch humanitarian aid to Burundi concentrates on Bujumbura Rural provinces and on the provinces bordering Tanzania, where returnees from Tanzania will be arriving in the future.

The provinces receiving aid from the Netherlands in DRC are North and South Kivu, Maniema and the Ituri district.

Although Humanitarian Aid is perceived as remaining necessary in Burundi and DRC, Dutch assistance strategy foresees a shift from emergency to more structural activities without creating false expectations. At present there is no possibility for bilateral relations. Currently, the Netherlands is considering how to remain involved in supporting Burundi in the coming years. A policy has not been formulated however.

In the health sector special attention is given to the active involvement by the population. Furthermore the access of the most vulnerable groups should be improved.[21]

4.2 Sectors funded

In principle, all forms of aid can be provided, but according to the Dutch policy there is a focus on a number of sectors. In Burundi and DRC the funding to these sectors is between 40 and 53 % of the total funding:

Sectors supported in Burundi and DRC, 2000-2004

Sector	Burundi		Democratic Republic of Congo	
	Expenditure	Percentage	Expenditure	Percentage
Multi-sector	€9,463,555	40.41	€10,594,923	34.83
Food aid	€3,607,783	15.41	€6,639,436	21.82
Agriculture	€2,713,014	11.59	€1,375,217	4.52
Psychosocial care / Trauma processing	€2,311,887	9.87	---	---
(Reproductive) Health care	€2,265,616	9.67	€7,835,855	25.67
Coordination and support systems	€1,425,248	6.09	€3,474,675	11.42
Income generation / Employment	€700,000	2.99	---	---
Education	€600,171	2.56	---	---
Repatriation	€309,515	1.32	---	---
Protection	€21,418	0.09	€278,785	0.92
Shelter			€224,099	0.74
Total	€23,418,207	100.00	€30,422,990	100.00

Source: Management Information System of the Ministry of Foreign Affairs

[21] Grant policy framework for humanitarian aid 2005, Region annex: Great Lakes, Burundi, DRC.

In Burundi The Netherlands is the lead donor in some sectors, such as protection (with ECHO-and although less than 1 % of the Dutch funding is spent for protection) and coordination (with UK). It ranks very low in health, and multi-sector. In DRC the Netherlands also leads on coordination and protection funding with Ireland and the UK, while it is the seventh largest donor both regarding funding through the CAP and outside, meaning directly to agencies (taking into account ToR figures, divided annually, for the latter).

4.3 Types of organisation supported

Emergency food aid is mainly (and in Burundi and Eastern DRC exclusively) channelled through multilateral organisations and in particular through WFP and UNICEF. The Dutch humanitarian aid policy states a coordinated approach and foresees close cooperation with the UN agencies (funding through the CAP, assistance to OCHA), the International Committee of the Red Cross and NGOs. To promote the coordination of international aid activities, the Ministry urges implementing organisations to actively participate in the UN coordination structure and coordinate their activities with other NGOs.

Types of organisation supported in Burundi and DRC, 2000-2004

Type of organisation	Burundi	DRC
Multilateral organisation	72.60 %	55.67 %
Dutch NGO	27.08 %	25.90 %
Other[22]	0.13 %	-
NGO in other donor country	0.19 %	-
ICRC[23]	-	8.95 %
Local NGO	-	8.49 %
Dutch Red Cross	-	0.99 %
Total	100 %	100 %

Source: Management Information System of the Ministry of Foreign Affairs

The Ministry finances the activities of NGOs that fulfil a number of criteria, of which some are for example the experience and track record in the areas concerned, proven knowledge and expertise in the relevant field, sufficient implementation and management capacity, and the involvement in coordination, in particular with the UN. The organisations also must have a positive assessment on the *Checklist for Organisational Capacity Assessment* (COCA) of the organisation's structure, strategy and financial capacity. For the cases Burundi and DRC the regional policy states explicitly:

> "Knowledge and experience of the complex nature of the conflicts and/or post-conflict situations in both countries will (…) play a key role in the evaluation of grant applications. Preference will be given to NGOs/INGOs that identify and implement their projects or

[22] Royal Netherlands Embassy in Kigali.

[23] In the period 2000–2004, ICRC spent €1,866,938 from Dutch contributions in Burundi; the figure for the DRC was €6,835,890. This information was provided by the External Resources Division of ICRC, since the Netherlands does not earmark its annual contributions to ICRC at country level; this disaggregated information does not appear in Ministry's management information system.

programmes in close collaboration with national NGOs, thereby substantially increasing the chances of sustainability."

The Ministry has a good contacts with the Dutch NGOs and there is a fruitful exchange on aid programming. During interviews especially those Dutch NGO partners whose core work is development work or assistance during the transition phase showed only week knowledge about working principles of the Humanitarian Aid division on the Ministry's side. According to the Ministry there should not be any Dutch "briefcase organisation" that just channels funds to local partners without much added value. However the added value of some of the international partners in the project sample that has been analysed in this study can be questioned (see section about project samples).

The Netherlands rarely finances the activities of local NGOs directly (funding to the Congolese NGO ASRAMES located in Goma is an exception). The channelling of funds through international NGOs to local NGOs is supposed to help to build local capacity and increase the sustainability of the activity as a result. Furthermore, local partners shall contribute towards the exit strategy of humanitarian aid organisations and a solution to the 'gap' problem. The success of this approach is limited as can be seen in the samples analysed for this evaluation (see section 4.4 for the profiles of the sampled projects).

The Netherlands is one of the biggest donors in the World Bank's Multi-Country Demobilization and Reintegration Program (MDRP) for the Greater Great Lakes Region. The programme seeks to enhance the prospects for stabilization and recovery in the region. The MDRP is financed through two separate but complementary windows: World Bank/IDA funds of up to US$150 million and a Multi-Donor Trust Fund (MDTF) of US$350 million. The Netherlands is committed to a contribution of US$ 100 million. This funding is not part of the humanitarian aid budget and also not the subject of this evaluation. However the demobilization process is of importance for the humanitarian situation and will be dealt with in this study where relevant.

MDRP Trust Fund - Donor contributions (receipts as of 30. June 2005)[24]:

Donor	**US$**
Netherlands	39.275.743
UK	15.000.000
Canada	11.172.191
Belgium	10.992.483
European Commission	10.916.000
Germany	5.883.708
Norway	3.533.070
Denmark	2.486.188
Sweden	2.190.820
France	2.078.600
Italy	1.714.050
Total	**105.242.853**

[24] MDRP Progress Report April to June 2005.

The Burundian government has established the National Commission for Demobilization, Reinsertion and Reintegration (NCDRR). The overall programme costs are estimated with US$ 84,4 million.[25]

The Transitional Government of the DRC established a national framework for Demobilization, Disarmament and Reintegration (DDR) in December 2003. The national commission for DDR –CONADER– is the implementation body, whose work is linked to joint decision making with military authorities in the region. The overall programme is expected to cost US$200 million for the demobilisation and reintegration of 150.000 ex-combatants.[26] With funding from the government of the Netherlands, South Africa is presently supporting operational "brassage" ("integration") sites in Mushaki and Nyaleke in North Kivu.

4.4 Project Profiles

The evaluation includes a sample of completed and ongoing humanitarian assistance operations in Burundi, as well as in eastern DRC. As mentioned these projects and programmes were selected on the basis of an inventory of activities and represents a cross section of sectors and organisations involved in implementation (UN, ICRC/Red Cross, international NGOs, national NGOs and local NGOs). It is not statistically representative, but provides a sufficiently illustrative sample of humanitarian activities supported by the Netherlands.

In both DRC and Burundi, the UN organisations are the most important partners in delivering Humanitarian Aid at local level. Dutch NGOs and Local NGOs are implementing partners of the UN, indirectly benefiting from Dutch project funding.

In Burundi, International Non-Governmental Organisations (INGOs) are directly involved in the implementation of Humanitarian Aid. Local NGOs (LNGOs) cannot directly get support from the Dutch Government. In DRC, Dutch policy is supporting INGOs that work through LNGOs and other civil society organisations, such as associations.

At the aid beneficiary level, Dutch Humanitarian Aid in Burundi and Tanzania arrives in IDP and refugee camps (the case of CORDAID and CARE NL in Tanzania), as well as in villages where refugees and IDPs are returning (UNDP programme). Targeted categories of beneficiaries of Dutch Humanitarian Aid also seem to include vulnerable people, who are not displaced. One example is CORDAID, which is supporting Primary Health Care Centres.

In DRC, the Dutch Humanitarian Aid (targeted to all vulnerable people) arrives at the level of Health Centres (ASRAMES, SC) and Feeding Centres (World Vision). The aim is to work closely with the local population and structures to respond to urgent crisis situations and to prevent health and nutrition emergencies. Emergency interventions are linked to capacity building of local organisations and personnel involved in health and nutrition.

[25] MDRP Country Profile Burundi, www.mdrp.org.
[26] Ibid.

These different channels (although under the same policy framework for all three countries) highly influence whether the aid arrives at the level of the target group who most needs the aid, as well as the way in which the aid is put to use.

Information about programme budgets in the following tables is based on the figures given to the evaluation team in the ToR and on the Ministry of Foreign Affairs documentation made available to the evaluation team.

UNDP Community Assistance Umbrella Programme (CAUP), Burundi

Programme Title	Community Assistance Umbrella Programme (CAUP)
Sector	Multi-sector
Organisation	United Nations Development Programme (UNDP) Multi-lateral
Objectives / Sub-objectives	Reconstruction and Rehabilitation of family homes, social infrastructures, income generation with the aim to enable Burundians to lead sustainable and self-determined livelihoods. Facilitating access to primary education. Access to agricultural inputs, sustain agricultural production capacities. Access to basic health care, improve general health conditions and cut down mortality. Provide shelter and improve hygiene conditions of most affected population.
Target group/beneficiaries	The most vulnerable: Women, IDPs, unaccompanied children (in a rural context)
Location	Mwaro, Kirundo, Karuzi, Gitega, Muramvya Muyinga, Kayanza, Karusi, Gitega Ngozi
Start date - end date	01.01.2002 – 31.12.2004
Total budget[27]	US$ 26,535,736
Funds provided by the Netherlands	€2,719,000

UNDP started its PCAC in 1999 for an initial period of two years. The main thrust of the first phase of the programme was to improve the livelihoods of communities hosting large numbers of internally displaced persons (IDPs), with special focus on the IDPs themselves, returnees and vulnerable members of the community, through increasing accessibility to housing, education, health services, potable water and improving the management capacities of the communities. A second phase of the programme (PCAC II) was initiated for the period 2002-2004 with broadly similar strategies to ensure continuity in ongoing projects. A new phase was scheduled to begin in 2005 but has had problems identifying a project manager and has thus far only succeeded in drafting four concept documents. It is entitled « Le programme d'appui à la réintégration/réhabilitation des sinistrés dans le cadre de la lutte contre la pauvreté » and constitutes a move towards addressing Millennium Development Goals.

[27] Total donor contributions 1999-2005 (PCAC 1&2), figures provided by UNDP Burundi.

According to Steering Committee reports, the MFA financial contribution to the UNDP Trust Fund managing the PCAC covered approximately 20 % of all activities throughout the period 1999 – 2004 (the USA was the biggest donor: 35 %). Most donors provide funding on a yearly basis whereas the MFA policy to finance on a two-yearly basis is much appreciated by UNDP, allowing for longer-term planning of its multi-year activities. MFA policy to provide unearmarked funds has also helped the agency to fill gaps in funding, whereas other donors have earmarked their contributions. In some – but not all - reports provided by UNDP, it is possible to trace the origin of funds for specific projects, but in the progress reports provided it was impossible to compile a coherent picture of MFA contributions over the two phases of the PCAC. It has therefore not been possible to analyse MFA funding trends throughout the lifespan of its contributions.

Repair or reinforcement of community infrastructure such as schools, roads and health centres – many of which were damaged in the conflict or dilapidated due to lack of resources for upkeep – has helped communities to deal with newly displaced or returning populations. The integral approach, aiming at not only repairing infrastructure but also – through related activities – ensuring their functioning, is supposed to cement improving conditions for these communities and safeguard investments by getting the project sites back in working order (providing supplies and equipment, ensuring deployment of professional personnel, etc.). The PCAC as a 'bridging project' is being implemented in several other countries (e.g. Eritrea and Rwanda) and, with closer coordination between UN Agencies and NGOs, could well become a model for transition phases.

OCHA Coordination of Humanitarian Assistance, Burundi

Programme Title	Coordination of Humanitarian Assistance
Sector	Co-ordination and support systems
Organisation	OCHA Multilateral
Objectives / Sub-objectives	Support the strategic and operational relief coordination.
Target group/beneficiaries	UN, NGOs, LNGOs, Government
Location	Not specified in contributions; focus on activities in Bujumbura Rural Province (specifically Bujumbura town, HQ OCHA) and Bururi Province.
Start date - end date	01.01.2002 - 31.12.2005
Total budget	US$3,408,170
Funds provided by the Netherlands	€1,249,600

The Dutch government is supporting OCHA with non-earmarked contributions from 2002 to 2004.

OCHA plays a key role in examining and addressing the daily challenges to humanitarian assistance in Burundi. Among others OCHA is undertaking rapid assessments of population needs, negotiates for the change in national health protocols, and does daily coordination (UN/NGO contact and other inter-agency planning forums, thematic groups and provincial Focal Points meetings). OCHA participates in the early warning systems on food security, SAP-SSA (*Système d'Alerte Précoce – Surveillance de la Sécurité Alimentaire*), which has been established by FAO-TCEO with a participation of OCHA, WFP,

UNICEF, DPAEs, and a number of NGOs. OCHA's information management activities support humanitarian decision making and response in Burundi by providing systems for the collection, analysis, dissemination and exchange of key information and data.

OCHA is also facilitating the Good Humanitarian Donorship Initiative, which is running a pilot in Burundi.

OCHA in Burundi operates through a staff of 22 (international and national staff) persons over the years, with three field offices and one in Bujumbura. The OCHA office is currently placed in the main UN building and under the authority of the Humanitarian Coordinator, who is the UNDP Resident Representative.

FAO Emergency Supply of essential agricultural Inputs, Burundi

Programme Title	Emergency supply of essential agricultural inputs to rural households affected by displacement, climatic hazards and precarious living conditions
Sector	Agriculture
Organisation	Multilateral
Objectives / Sub-objectives	2002-03: Provide affected families with basic agriculture inputs for the three upcoming cropping seasons (seasons 2002B+2002C+2003A). 2003-2004: Co-ordination of agriculture emergency operations; Provide inputs to the most vulnerable families in season 2004A. 2004-2005: Assistance to returning population and the most vulnerable.
Target group/beneficiaries	Returnees, IDPs, most vulnerable households
Location	Ruyigi, Makamba, Rutana, Cankuzo, Muyinga, Bururi
Start date - end date	01.01.2002 - 31.07.2006
Total budget	US$4,280,750
Funds provided by the Netherlands	€1,638,163

In the period 2000-2005, the Humanitarian Department of the MFA-NL has financed the Emergency Department of FAO in Burundi. Major projects implemented by FAO-TCOR are:

- Distribution of seeds and tools to IDPs, repatriated households, and chronically vulnerable households, with a special focus on gender relations. Chronic vulnerable groups are children heads of households, isolated old people, Batwa, chronically ill persons, including households with an HIV/AIDS infected member. Temporary vulnerable people are those affected by draught, IDPs and returnees. Distribution of seeds and tools takes place in the two main agricultural seasons (Season A and B).[28]
- Support of vulnerable households in vegetable production and home gardening in urban and peri-urban areas, also with a special focus on gender relations. This in order to increase income generating opportunities and food security.

[28] Most parts of Burundi do have three agricultural seasons. The B season is from February to June, the C season is from June to October and the A season is from September to February. The most appropriate season for cultivating beans is the B season.

- Support to farmers' groups in commercial seed production at the communal level, including support to seed institutes in the production of high quality early generation seeds.
- Support the Ministry of Agriculture in order to coordinate emergency agricultural operations.
- Support to the coordination of emergency agricultural assistance and strengthening early warning systems and food security surveillance mechanisms (SAP-SSA).

The Dutch Humanitarian Department has financed 5 projects in the 2000-2004 period. All projects aimed at distribution of seeds and tools. Beans, maize, sorghum, vegetable seeds and hoes were the most important inputs provided to 309.000 households affected by drought and conflicts.

In every province one NGO is in charge of leading and coordinating the identification of beneficiaries, ensuring the transport of inputs to the communes, distributing inputs together with local management committees. Those NGOs, the ministry of agriculture, and other stakeholders meet in a Committee for Agricultural Coordination (CCA) at national level, in order to coordinate the needs assessment and delivery of inputs at national level.

Dutch funding for the seeds and hoes programme has been pooled with funding coming from other donor agencies like Belgium, Sweden, ECHO, USAID, United Kingdom, Japan and the Banque Africaine de Développement (BAD).

CORDAID Basic Health Care Programme, Burundi

Programme Title	Basic health care programme supporting health centres in Burundi
Sector	Health
Organisation	Cordaid
Objectives / Sub-objectives	Improve the access to primary health care by the vulnerable population both geographically and financially. Ensure a better quality of health treatment by the health centres that are included in this project; Ensure a permanent availability of essential medicine and guaranty the continuity of the system through community participation. Protect vulnerable or indigent groups and in particular children from the rain and the cold, respiratory diseases, malaria by offering shelter and cover for children. Particular emphasis is placed on reproductive health and better support of pregnant women.
Target group/beneficiaries	2000 households and 6000 children for medical aid in 8 Public Health Centres.
Location	Bururi, Makamba, Bubanza, Cankuzo; focus on activities in Bururi and Makamba provinces.
Start date - end date	01.09.2002 – 31.10.2005
Total budget	€4,245,491
Funds provided by the Netherlands	€802,012

The evaluation concerns the project "Programme of Health Relief in the Province of MAKAMBA" The Dutch Government and ECHO have given aid to Cordaid in Burundi and its programme in the province of Makamba since 2002. The situation of the health parameters is one of the worst in Burundi.

The global objective of this project consists of "contributing to an improvement of the quality of life and the quality of health treatment for the population of the province of MAKAMBA in general and the vulnerable parts of the population in particular". It is worth noting that the work began in the period when the province of Makamba was still in the middle of a civil war. The Ministry of Health was therefore incapable of maintaining or re-establishing the health centres that eased to function during the war.

The specific objectives are summed up as follows:

- Improve the access to primary health care by the vulnerable population both geographically and financially;
- Ensure a better quality of health treatment by the health centres that are included in this project;
- Ensure a permanent availability of essential medicine and guaranty the continuity of the system through community participation;
- Protect vulnerable or indigent groups and in particular children from the rain and the cold, respiratory diseases, malaria by offering shelter and cover for children. Particular emphasis is placed on reproductive health and better support of pregnant women;

  Cordaid has formulated the expected project results as follows:

- 90 % of the IDPs and indigent people have access to primary health care as offered by the health structures;
- The infrastructure and the equipment are adequate;
- The staff is competent and motivated and the beneficiaries are satisfied with the quality of the treatments and the reception they get;
- A stable supply system of essential medicine is put in place in the seven health centres; the beneficiaries are effective integrated in the management and in the system of recovery of costs;
- The indigent groups are less vulnerable to malaria and infections in the respiratory system;

CARE NETHERLANDS Community mobilisation and education in two refugee camps, Tanzania

Programme Title	Community mobilisation and education in two refugee camps in Kibondo
Sector	Multi-Sector
Organisation	Care Netherlands, Care Tanzania, South African Extension Unit (NGO)
Objectives / Sub-objectives	At beginning: local capacity building to gain ownership of community mobilisation and education programmes gradually hand over to local organisations. Changed to: local capacity building in supporting the refugee community to gain ownership of community mobilisation and education programs in view of an eventual peaceful and voluntary repatriation, emphasis will be placed on those activities that will prepare reintegration in home country.
Target group/beneficiaries	whole refugee population plus SAEU staff (capacity building)
Location	Mtendeli and Nduta refugee camps, Kibondo region (north west Tanzania)
Start date - end date	01.03.1998 – 31.03.2006
Total budget	US$4,833,695
Funds provided by the Netherlands	€1,839,650

Care Netherlands through Care Tanzania and the Southern Africa Extension Unit (SAEU) implements the Community Services and Education Project in two Burundian refugee camps in the western Tanzania Kibondo district: Mtendeli and Nduta camp. The programme emphasizes activities that assist the refugees in preparing for their repatriation and reintegration. Project activities are manifold (11 in total) and include construction and rehabilitation of classrooms, production and repair of school furniture, provision of educational materials, training of refugee teachers, training of school committees, vocational training, caring for vulnerable individuals, awareness raising on HIV/AIDS, and peace and reconciliation activities.

In 1997 the Dutch Relief and Rehabilitation Agency (DRA) began the programme in Mtendeli and Nduta camps with funding from the Dutch government and UNHCR. The same programme is coordinated by UNHCR in all the camps in western Tanzania with different implementing partners. Further donors are UNICEF and the Refugee Education Trust (RET). In 1999 a planned hand over of the activities from DRA to Caritas Kigoma failed and SAEU was selected in 2000 as a local implementing partner through a competitive bidding process. In July 2001 DRA became Care Netherlands.

Care Netherlands is responsible for the overall project and monitoring. Care Tanzania is responsible for project management and capacity building of the local implementing partner SAEU. SAEU is a non profit education and training NGO. It was established in 1984 by the Commonwealth Secretariat (COMESA), UNHCR and the Government of Tanzania to provide training

and education to South Africa exiles. After the repatriation of the exiles in the 1990s SAEU reoriented its activities.

WFP Protracted relief and recovery operation for war-affected victims and vulnerable groups, Democratic Republic of Congo

Programme Title	Protracted relief and recovery operation for war-affected victims and vulnerable groups
Sector	Food aid
Organisation	World Food Programme Multilateral
Objectives / Sub-objectives	Supply long-term relief aid to displaced persons, refugees and vulnerable groups for their survival but also to facilitate their reinsertion into their places of origin. Support the efforts of the local populations in reducing the negative impact of the presence of the refugees on the environment and the infrastructure. Contribute to food self-sufficiency and economic independence of resettled women and men by building up their means of subsistence the rehabilitation of rural and social infrastructure, environmental protection and agricultural production. Encourage displaced and resettled women facing food insecurity to have vocational training so as to become independent.
Target group/beneficiaries	IDPs and other war affected populations
Location	Not specified in contributions; focus on activities in North Kivu.
Start date - end date	01.01.2002 - 31.12.2005
Total budget	€127,000,000 (EMOP & PRRO, PRRO is €95,000,000)
Funds provided by the Netherlands	€4,375,650

Since 2001 the Dutch government has funded WFP's food distribution in Eastern DRC with 4.375.650 US$. WFP provided assistance to Displaced Persons, Returnees and Vulnerable Groups in Northern and Eastern DRC. WFP targeted according to vulnerability criteria, which included households with severely malnourished persons, especially, children, female-headed households and households headed by unaccompanied minors or elderly persons without other support. Additionally WFP has informed the implementing partners about WFP's strong commitment to women. The Memorandum of Understanding signed with WFP's implementing partners (there are up to 37 implementing partners mentioned in WFP's appeals, they range from FAO and GTZ to ICRC and MSF) highlight this commitment explicitly. This targeting is in line with the Dutch policy of providing relief aid to the most vulnerable people, mostly women and children.

ASRAMES Distribution of essential medicines, Democratic Republic of Congo

Programme Title	Distribution of essential medicines to NGOs in North and South Kivu, from Goma depot
Sector	Health
Organisation	ASRAMES (local NGO)
Objectives / Sub-objectives	Ensure permanent availability and accessibility of essential drugs and medical equipment at the level of community health centres that are integrated in the Primary Health Care policies, as well as for humanitarian organisations. Promote the rational prescription and use of essential drugs. Improve performance and rational use of resources in the Health Sector in the North Kivu province.
Target group/beneficiaries	Population of North Kivu: 3,6 million
Location	19 health zones in North Kivu
Start date - end date	01.01.1999 – 31.05.2005
Own capital stocks	2002: €2,754,963, 2003: €3,716,916; 2004: €3,128,499
Funds provided by the Netherlands	2000-2004: €2,549,367

Since 1997, the Dutch Government has financed the "Association Régionale d'Approvisionnement en Médicaments Essentiels" (ASRAMES). Its overall objective is to make health care accessible for the whole population in North Kivu. Specific objectives are to:

- Ensure permanent availability and accessibility of essential drugs and medical equipment at the level of community health centres that are integrated in the national and provincial DRC Primary Health Care policies, as well as for humanitarian organisations.
- Promote the rational prescription and use of essential drugs
- Improve performance and rational use of resources in the Health Sector in the North Kivu province.

ASRAMES is a Congolese not-for-profit organisation. Both national and international organisations are the founding members of ASRAMES. National founding members are ADOSAGO (Association des Donneurs de Sang de Goma) AMI-Kivu (Appui Médical Integré – Kivu), BDOM-Goma (Bureau Diocèses Oeuvres Medical), and ECC (Eglise du Christ au Congo) International founding members are MSF-H (Médécins Sans Frontières), Fondation Damien and CEMUBAC (Centre Scientifique et Médical de l'Université Libre de Bruxelles). This list of founding members highlights the general societal and international support given to ASRAMES for becoming a key-player in the Health Sector in the North Kivu. This in order to start implementing primary health activities in a province where the governmental Health System and the IPS (Inspection Provincial de Santé) were not functioning. MSF-H took the lead in creating this general support for the creation of ASRAMES in the beginning of the 1990. In 1993 ASRAMES became independent from MSF-H with its own legal structure.

In the period 2000-2004, ASRAMES has received €2,549,367 from the Humanitarian Aid Department of MFA, for the implementation of 4 different

contracts out of 11 contracts financed by the same department since 1997. All the projects were co-financed by the EU (ECHO and PATS II) with NOVIB (OXFAM-NL) as intermediate partner. Dutch funding has been used for salaries of both international and local staff, operational costs, contracting of consultants, transport of essential drugs, international travelling, training and supervision activities for both own staff and staff in the Health Care system, equipments, establishment of Health Information System, research and studies.

EU funding (ECHO and PATS-II) has been used for essential drugs procurement and other medical equipment and materials.

Currently the funding of PATS II has ended and a new FED Health Sector programme is expected to start in the first semester of 2006. The health sector is recovering from the humanitarian crisis that started in the beginning of the 1990.

Until 2003, ASRAMES was a direct partner of the Humanitarian Department. As of 2003 Health Net International has been working as the intermediate organisation between the Dutch Government and ASRAMES, in particular with the ASRAMES public health department.

ASRAMES, because of its ability to gain the trust of key donor agencies (MFA and European Commission), became over the years the most important organization in the Health Sector in the North Kivu. At first, ASRAMES only specialized in the supply of essential drugs and health equipment and materials. In a second phase, ASRAMES developed its public health department – which evolved into CIF-Santé in 2004 – took the lead in the supervision and training of the Health System, and to set cost recovery policies with the Inspection Provincial de Santé (IPS) and the Health Zones.

Only in the third phase, at the end of the EC's PATS II funding in 2004, IPS with the assistance of CEMUBAC and NOVIB took over control, coordination and supervision functions from ASRAMES. As of that moment ASRAMES limited its interventions in the sector to the supply of essential drugs and other materials and its Public Health Department became independent under the name of CIF-Santé. Today, ASRAMES-CAME is completely relying on its own funds and the procurement and supply of drugs.

Until 2000, the Public Health Department within ASRAMES, was in charge of supervision and training of all Health structures in North Kivu (Health centres, hospitals, zonal health offices representing the IPS and the IPS itself). The health department intervened in all 19 health zones. After that, the public health department concentrated its intervention in 7 out of 19 health zones, and transferring similar responsibilities in the other zones to the IPS and CEMUBAC.

CIF-Santé has turned into a well performing organization, however not financially viable at the moment. CIF-Santé transformed into a training, consultancy and applied research organization, while at the same time intending to continue with the direct implementation of development

projects. The quality of their services is highly appreciated by all health partners but they cannot charge fees that enable them to operate on the basis of cost-recovery.

CIF-Santé is closely working with MDF-ESA, the Management for Development Foundation located in the Netherlands. This relation is based upon personal relations of two persons – a couple – who have been involved with ASRAMES since 1993 and have occupied different positions at different moments. In the first period both worked for MSF-H. Later on one person became the director of ASRAMES and later the director of MDF-ESA, while the other person (in the same period) became the Health expert in the Public Health Department and started collaboration with MDF-ESA on the basis of consultancies.

SAVE THE CHILDREN Emergency Health Programme, Democratic Republic of Congo

Programme Title	Emergency Health Programme
Sector	Health
Organisation	Save the Children (NGO)
Objectives / Sub-objectives	2000: 1. epidemics: To act against and prepare the population and the official health structures for health emergencies that are potentially epidemic. 2. nutrition: To reduce the mortality caused by acute malnutrition to less than 5 % in nutritional centres. 3. Medicines supplies in Katanga: To improve the accessibility to health care in Kalemie and Moba. 2003: 1. build up the capacity in MinHealth at provincial and zonal levels to maintain minimum standards at health facilities. 2. Implement practical solution to facilitate access of children to basic health services. 3. improve education for former child soldiers and other children excluded from schooling.
Target group/beneficiaries	1999/2000: Children under 5 and women in the reproductive age group; indirect 1 million. 2003: vulnerable children; 445.000 people, incl. former refugees, displaced persons, children who have been associated with armed groups.
Location	North and South Kivu
Start date - end date	01.03.2000 – 31.03.2005
Total budget	2000-2004: 1,137,845 GBP
Funds provided by the Netherlands	€2,138,799

Save the Children is implementing an Emergency Health Programme with Dutch funding in North and South Kivu in Eastern DRC. The objectives are to increase the preparedness of the population and the official health structures to health emergencies that are potentially epidemic (measles and HIV/AIDS for example), to reduce the mortality caused by acute malnutrition to less than 5 % in nutritional centres, and to supply medicines in selected regions. In North Kivu Save the Children is working in Kirotshe,

Rutshuru, Kayina, Lubero, Kyongolo, Ocha, Mutwanga, Mweso, Masisi. In South Kivu the organisation is active in Fizi, Nundu, Uvira, Lemera, Katana, Walungu, Mwenga, Kaziba. In Katanga Save the Children implemented projects in Kalemie and in Moba.

WORLD VISION NETHERLANDS Kirotshe Health and Nutrition Programme, Democratic Republic of Congo

Programme Title	Kirotshe Health and Nutrition Programme
Sector	Health
Organisation	World Vision Netherlands, World Vision DRC NGO
Objectives / Sub-objectives	In 2001: 1. Reduce malnutrition in line with international standards. 2. Increase capacity amongst health personnel and local NGOs. 3. Reduce impact of IDPs on the nutritional status of the host community. 4. Increase overall coverage of EPI to 100 % amongst 0-11 months and 90 % in the 12-59 months. 5. Provide health and nutrition education and social welfare amongst care givers. In 2004[29]: 1. Provide nutritional treatment for malnourished children through therapeutic and supplementary feeding centres. 2. Increase community food production capacity in 21 areas through the provision of agricultural inputs and education. 3. Strengthen the capacity of 39 health centres in the project area with special emphasis on EPI and reproductive health.
Target group/beneficiaries	2001: 7,440 children under five from host population and IDPs, 6,480 of U5s will receive support in the Supplementary Service Centres, 960 will be treated at the Therapeutic Feeding Centre. 2004: 9,231 children in nutrition component 21,184 children and 0-11 months in EPI component 6,897 pregnant women for vaccination 19 farmer groups for community gardens 78 health centre staff and 21 feeding centre staffindirect beneficiaries in health zones.
Location	Kirotshe and Rwanguba, Goma, North Kivu
Start date - end date	01.10.2001 – 31.12.2005
Total budget	US$ 4,995,388
Funds provided by the Netherlands	01.10.01 to 31.01.07: €1,885,583

The main thrust of World Vision's assistance programme in North Kivu Province since 1998 has been to provide emergency health and nutrition services to populations in need, in particular the internally displaced and the host communities where they have found refuge. Due to improved nutritional rates among the target

[29] There was now reformulation of the objectives reported in the project documentation for the years 2002 and 2003.

population as of early 2004, the programme initiated a change of direction towards reproductive health and food security interventions with a view to phasing out at the end of 2005 (due to cessation of funding from the MFA) and to reorient its activities for a new programme focusing on HIV/AIDS interventions beginning in 2006.

The progression of projects with Dutch financial contribution is as follows:

Period	Location	Total budget US$	MFA contribution	%
01.10.01–30.09.02	Kirotshe Health Zone	681,609	€284.609	42
01.04.02–30.03.03	Rwanguba Health Zone	778,987	€255,837	33
01.11.02–31.10.03	Kirotshe Health Zone	788,219	€372,219	47
01.07.03–03.07.04	Kirotshe and Rwanguba Health Zones	1,063,440	€515,000	48
01.07.04–31.12.05	Kirotshe and Rwanguba Health Zones	1,683,133	€731,550	43
Total		**US$4,995,388**	**€2,159,215**	**43**

A cursory reading of this chart shows that project needs have nearly tripled over the four years of the programme while the MFA contribution hovers throughout the period between 33 and 48 %. The increase is mostly due to a gradual opening up of access to parts of the province, thanks to a decrease in the conflict, allowing WVI and other agencies to start – or re-start – relief activities.

5 LEVEL 1: POPULATION: BENEFITS IN TERMS OF RELEVANCE AND EFFECTIVENESS

5.1 Relevance to Needs

5.1.1. Assessment and definition of needs

There is a clear alignment of the design of programmes to an assessment of the needs. The definition of the needs could be refined, but is overall correct as regards standard aid sectors.[30]

The example of the FAO Burundi - Emergency supply of essential agricultural inputs to rural households:

For this part of our analysis we have focused on the FAO programmes in Burundi. We find that as regards the FAO contributions, relevance of seeds and tools distribution to the population is high. Beneficiaries expressed their satisfaction with the seeds and tools obtained by FAO and its NGO partners in the field.

- *Hoes* are very much appreciated because they are not only used at one's own plot, but also constitute an asset for earning income as a daily agricultural worker. This is especially relevant for those very poor and poor households who hardly have land. Those two categories of households make 85-90 % of their living as daily workers. A majority of households wants to have 2 hoes, because they count 2 to 3 active members. Having a hoe really contributes to the increase of the household asset base and hence increases livelihood strategy options.
- *Vegetable seeds* are also highly appreciated among interviewed beneficiaries because they contribute to the improvement of the nutrition quality of household consumption and they are a source for income generation. Horticulture activities are very relevant income generating strategies for households who do not have farm land but are entitled to do home gardening, and it requires less labour force than agriculture. However, distribution of vegetable seeds without phytosanitary products and without taking into account fertilization strategies (small animal husbandry or chemical fertilizers) is less efficient. FAO implements small animal husbandry projects aiming at improving soil fertilization (compost) on the first hand and the protein intake (nutrition objective) on the other hand. FAO also provides fertilizers, and work towards soil preservation in agro forestry in other projects. However, FAO does not have the financial capacity to supply beneficiaries with fertilizers in emergency projects. Phytosanitary products and chemical fertilizers are very expensive on the local market. About 15-18 % of seeds distributed are sold, because there is no place to cultivate or because the seed is not matching the type that the beneficiary wants to have.
- *Distribution of beans* are found to be especially relevant for those households who have farm land and who have the resources and means to cultivate it. Apart from some minor parts of Burundi, beans are the most important staple food used. 90-95 % of the population is depending on agriculture as a main source of

[30] Standard aid sectors: health services, water & sanitation, food security and food aid, shelter and settlements

income. This is also applicable for IDPs.[31] In 2005, on average 78 % of IDPs has access to land, except for some parts of the Western Province, where 50 % of IDPs do not have access to land. But small sizes of land plots, insecurity, crops that are stolen and not enough time to work on the land, reduce self-sufficiency. Access to land is also becoming a problem in the provinces that host refugees coming back from Tanzania, and more generally for the whole country because of demographic pressure. For women it is more difficult to own or inherit land, hence affecting the impact of distributing beans to female headed households.

We noted however the absence of systems in place to monitor and evaluate effects and impact of distribution programme. Although the seeds distribution programme is the most important FAO emergency component in terms of funding and work, there is no system in place that enables regular monitoring and evaluation of effects and impact of seed and tools distribution in the field. However, FAO has commissioned some interesting and relevant impact assessment studies in the period 2000-2004.

In some cases the figures used are too optimistic. Expected yields for example, presented in reports need to be downscaled. Expected yields of the distributed bean seeds need to be reviewed, because not all the seeds are being used for agriculture and yields are not as high as expected. FAO is working with yields that are obtained on research plots with the use of fertilizer inputs. It expects that 1 kg of beans sowed will produce 10 kg of yields and that average yield per hectare is about 650 kg per hectare on average. Under the prevailing conditions without fertilizer inputs, average productivity is low. A farmer harvests about 5 times the amount of seeds in a bad season and 5-10 times in a good season.[32] Tearfund in Makamba is obtaining between 200 and 450 kg of beans per hectare and yields in Muyinga are estimated at 500 kg per hectare. This implies that expected outputs need to be downscaled with some 50 %.

Major causes of low yields relate to environmental degradation, because livestock has been concentrated around Bujumbura for safety reasons, to agricultural input markets that are not functioning, widespread malaria affecting labour force, some 300.000 persons internally displaced and not that productive (120,000 in 2005), and refugees returning (285,000 from 2002 to 2005) and who are also looking for agricultural plots.[33]

Yields also need to be decreased in agency reporting because beneficiaries do not sow all the bean seeds that they obtain from FAO. For instance, in the period 1999-2004, between 46 – 60 % of bean seeds distributed in Gitega have been sowed, the rest has been consumed directly or stored for the next agricultural season. Reasons for such consumption are:

- The agricultural season is not the most appropriate season to cultivate beans (A season).[34] The B season (from February to June) is the most appropriate season for bean culture. Seeds distributed in the 2004 A season (from September to February) have been sowed for 40-60 %.

[31] www.idpproject.org

[32] Felix Gebbardt, FAO consultant, Impact assessment study, agricultural relief projects in Burundi, final report, November 2000.

[33] Figures provided by FAO.

[34] Most parts of Burundi have three agricultural seasons. The B season is from February to June, the C season is from June to October and the A season is from September to February.

- Seeds are coming too late. Either because of distribution problems or because the rains are coming earlier than expected.
- Quality of the seeds is not very good, which means that household have to make a selection of good seeds for agricultural production, while eating the rest.

In 2003, the percentage of beans directly sowed has increased to 90-98 % in some provinces, because seed quality improved considerably according to beneficiaries, agricultural field workers and local authorities. More follow-up is required to check whether these high rates have been maintained in the 2004 B season.

The households in the distribution programme are not entirely dependent on the FAO seeds. FAO seeds contribute to 15-45 % of all seeds sowed, other seeds having been conserved from previous harvests or bought on local markets. On this basis the FAO seed multiplication program at local level seems to provide an interesting complementary strategy to the distribution programme, because it intends to increase the availability of good local seeds at local markets.

5.1.2 Absence of structural assistance

A deep rooted rigidity exists which reduces the effectiveness of the programmes in all cases reviewed in the sample. Because of the perceived strict nature of donor guidelines, the projects tend to treat structural vulnerability as though it were situational. There is an absence of funding instruments (no strategic vision, no long-term funding) in the emergency phase to deal with connectedness (short-term assistance addressing structural causes).

The example of CARE/SAEU - Community mobilisation and education in two refugee camps in Tanzanian refugee camps:

The CARE SAEU programme in Tanzania is targeted at the whole refugee population in the two camps with special emphasis on the most vulnerable: children, adolescents, the elderly and women. The final targeting of the programme beneficiaries is left to the refugees themselves.

The provision of community services and education to refugees (Burundian teaching material, textbooks, teacher training, skills training and reconciliation activities) is highly relevant. First, the community services give structure to the life in the camps. Some of the refugees have resided in the camps since their establishment in 1996. Thanks to international assistance the refugees benefit from comparably high standards with regard to health facilities, schooling and free food distributions.

Missing for many years has been a perspective for the future and an occupation for the day. Widespread unemployment, poverty and continuing dependency on the international community have many influences on social life. Uncertainty about repatriation has compounded this in the aid effort. The community services programme addresses this need for a structured life and gives opportunities for meaningful activities that are aimed at improving the refugees' skills for their eventual return to Burundi. However for different reasons the programme misses some opportunities in this regard. The reasons lie partly within the programme, partly outside.

The micro projects component suffered from the fact that refugees are officially not allowed to leave the camps and Tanzanians are not allowed to enter the camps for trading. The restrictions on timber harvesting (lifted in September 2005) have affected the school construction and rehabilitation works.

The Tanzanian and the Burundian governments do not favour durable solutions for the refugees in the camps and delegate access by the refugees to secondary education. The argument is mainly related to Tanzanian internal policies, where the refugees are seen as a threat to the security of the border region. The Burundian government is not interested in a parallel Burundian education system outside the country. In the Tanzanian Refugee act of 1998 it is stipulated that provision of secondary education is allowed. Refugees attend secondary school in Mtendeli and Nduta refugee camps, and there are also refugee students studying in Tanzanian secondary schools (Mabamba and Korogwe) under the sponsorship of Tanganyika Christian Refugee Services (TCRS). Secondary School education is not included in UNHCR's mandate; however UNHCR has initiated efforts to support secondary school education through the Refugee Education Trust (RET) fund. Since 2004, advanced level secondary education students have been passing the Burundi government examinations (the Burundi government is managing these examinations).

Yet the international aid community has difficulties in providing assistance in this area. UNHCR is only funding primary education and SAEU and its partners support secondary schools with fewer resources than primary schools. Primary school teachers for example receive a salary, whereas secondary school teachers only receive incentives. The fact that the aid community could not agree on common standards for incentives (in kind or in cash) for voluntary community work led to a low morale among some of the refugees.

The coverage of primary education is satisfactory (about 90 % in the last years) whereas the rate for secondary education is comparably low (13,6 % of 14-20 year old follow secondary education in Mtendeli and 9,8 % in Nduta camp).[35]

Another factor, which worked contrary to the programme's aims, was the reduction of WFP rations in October 2004, and in February and June 2005. The reasons were pipeline and funding problems (the latter partly because of the Darfur and Indian Ocean Tsunami crisis). Although this is questioned by WFP, it has been said, and is probable, that the reductions have led to tensions, increased domestic violence, lesser school attendance and a decrease in voluntary work. In another area of Tanzania it has led to an increase in repatriation, at least as regards Congolese refugees (not originating from Kibondo) who were interviewed upon their arrival in South Kivu.

The education component suffered from the fact that Burundian learning material is limited in the camps. Procurement of Burundian learning material was conducted using a list of books provided by Burundi refugee teachers themselves. Refugee teachers were thus selecting Burundian learning material but they were not involved in procurement. The refugees have raised this issue on various occasions with SAEU and SAEU has tried to organise material in Burundi. Because of a lack of knowledge of the specific requirements, SAEU did not provide the right material.

[35] Peace and Conflict Impact Assessment of a Community Services and Education Project in two Burundian refugee camps, Western Tanzania, SAEU and Care Nederland, Eveline Rooijmans, May 2002.

For the NGOs working in the Kibondo camps it was comparably easy to procure sewing machines and to organise training in tailoring. This has led to competition between refugees producing clothes. Refugees benefiting from the SAEU programme complained that other tailoring workshops had better machines and that after the three months training there is no way to use the learned skills as the refugees have no sewing machines at their disposition for income generating activities.

Some of the refugees would have preferred other skills training, which was not open to them or would have liked to work in agriculture as they did in their home country, also not an option given the policies of the Tanzanian government. CARE and SAEU did bring the issue of enrolling teachers on return to Burundi up with UNICEF. In the camps, unqualified teachers have been sitting for teachers' examination since 1999. After passing the examination, teachers are awarded a UNHCR & UNICEF certificate, which is recognized in Burundi upon repatriation. During cross border meetings the issue of teacher enrolment/integration has been discussed and the Burundi Ministry of Education promised to accept UNHCR & UNICEF certified teachers. Those refugee teachers who were already qualified before becoming refugees are accepted in the education system and the Ministry still has their documents.

Trainings provided lead to the above examination, which determines whether one is qualified, or not. All these trainings, examinations and issuing of certificates are done by SAEU in collaboration with UNICEF and UNHCR.

The refugees expressed that they want to have more interaction with UNICEF so they can ensure they would be enrolled to become teachers upon their return to Burundi, but SAEU advocacy work on their behalf did not allow the creation of a link between teaching in the camps and return to a teaching job.

These examples show that the programme is static and not flexible enough to react to the specific needs of the refugees.

Some refugees will have difficulties to reintegrate in the rural areas where they come from as they have lived in camps for many years. Life in camps can be seen as similar to life in an urban centre. Refugees were refused access to arable land except for some vegetable gardens and small areas designated by the Tanzanian government. There is also the problem of loss of assets during repatriation as returnees are limited to 50kg of luggage (because of limitations in UNHCR logistics which have improved only in September 2005) and are not allowed to take livestock with them on the transport facilitated back to Burundi by UNHCR. When questioned on this point, UNHCR indicated that it is considering a revision to its policy on two aspects:

1. to allow the refugees to bring back assets they have acquired in the camps, such as sewing machines and livestock, over and above the allotted 50kgs. They will need to work out modalities with border authorities to allow this greater flexibility.
2. to assist those refugees who share an asset, such as a sewing machine, to obtain a similar asset or receive compensation in lieu. The evaluation team considers that these two important nuances to the repatriation programme are crucial to promote the benefits of repatriation in the minds of the refugees, and to enable refugees to bring with them tangible assets they have acquired

over their stay in the camps. Otherwise, those refugees interviewed made very clear they would stay on in the camps until the last minute so as not to lose their assets and, with them, the income generated from them.

5.1.3. Targeting of the more vulnerable

As regards most international interventions, there is a deliberate intent to target the more vulnerable. The overall priorities are also correctly identified, even if contextual factors considerably reduce the overall performance.

The example of World Vision – Health and Nutrition Programme in Kirotshe (DRC):

World Vision's intervention strategy has been guided by the following criteria: accessibility of the region; presence of IDPs, and level of malnutrition among IDPs; deterioration of health and nutritional status of host populations.

Unfortunately much of WVI's project baseline data was burnt in the aftermath of the January 2002 eruption of Mt. Niyarogongo, and it is therefore impossible to evaluate the initial rationale for intervention. However, it is safe to say that the above factors were highly relevant at the time the programme started and led to focused beneficiary targeting.

The Kirotshe health zone is close to Goma and the health centres are easily accessible, whereas during the early phases of the project the ongoing conflict precluded access to the interior of the province rendering it impossible to ascertain – let alone meet - the needs of the populations there. In 2001 Kirotshe hosted a high number of IDPs fleeing instability in neighbouring Masisi whose malnutrition levels, as well as those of the host population, merited intervention. As security levels led to an opening of other parts of North Kivu from early 2004 onwards, WVI was able to penetrate hitherto inaccessible areas and to extend its interventions. The programme in Rwanguba opened in October 2002 due to similar reasons of accessibility, presence of IDPs and acute health and nutrition needs.

Malnutrition rates peaked in both Kirotshe (up to 20 % of global acute malnutrition and 12 % of severe acute malnutrition) and Rwanguba (to 30 % GAM and 14 % SAM) in October 2002, corresponding to an increase in the conflict that further destabilized communities and renewed population displacements. Thus, despite the achievements of the programme in 2001, needs increased with the steady influx of IDPs from the insecure areas of Masisi and Pinga.

The presence of the IDPs created pressure on the resources of the host community whose malnutrition and health status were assessed to be deteriorating. Vaccination (EPI) coverage was improving but needed continued intervention due to the low level (40 %) of coverage in neighbouring health zones. An external evaluation conducted in October 2002 concluded that while satisfactory results had been obtained from the programme to date, it would be necessary for WVI to continue its activities for a further one-year period. Given the still high malnutrition rates and low vaccination coverage of the target population, this recommendation was sound.

5.1.4 Neglect of population pockets

There is a pattern of neglect of particular population pockets and situations among many of the agencies evaluated. This often reflects the predominant bias in the prevailing culture, or the fact that the type of supplies provided are

more adapted to some groups than others. The agencies appear not to be equipped to correct these biases, or not able to recognise them, mostly because of poor monitoring mechanisms (of management committees, local partners, and end users).

The specific needs and conditions of women and children are not well covered, and when they are often seem to respond to very general donor policy preferences, not necessarily adapted to local reality. Women's needs differ from those of adult men in the region, as a result of the effects of war on social structure and culture. The focus on basic needs (food and physical health) leads to a neglect of trauma, gender based violence, and cultural understandings of the crisis by the population. This is seen by the evaluation as laying the seeds of future societal instability, in the form of disenfranchised groups and continued patterns of abuse.

Acute vulnerability has increased through politically inspired violence and social and psychological disruption (see Annex 3). It also spreads to the economic sphere because of:

- Insecurity and harvests being taken from the fields, household assets being taken away, including small animals, agricultural equipments, houses being burned down, clothes etc. People are abandoning agriculture, animal husbandry and opt to live in the forests and picking fruits and roots and wild animals.
- Roads deteriorating because they are not maintained anymore, because of insecurity, which implies that markets are not functioning any more.
- Governance imploding because people with leadership capacities are being killed or flee abroad where their skills will be recognised.

Agencies deal in different manners with structural vulnerability.

The example of World Visions Kirotshe Health and Nutrition Programme:

World Vision's policy of intervening in HIV/AIDS high prevalence areas to provide essential drugs for pregnant women, does not appear to be an activity with much degree of sustainability once the project comes to an end. The programme activities help to reduce women's vulnerability to nutrition stress and further consequences to their babies by providing them with daily supplements of iron and folic acid as preventive measure for iron deficiency. This goes along with gardening activities aimed at contributing to a more diversified diet in participating households and community as a whole. Malaria prophylaxis is also provided to pregnant women.

The education and community sensitisation aspects of the programme are of more long-term benefit to all members of the community but distribution of medicines will only help people while the programme is operating and will not contribute to long-term improvement of reproductive health. Interventions in HIV and other reproductive health issues that cause high morbidity and mortality in the project area are relevant in theory, but also evoke suspicions of a higher attention in the public rather than needs-driven activities.

For an agency that has the possibility of moving into sectors where it is not traditionally active, WVI does not appear to have considered the provision of psycho-

social assistance to targeted beneficiaries in communities. WVI is providing psychological support in the feeding centres to caretakers to ensure their active participation in the caring and support of their sick children who need it for socialization as they recover. However given the widespread incidence of violence to women and children over the past decade there is an urgent need for more profound assistance. Whereas active disarmament and demobilization of child soldiers is taking place, there is clearly not enough thought by NGOs being given to their psychological welfare which, if left untended, may yet cause disruptions in their home communities. WV would be well-advised to liaise closely with SFC to follow the children to their home communities and proactively explore the possibilities of becoming involved in this low-visibility but crucial activity. Indeed, more coordination is needed between other agencies to give meaningful follow-up to the UN's DDR programme. Many respondents in this review deplored the lack of coordination regarding transitional activities to anchor communities and foster peace and reconciliation and are unanimous in expressing the need for it.

The example of Save the Children in Eastern DRC:

The Save the Children programme for the reintegration of ex-child soldiers provides only limited psychological support, or in some cases this aspect is completely absent. It generally takes the form of discussion or an interview with social assistants or nurses who have not been trained to deal with severe trauma. Children, many (no figures available) of whom are ex-child soldiers and have experienced years of violence, are highly unlikely to undergo a successful reintegration if reintegration activities do not take into account the psychological aspect of their suffering. A special aspect is the fact that child soldiers have been aggressors and victims simultaneously. As children however they are not guilty for their acts, but they accomplished them and have to deal with it.

The example of Cordaid in Burundi – Emergency Basic Health Care Programme:

One finds the phenomenon of overseeing population segments in the programmes of Cordaid in Burundi. The project "Programme of Health Relief Treatment in the province of Makamba" in the south of Burundi has responded to real needs in the health domain. The health conditions as well as the access to treatment have improved considerably. The majority of the needs have been recognised and are being addressed in the field even if all needs are far from addressed (due to a large number of people needing treatment and limited resources). However there are certain gaps, such as the exclusion of the Twa and missing psychological assistance.

<u>Rehabilitation of health infrastructure</u>

On the positive side it has to be stressed that the programmes made the health centres that had been closed due to the civil war functional and strengthened the ones that had been functioning with difficulties. Seven health centres were rehabilitated and functionalised including the health centres of Makamba, Muguruka, Kazirabageni, Nyanza-Lac, Kabonga, Muyange and Bukeye. Moreover five posts for treatment were established while waiting for the establishment of actual health centres.

The rehabilitation of infrastructure and equipment has been conducted. The technical and non-technical equipment, responding to primary needs identified by

the centres, have been delivered. The condition of certain equipment needed to be improved especially the refrigerators that are necessary in order to preserve certain pharmaceutical products such as vaccines.

The health committees (two people per hillside –one woman and one man are elected by the community of each hillside[36]) ensure the functionality and the connection between the health centres and the population. The presence of nurses (in all the centres one finds only nurses, the two doctors in the province are both in the hospital in Makamba) ensures the quality of the treatment and a night and weekend service ensure the continuity.

Aid has been granted on three levels: in terms of prevention, vaccine campaigns, pre-birth consultations, family planning as well as nutritional education has been granted to the population both directly by the centre and indirectly by the health committees that are in charge of the awareness campaigns in their respective Hills.

With regard to interventions the centres either perform them in the centre itself or ensure a transfer to the district hospital in case of serious diseases. The centres do however have beds. Moreover they all have a minimal laboratory where they are able to conduct certain examinations (HIV/AIDS, malaria testing) On the third level the ex-post intervention is ensured with regard to the actual birth and the period following the birth, but is non-existing with regard to other aspects (control, follow-up).

The centres are mostly acting on the relief level. The people only come to the centres as a last resort when it is very serious (for example the women that give birth often come at the last stage of the actual birth when they are completely exhausted and incapable of continuing which often make a urgent Caesarean necessary).

The beneficiaries that the evaluation team have met in the three centres in Muguruka, Nyanza-lac and Bukeye have expressed great satisfaction with the rehabilitation of their centres and they are grateful for the aid granted. They express however some concern especially with regard to the withdrawal of the aid granted by Cordaid due to the improvement of the security situation as the centres are not autonomic. They fear a setback to the previous stage.

Focus on women and children

The main emphasis is on women and children, a part of the population which is really reached by the programme of Cordaid. The infant mortality is primarily due to malnutrition and malaria.

The nutritional centres and the nutritional education for the mothers as well as the nutritional programmes and support for children that are put in place are much appreciated. The nutritionist continues to weigh the baby regularly until the correct weight is obtained. The children that do not obtain the correct weight in the 12 weeks period are considered not responding and are consequently transferred to the district hospital.

Mortality at birth is (3.19 %) and children (12.9 %) is primarily due to birth conditions (mortality of newborns) as well as low weight at birth (>2.5 kg: 16 %) and

[36] 'colline' is the administrative unit in a commune.

the health condition of the mother. The infant mortality is mainly due to malnutrition itself. Moreover malnutrition lowers the resistance to the majority of other diseases. The maternal mortality is 0.85 % in Burundi (figures measured over time are not available) The primary cause of mortality in Burundi is AIDS with a prevalence of 20 % in urban areas and 7.5 % in rural areas.

Obstacles: minority groups, sexual and gender based violence (SGBV) and psychosocial care

On the negative side it has to be noted that there is actually a part of the population that is not benefiting from the support of the health centres. This is due to the list of groups in need that is drawn up by the local authorities.

The Twa for example, which is a group of pygmies, do not figure on the list, even if they do not have the means to pay for the necessary treatment. They are not considered a local population since they are semi-nomads and therefore not included on the lists of the health committees. The Twa, whom the evaluation team met, did not benefit as all from the humanitarian aid even if they have limited financial means.

A family father noted that three out of his five children had died. If a child was sick the family would keep he or she at home in order not to pay for health treatment. The way the committees draw up the lists is problematic as objectivity is not part of the considerations.

In terms of reproductive health real efforts are been made and real problems have been recognised. Pre-birth consultations and family planning have been incorporated into the routines of the centres and the services are much used.
The birth problems are: access to health centres for women giving birth is difficult especially at night time. Often they have to get to the centres on foot or by bicycle (by the bicycle taxis). The ambulance reserved to mothers giving birth is a very positive initiative although highly insufficient as there is only one for the whole district.

The presence of traditional midwives is both a help and a disadvantage. They are present when necessary but their considerable lack of birth physiology and their total lack of sterile equipment are problems that contribute infant mortality of newborns and their mothers. It is suspected that certain midwives are infected with HIV/AIDS but they are not diagnosed due to fear and lack of means.

The problems associated with sexual violence to women and children (it is worth noting that the number of boys or men that are victims of sexual violence is on the rise) although very serious for the population are often hidden or denied. The symptoms are only recognised and treated on the physical level (damaged places in the front and behind, prolapsus, mechanical lesions, sexually transmitted infections (STI) and HIV/AIDS). The treatment afterwards, the morning after pill and anti-viral treatment are generally conducted if the women make it to the health centres.

On the other hand the severe emotional burden associated with sexual violence (shame, guilt and fear), the treat of stigmatisation by the community and the rejection by the family prevent a lot of women from going in the required time to the centres for rapid preventive treatment. The lack of medical supplies often has dramatic results in these cases.

The psychological side (severe trauma, often multiplied and accumulated) is only dealt with in a basic way. "Listening Houses" are installed in the province of Makamba. The partner (Search of Common Group) is the principal donor agency in this field. They are trying to help women who are victims of violence (sexual or otherwise) with a questionable policy in relation to treatment of trauma: they try to reconcile victims and aggressors (the tormentor according to them) in order for the victim to be able to forgive the aggressor.

The fundamental idea of reconciling a population in conflict is, although quite good, not adapted to a context of severe traumatism. Especially not with only three or four preceding sessions. The many little girls which have been victims of sexual violence (which is also widespread in the Kivus in DRC and is now linked to the « activation » of the fetish) are only summarily treated, and mostly at the somatic level, whereas the trauma is enormous and lead to multiple disorders in adult women, as has been demonstrated in many studies of childhood sexual trauma.

The health centres in the province of Makamba constitute a network of maximum 10 km with maximum 5 km walking distance for each person. 90 % of the population should have access to the centres.

5.2 Relevance to Social Structures and Coping Mechanisms

5.1.1. Review of needs

The needs of all categories of people have been reviewed in the three countries, whether they are displaced, refugees, or simply affected by war. The material effects of the projects are tangible and positive, as can be seen through direct observation or in the agency reporting.

The example of Save the Children in DRC – Emergency Health Programme:

Save the Children in Congo exhibits panoply of good practices in its relations to social structures and highlights the importance by a WFP partner of household vulnerability. Highly specialised programmes as those in health or the reintegration of child soldiers require a sociological understanding of the conditions of beneficiaries.

Given the unstable context in which Save The Children works, it has focused its activities on increasing population resilience (population's capacity to 'bounce back' following a crisis or prolonged tension) by means of strengthening social capital and bolstering the role of key resource people in public delivery structures. Some of the activities undertaken in Save the Children's health programmes work towards this objective, including:

- Involvement of the population in the management of the health centres by providing support to health committees[37] in areas where they have been weakened or by helping populations to set up health committees in areas where they do not exist.

[37] In French, Comités de Santé (COSA).

- Identification, with the population, of community health workers who receive training in disseminating community health information and are taught key lessons about preventive medicine (vaccination, hygiene, child nutrition, etc.). These activities are greatly appreciated by the populations themselves.
- Collaboration with traditional authorities and local administration in the design of health services.

Feeding centres are providing good care for malnourished children. Malnourished children who are admitted to Therapeutic Feeding Centres (TFC) or Supplementary Feeding Centres (SFC) are well provided for on a nutritional and/or medical level.

The evaluators' observations indicate that there is cause for concern with regards to the sanitary and nutritional conditions in the households concerned, and more generally with regards to the lack of integral response for identified needs. During our visit to the Masisi TFC, a mother (whose child had been admitted and taken care of in the TFC) and another child under twelve months were discovered in extremely poor health. Save The Children pays great attention to the families of malnourished children, supplying those accompanying the sick children, and sometimes the whole household (according to project reports), with WFP food aid. However, the above example highlights the limitations of WFP food aid, as contents are often ill-adapted to local diets.

In relation to the complex issue of the reintegration of ex-soldiers who are children (difficulty in estimating the number of child soldiers, difficulty in identifying and providing support for female child soldiers, etc.), Save The Children has adopted an innovative approach which aims to strengthen social capital within a community via the concept of 'social debt'. This concept aims to reintegrate ex-child soldiers into their original environment, allowing them to establish themselves within the community and ensuring that they become *equals* in respect to other children. This was not the case beforehand, where child soldiers received for example material benefits through reintegration programmes. Child soldiers were in fact because of the attention the receive from aid organisations and demobilisation programmes privileged compared to children that succeeded in avoiding recruitment by armed groups. One can easily imagine the effect of such privileges in reintegration programmes. In a new conflict: it will become very "attractive" to become a child soldier.

Save the Children's new approach is best demonstrated by the following examples:

- Each child is appointed to an instructor who is responsible for the child's training. The instructor is generally paid in kind by the child's family (they receive a chicken or vegetables from time to time). Within a given district, most children will serve their apprenticeship in this way.
- Younger ex-child soldiers are allowed to start school again for example without paying schooling fees. However, Save The Children helps the child purchase a pair of clippers (less than US$10) and his role is to cut teachers' and pupils' hair during his/her schooling.

This approach seeks above all to forge social links and to recreate the networks that traditionally support children in a community. The child's family has an important role to play in their child's reintegration and Save the Children's work tends to concentrate on supporting partner networks rather than the children themselves.

The child remains indebted towards society for life (which is what is wanted), to create a social network created which can be activated should problems arise, in both senses, for the ex-child soldier or for his network.

This new approach shows promise in terms of reintegration, but Save the Children is still alone in implementing this approach. This has caused problems with other ex-child soldiers who do not want to be 'Save' children because other actors offer more attractive incentives, at least in the short-term. It highlights the challenges of this sector, which is still ill defined in humanitarian aid, and of coordinating activities within it.

5.3 Wider Effects and the Transition to Development

5.3.1. Unaddressed aspects of vulnerability

All aspects of vulnerability are not fully addressed, particularly because of limited work done in protection by the partners selected, discrimination in access to services, and a focus on emergency food aid for food and health insecurity, which in fact has societal origins.

There is a tendency to phase out the emergency programmes when indicators improve and the emergency is considered "over", and/or it is considered time to handover to development. The evaluators find that the needs are still there, unaddressed, and sudden withdrawal will lead to loss of life and undue hardship because of the absence of public services.

The example of World Vision's Health and Nutrition Programme in North Kivu (Kirotshe):

With the progression of the Congolese peace process since early 2004 and 2005 and the gradual disarmament and demobilization in their ranks, formerly displaced people in North Kivu have moved back to their communities of origin and resumed the cultivation of their land. Others decided to settle within the project area and have no intention of moving back to their original homes. In both cases, the ability to resume active pursuit of livelihoods led to a drop in malnutrition rates to below 10 % in both Kirotshe and Rwanguba by April 2004 when a new phase of the programme was proposed.

The phase-out strategy of the programme from July 2004 to December 2005 (partly triggered by the fact that other donors have decided that as the emergency phase is over they would cease funding, in particular the Office for Foreign Disaster Assistance of USAID) has been to reduce emergency interventions and move to a rehabilitation phase of activities centred on fostering the ability of people to manage their health and nutrition situation themselves.

Activities are now geared towards strengthening the capacity of local health centres to take over the nutritional programmes and reducing the number of beneficiaries, with a parallel drive to increase community food production capacity through the provision of agricultural inputs and education. The programme also aims to strengthen the capacity of the health centres to take over the EPI component after project closure and to promote reproductive health.

Despite the fact that the phasing-out period is rather short, these activities constitute a sensible follow-up to the earlier emergency interventions. At the same time they

allow WVI to maintain a watchful eye on its traditional areas of intervention to ensure that, should the fragile security situation unravel and renewed conflict break out, necessitating a sudden reversal to emergency needs, it is well placed to assess the situation and intervene if necessary.

Nutritional surveys conducted every six months have maintained an essential monitoring of the strategy and concluded in observing greatly reduced rates of malnutrition to less than 5 % of GAM and 2 % of SAM in both areas. This has enabled a gradual closure of therapeutic feeding centres from 21 in July 2004 to 2 in August 2005. In certain cases the centres have been closed too rapidly (only with two months' warning) and the residual caseload was left to fend for itself as there was no alternative structure to hand over to. Frequent fighting between the army and militias caused people to flee their homes. Both the military and the militia occasionally launch raids to villages, looting, destroying and steeling property including food reserves, crops and livestock.

WVI's criteria for closing therapeutic and supplementary feeding centres were examined. It is almost universally accepted by international health experts that therapeutic feeding programmes are not so much nutritional as medical interventions and that the need for them does not disappear altogether even though the general nutritional standard of the population may improve. The only reason that WVI is closing its TFP is due to the stated intention of USAID, ECHO and the MFA to phase out funding contributions to the programme in the name of an overall shift to recovery. The evaluators consider the reasoning to cease funding – that of improved nutritional rates – to be questionable and in need of closer examination. Especially since the numbers of children currently enrolled in TFCs are still high: 36 in Rwanguba and 42 in Kirotshe. A similar programme in Uganda run by MSF-F had the criterion of not phasing out of a TFC until attendance was 20 or under. The existence (or not) of public health structures should also be taken into account.

While malnutrition may be falling to within internationally accepted standards, the local health structures are observed to be incapable of taking over therapeutic feeding, an activity that needs personnel, food and professional standards. Even though WVI has run a training programme for TFC personnel, if people are not paid for their services (they receive only incentives, not salaries) and if the hospitals do not have the means to pay for infant formula food, which they currently do not, the children will not get fed and morbidity due to malnutrition is likely to rise, albeit in a manner which will not be caught in statistics because of the absence of agencies to do monitoring. World Vision also has urged UNICEF which provides technical support in nutrition programme to the MOH to own the goal of ensuring an overall exit strategy for SFP is developed and communicated.
The only way to persuade the State to take care of its own citizens is indeed by letting go of the 'safety net' provided by international health interventions. In this respect, the MFA's reasoning – along with that of most international donors – is not without merit. The evaluators are of the opinion that the strategy could work if:

- Agencies are able to monitor the nutritional status of the population closely for at least one year after the closure of TF and SFPs.
- Health centres can cope with the smaller numbers of cases needing attention.
- Chronic diseases (such as HIV/AIDS) that lead to a gradual weakening of the body can be treated before they become life-threatening, requiring therapeutic feeding.

- Intervention of an emergency nature can be re-activated if the security situation should change for the worse, resulting in the downward spiral of renewed displacement, food insecurity and malnutrition.

Both donors and agencies attest to their flexibility and willingness to adopt these approaches, thus it may be concluded that 'cautious project closure' could indeed work and, additionally, encourage the handover with due care to the State with regard to provision of basic services to its population. So far, WVI has closed seven TFCs in 2005 and two remain, one at Kirotshe hospital and the other at the Rwanguba hospital, both due to close at the end of the year.

The WVI criteria for closing a supplementary feeding centre are:

- A diminishing number of new cases being admitted to the programme.
- The geographical situation in terms of access to the population.
- The security situation has reverted to a measure of normalcy, permitting people to cultivate crops and tend animals.
- Or lack of funding.

In the case of supplementary feeding the WVI project will have put in place in all 'aires de santé' where it has been operating SFCs, food security activities for the community. Children now exiting the programme are given a small animal to care for and training in animal husbandry to ensure proper maintenance practices and reproductive facilitation. The programme stipulates that families must share the offspring of project animals with other families, ensuring a multiplier effect. The beneficiaries themselves have chosen the species of animal after discussions in focus groups and in light of their experience and means. All these facets of the programme can be considered as useful aides to foster a spirit of self-help while simultaneously strengthening community ties and building peace. During 2005, the number of SFCs was reduced from 25 (12 Dutch, 5 OFDA and 8 ECHO funded) to 4 (3 Dutch funded and one supported by World Vision Taiwan). So far there have been no reports of rising malnutrition rates.

As with the TFCs, the closure of SFCs can be seen as a positive development, decreasing attendance being an indicator of improved security, increased income-generation potential and improved self-sustainability of populations. Thus with close monitoring of nutritional levels and of the development of the food security programmes, the safety net is in place for a responsible phase-out.

Food security aspects of the project, running concurrently with the decreasing nutritional programmes, were observed to constitute a rational phase-out strategy. By enabling communities in the areas of intervention to grow more vegetables such as amaranth and cabbages, and staple crops such as manioc and maize, coupled with animal husbandry activities designed at reducing protein deficiency levels (by increasing the stock of small animals that can be eaten) formerly displaced populations are becoming self-sufficient in their new settlement communities. Furthermore, host populations are also able to benefit. This should foster a spirit of peaceful co-existence since the targeting does not discriminate between particular groups but benefits the entire community.

While the above policies appear to be rational *prima facie*, some of their underlying assumptions need to be questioned.

1. It is a potentially questionable policy to assist displaced people to settle in their host communities rather than promote return through the promise of assistance should they return to their original communities. Two groups of some 60 beneficiaries (predominantly female-headed households), in Kirotshe and Rutshuru districts were questioned during the review on this point. They maintained that they did not intend to return to their former homes for two reasons: firstly they considered themselves to be more vulnerable in the isolated upland areas from which they fled during the conflict, particularly from roving armed groups of rebels or bandits who continue to lead sporadic attacks against people and property. Secondly the more highly populated lowland areas where they have settled afford an improved level of access to local markets where they can sell their produce. A third, but unverified possibility is that they have found a greater measure of social intercourse in the more populated lowland areas which has helped them feel more secure (safety in numbers), closer to essential services such as schools and health centres, and a feeling of reduced isolation. A gradual but irreversible rural to urban shift is thus being experienced in Kirotshe district where the evaluation team conducted a visit. It would, however, be untrue to state that this is happening because of the project activities – rather in spite of it, since the people became displaced prior to the project's intervention.
2. A second potentially questionable policy is the provision of small animals as a protein source for the communities. While rabbits and guinea pigs undoubtedly constitute good sources of protein and are rapid reproducers, they need a minimum of care from their owners. The previous evaluation picked this up as a weakness in WVI's implementation, noting that many of the animals provided under the project had died. The evaluators further investigated the policy, believing the reproduction of rabbits to be potentially harmful to the environment. However, expert sources have since indicated that rabbits in captivity, contrary to over-breeding and being harmful to the environment, are prone to sudden death and not at all reliable for breeding purposes. It would seem therefore that the investment in rabbits may ultimately fail unless carefully managed (which has been observed to be possible in the Caritas Rutshuru Nutritional Centre). WV is presently monitoring this programme carefully and is aware of the sensitivity. This activity is funded by World Vision Canada, not the MFA, but it is relevant because of its impact on the nutritional status of communities. Its implementation should be carefully monitored in order to assess its impact and success rating.
3. Given the remaining fragility of the national health structure, the remaining pockets of child malnutrition, and the unavailability of vital nutritional inputs, it is recommended that WVI retain a close watch, through its links with the community, the hospitals and health centres, on the nutritional status of children – especially in areas where there is still a high level of population displacement - and be prepared to intervene with renewed therapeutic and supplementary feeding programmes if necessary. Donors have shown themselves to be amenable to this position and profess that they would be ready to revert to funding emergency relief activities in areas where and when it might be necessary.

MOH has organized a meeting of all partners to be held this November in Kinshasa aiming at communicating and reviewing nutrition work that has been done so far and identifying gaps and formulating recommendations.

The example of Cordaid's Emergency Basic Health Care Programme in Burundi:

Cordaid has an exit strategy from Makamba, which includes a strong involvement from the Provincial Health Office. The number of staff from Cordaid is going to diminish following this involvement from the Provincial Health Office. Moreover the incorporating of this community governance through the health committees confirms the sustainability of the supported programme and strengthen the social capital of the local population. Furthermore the health committees are in charge of information and awareness building activities of the local population to ensure the contact between the health centres and the local population that is often spread out in the hills.

The health committees on the other hand are founded on the work of volunteers. A factor that could pose problems and a reason for inefficiency due to the volunteers' lack of motivation and fatigue. Moreover certain members believe that they are entitled to treatment free of charge because of their involvement and voluntary work.

As in DRC, the phasing out of the assistance programme (to restore the primary responsibility to the government and carry out capacity building) announced by Cordaid risks being premature as fragility is still lingering over the system. The vulnerability is following from the general poverty in the villages. Furthermore it has to be stressed that the repatriated and displaced are little by little reintegrating their households but they will not be ready to take full charge of their lives in the immediate future. Moreover the centres are not and will maybe never be autonomous and they are therefore dependent on the agencies.

Of great concern is the serious increase in the population in a small country like Burundi. One should not underestimate the physical and physiological effects when the vulnerable part of the population will rise with 13-16 % in 2005. In this situation other programmes should be planned in order to supplement the relief programmes in the field of health care to make sure the result of the later is being safeguarded. No such programmes have been planned due to the continuing uncertainty of the peace process and a political process, leading to sector programmes that are still being drawn up. There is no transitional programme on the ground linking relief with development, even if some very creative suggestions for programmes from Cordaid are under consideration in the Netherlands (cf. the footnote for recommendation 5 at the end of the report). These programmes involve financing public bodies with precise financial governance, which will probably not be financed by the Dutch Humanitarian Department due to the guidelines it has to apply, focusing on relief.

5.3.2. Emergency interventions in a long-term crisis

This focus on humanitarian needs in the midst of a long-term crisis leads to a loss of effectiveness of the emergency interventions. There is clearly a need to take into account the longer term and more structural factors of suffering.

The example of UNDP's Community Assistance Umbrella Programme in Burundi:

Under UNDP's PCAC, the 'CARE caprin' intervention strategy – a revolving livestock micro-credit project aimed at improving the quality of life of beneficiaries and, by extension, overall food security in the community - was relevant, creative and

well-coordinated with overall needs and other agencies. Directed at helping the poorest families in communities that had been particularly ravaged by conflict, it constituted the core of a solidarity community chain and support network. There was little evidence, however, that the project had significantly enhanced household incomes through the commercialisation of outputs produced, as intended.

The example of the assistance in the health sector in Eastern DRC through ASRAMES:

In Congo, ASRAMES contributed to improved public health services by means of provision of essential drugs, training of staff at both provincial and district – zonal level and by monitoring of performance of health structures until 2004. Those activities contributed to the structural and institutional strengthening of the Health sector in the North Kivu province. However, they did not sufficiently improve the access of vulnerable households to health services.

The evaluation was able to collect information concerning access to health services improved in the period 2000 – 2004 in North Kivu. The population there has increasingly used the health structures. This is because the number of health structures that received essential drugs from ASRAMES has increased from 306 in 2000 to 362 structures in 2004. Access to essential drugs has considerably improved when ASRAMES opened its warehouse in Musienene in 2000, which is providing essential drugs to 10 health zones out of 19 in the whole North Kivu province.

At the same time, health centres were more frequented. In August 1999, 22 % of the population living in the health service area, frequented a health structure, in August 2001 and 2002 it was about 47 % of the population. In 2003 and 2004 this rate has remained stable at the 2002 level of 46-48 %. This percentage is below the WHO norm of 1 visit per year for every person in the ser vice area (100 %). Generally speaking, drugs are available on a nearly permanent basis in those health structures at communal level and even at the level of ambulant health workers.

However, increasing access to public health services has limited benefits for vulnerable people including the destitute. The provision of essential drugs through ASRAMES has improved access to health centres but there is only limited impact on the overall health situation.

Poor people are required to pay for health services, even when their resources may be extremely limited. On the other hand, other members of the community (armed forces, occasionally traditional authorities and local administration, etc.) use these services free of charge, exhausting medical supplies, and creating distortions in the intended policy.

International agencies (including WHO) are aware of the occurrence of such inequities, yet profess themselves powerless to do anything, stating that the problem is one that the State should address. Since the State is weak or non-existent in most parts of the Congo, this highlights the need for an alternative system that would have to be developed at the level of the aid agencies themselves.[38]

When ASRAMES was still the lead agency in the Health Sector and covering the whole province (Until 2000), it was also in charge of management training of Health

[38] The evaluation mission discovered the same problem of unequal access to health services in the Makamba Province in Burundi – Cordaid evaluation.

Centres, Hospitals, Zonal Offices of the IPS (Inspection Provincial de la Santé), monitoring of the performance in part of those Health Structures and carrying out Information, Education and Communication activities in all 19 health zones (later transferred to the newly created CIF-Santé). Until that moment ASRAMES intervened when confronted with those irregularities. As of 2000, CIF-Santé continued to supervise and train 7 out of 19 health zones (which they do very consciously, as we have noted during a field visit to Masisi). IPS together with CEMUBAC is supposed to deal with this issue in the other zones. As of 2004, ASRAMES restricted its mission to essential drugs supply, therefore less responsible for unequal access issues. However, generally speaking the evaluation mission has to conclude that the issue of equal access to health services – also to the poor, is not been seen as an important issue by the stakeholders in the Health System in the North Kivu, because they are prioritising their efforts on getting the health system work (cost-recovery, rational drugs prescription) rather than taking into account who are being served.

Main reasons identified by ASRAMES and CIF for not frequenting health services are the following:

- Cost recovery policies.[39] Cost-recovery policies for both consultation and drugs have changed several times in 2000-2004, having implications for frequency rates. In 2000, patients paid US$1 in stead of US$0.5 for consultation in the rural health centres and frequentation dropped immediately. The same happened when patients had to pay separately for essential drugs and for consultations. When the old cost recovery policy was again re-established, frequency rates increased.
- Purchasing power of especially rural households is very low.[40] In 2003, 15 % of the households did not go to a health centre because of lack of money. Most households visiting a health centre do not have problems in paying, but 24 % is selling an asset, 12 % are taking a credit with the health centre and 6 % takes a credit within its family. Between 2003 and 2005 some improvements on purchasing power can be reported. Those households representing the very poor (with less than US$6 per household per month) dropped from 18 % to 3 %. Those households representing the poor (between US$6 and US$25) also dropped from 52 % to 31 %.[41]
- Other places ill people go to are drug stores for auto-medication (29 %), private drug stores (8 %), health posts (more decentralized than health centres – 7 %) and others.[42] Most important criteria for choosing a health centre are its proximity. However, average distance to a Health Centre in the North Kivu province is 18.3 km, which is considerably higher than in the Sud Kivu, Maniema en Katanga.
- CIF-Santé, in its 2005 study,[43] has doubts about health centres respecting the consultation rates set by *Inspection Provincial de Santé* (IPS). Households report average costs for consultation, medication and laboratory that are

[39] Taux de fréquentation 1999 – 2002, janvier 1999 - décembre 2000: 17 ZS et de janvier 2001 à décembre 2002:19 ZS). Le Financement du Secteur de la Santé dans le Nord Kivu, Comité de Financement, IPS et Novib, présentation faite lors de la mission d'évaluation, 2005.

[40] Robert Soeters et al. Constats et Analyse sur la Catastrophe Sanitaire dans la Province du Nord-Kivu, enquête ménage 6-23 May, ASRAMES-CE/PATS, 2003.

[41] Enquête Socio-Economique et d'accessibilité aux soins dans la Province du Nord-Kivu, NOVIB et IPS/Nord Kivu, réalisée par CIF-Santé, mars 2005.

[42] Ibid.

[43] Ibid.

three times higher than the rates formally set. At some occasions, drugs have been found on local markets and in private drugs stores. Subsidized drugs are a very easy source for non-transparent and non-planned economic actions.

- Very poor and vulnerable people are not exempted from paying for health services. Officially, a Health Committee of every Health Centre is in charge of establishing lists of people who are exempted from paying for health services, but in practice, those who are on these lists are the members of those committees, local authorities, local technicians, local police and military people. In several places a trend has been observed to enlarge the number of members in the Health Committees and to talk about Community Development and Health Committees. Very poor and vulnerable people are not on those lists and whenever they use health services without being able to pay directly, ambulant community health workers, in charge of Information, Education and Communication (IEC) activities, are used to recover credits for consultations by the poor. This practice has been triangulated on all locations and field visits where health centres are functioning.[44]

The impact of improved drug use at population level is not evident. The most important disease is malaria, but prevention of malaria by using mosquito nets (5.2 % of households) is very low, hygiene measures are very rare and the introduction of new drugs at household level (Sylphadoxine Pyrimethamine) is rare. About half of the population uses chloroquine which is not very effective anymore. Despite several projects and actions, malaria has not yet been rolled back.

6 LEVEL 2: DELIVERY: BENEFITS IN TERMS OF EFFICIENCY

6.1 Resource Cycles

6.1.1. Dependence of external structures

Good performance is however based on external structures which are about to go through a difficult transition in the movement to reconstruction, requiring careful thinking. This thinking, which should be undertaken at the level of donors, is not in evidence. Delays in funding and operational implementation pervade the projects, in spite of the multi-annual funding cycles adopted by the Ministry of Foreign Affairs.

The example of Cordaid's Emergency Basic Health Care Programme in Burundi:

With the support of Cordaid the medical supply systems have been put in place in the seven health centres. This system is heavily depending on external aid but still does not function without interruptions and serious delays in deliveries of drugs. The lack of supplies is too frequent to be within the norm.

The beneficiaries feel the consequences very strongly. All NGOs working in health programmes are severely affected. The Ministry of Health intervenes by rewriting the

[44] Observations made during several field missions and confirmed by different members of the evaluation team.

original requests. This process leads to further delays in the purchasing process, which may take many more months.

The process is complicated by the fact that some donor instructions (for example ECHO) require 100 % imported medicine, and no form of local purchase is permitted.

The beneficiaries are effectively associated with the governance of the system of recovery of costs. However strategies of ownership still need to be developed to increase the involvement and motivation by the partners.

The example of CARE/SAEU - Community mobilisation and education in two refugee camps in Tanzanian refugee camps:

The CARE project implementation in the refugee camps in Tanzania is marked by a number of delays and budget cuts, resulting in repeated no-cost extensions. The fifth phase of the project was supposed to start in May 2001.[45] Only in July 2001 (1 month delay) the first instalment was received and up to the end of September only 29% of the project activities had been implemented. The sixth phase[46] was supposed to start in April 2002 but only at the end of December 2002 (8 months delay) the first instalment was received. In September 2003 CARE/SAEU has submitted a proposal for the programme period starting January 2004. Only in June 2004 (5 months delay) the first payment reached SAEU in Kibondo. At the same time UNHCR had to face some budget cuts, which are related to reductions in its global budget.

On certain occasions Care Tanzania could step in with funds from the international Care network and pre-financed some of the capacity building activities.

The example of ASRAMES assistance to the health sector in Eastern DRC:

Similar delays occurred in the long-term funded program of ASRAMES in DRC and are mentioned here as well. Delays in funding by DGIS were about 3 to 4 months in the years before 1998, but ASRAMES was able to continue its drugs supply activities by using its proper funds. The delays in funding for the 2000 project, covering initially 12 months, were 6 months. This delay is to be attributed to the Ministry.[47] However, ASRAMES was not able to cover a period of 9 months for the effective start-up in 2003 (contract DMV0016985 with Health Net International). This delay of 10 months is to be attributed to the Ministry, who took 4 months to decide positively on financing the proposal and 6 months to HNI, who was not willing to disburse money to ASRAMES on a lump sum basis.

The health system is not financially viable, and this has repercussions on the accessibility of health services and drugs provided by ASRAMES. The delivery of health services is highly depending on the financial viability of 19 health zones (*Zones de Santé*), that all have one public hospital and a number of Community Health Centres (*Centres de Santé*). Apart from charging patients for consultations, drugs

[45] Project B1003105

[46] Project B1003106

[47] ASRAMES submitted the proposal on December 16, 1999 and it arived in the Ministry on January 10, 2000. After receiving a reaction from the Dutch embassy in Kinshassa on February 9, the appraisal memorandum (BEMO HH-0755/00) was adopted on May 15 and the financial agreement was dated May 23, 2000. The first payment was effected on June 23. People in charge of this file at the Ministry during this period: two persons. The initial project duration was extended from 12 months to 18 months (1-1-2000 to 30-6-2001).

(formally incorporated in the consultation fee) subsided essential drugs supply through ASRAMES (and IPS) and for some interventions (child delivery), the community health centres do not have other sources of income. Of all the monthly income:

- 10 % is paid to the health zone in order to ensure supervision by the "Bureau Central de la Zone de Santé" (BCZS).
- 30 % is used for operational costs, including the pre-payment of 8-20 % of the value of the drugs to ASRAMES and since 2004 to IPS.
- 60 % is used for paying the staff of the health centre. As an example, the person in charge of the health centre in Massisi town, gained in one month about US$29 , less than US$1 a day. The "sentinelle" received US$8.
- Most important sources of income of health centres are child births for which US$5 is charged, but in the case of the Massisi Health Centre the BCZS told that all child births should be done in the nearby hospital, therefore depriving the community health centre of its own sources of income.

The BCZS have an important role in supervising the performance of the Community Health Centres, rational prescription of drugs and centralizing lists of drugs to be ordered via IPS with ASRAMES. A study carried out on behalf of IPS in 4 Health zones, shows that health zones are capable of covering about 15 % of the total budget needed to run the "Bureau Central de la Zone de Santé". The missing part should be covered by the State or by NGOs.

6.2 Management and Efficiency

6.2.1. Technical Standards and the context

Technical standards are generally well implemented. The context has played a significant role in determining what happens on the ground, but the agencies selected for funding by the Ministry of Foreign Affairs have done their best in very difficult circumstances.

The example of FAO Burundi - Emergency supply of essential agricultural inputs to rural households:

Burundi has many different agro-ecological zones, climatic conditions and people having different food consumption habits, sometimes eating beans and sometimes eating manioc, and with different flows of IDP and returning refugees, who all have to be accommodated. This makes the distribution of seeds a very complex action, because it is a national distribution program that needs to take into account all the different local conditions.

Reflecting well this diversity, the FAO program is implemented in a very professional way and reaching the people which are targeted.

Targeting through FAO, UNICEF and WFP:

At the national level in Burundi, FAO, UNICEF and WFP have established very specific norms for households that do meet the criteria to get for seeds & hoes and seed protection food aid kits, as well as households that only get seeds & hoes. Those national policies have been adapted on a regular base to local circumstances, taking into account the situation of IDPs or people returning from Tanzania. On the basis of the national policies and criteria set, local authorities and local committees, including hillside chiefs and sector chiefs have been very carefully targeting the final beneficiaries up to the household level with the assistance of the NGOs. Most critical issues in targeting are:

- The performance and composition of the local committees in charge of identification. Non performing and non-representative committees (gender, ethnicity, age) contribute to non-transparent establishment of beneficiary lists and corruption required in order to be put on those lists. This implies that vulnerable households and intended beneficiaries of the seeds & hoes project are not reached because they are not able to give a bottle of beer to those in charge.
- Batwa people are very easily forgotten in all provinces and communes. Often local authorities suppose they do not have access to land, they are not considered as inhabitants and being part of the hillside community nor the commune.

Distribution and the seed protection food ratio:

Generally speaking, distribution of seeds & hoes has been carefully done and in a professional way. Most critical issues are:

- Weak communication between actors at provincial level, as well as communication between national-provincial-community and beneficiary level. The major consequence is that intended beneficiaries are not informed about the place and the date of delivery of their seeds and hoes. Other households not initially targeted receive the seeds and hoes.[48]
- Complaints of those not targeted have increased, and sometimes those last categories are refusing to contribute to communal work commissioned by local authorities. Some local authorities refuse to distribute the seeds and hoes according to the lists established previously, saying that every household in their commune is vulnerable. On those occasions, the seeds and hoes are distributed to the whole population.

No clear statement could be obtained about the distribution of seed protection ratios –meaning those food ratios distributed by WFP to prevent the consumption of seeds by the poorest- and its influence on the consumption of seeds delivered for agricultural purposes. WFP is having problems with timely and sufficient delivery of seed protection rations, but their influence on FAO distribution is not observed. More information is needed in order to be able to formulate conclusions about the effects and impacts of joint delivery of seeds and hoes on the one sight and the seed protection ratios on the other side.

[48] Evaluation conjointe FAO/PAM de l'opération de distribution des semences et de la ration de protection des semences (RPS), saison 2003 A et 2004 A.

Aspects of quantity and quality of seeds and hoes:

The quality of beans has increased over the past years, but the ratio distributed has decreased. Initially, 15 kg of beans were provided. As of 2003 this became 10 kg, which was compensated for by the improved quality. 10 to 15 kg is estimated to be enough for those households who have less that 0.5 ha of land. Those households who do not have much land are not complaining about the amount of seeds distributed, but those who have more land do. In practice, on some occasions, intended beneficiaries do not get the whole package, because more people show up during the distribution or because local committees decide to include every household in the distribution programme.

The strategy of accompanying the distribution of vegetable seeds with other inputs and livestock needs to be studied in detail. The quality of hoes has changed, since FAO engaged in the procurement of hoes from China. Average lifetime decreased from 2-3 years to 1 year.

Procurement:

The procurement of agricultural and horticultural seeds at the national level (as much as possible) is successfully being implemented. The procurement of hoes at the national level is being improved, trying to involve more local traders in the tender procedures.

Appreciation of partner NGOs:

Identification and delivery of seeds and tools is considered to be a burdensome task by NGO partner organizations. NGOs working in the agricultural sector - like Tearfund in Makamba - are happy that other NGOs take over parts of the distribution programme. Tearfund will stay involved in the distribution program but it is professionally motivated to continue with the seed multiplication programme that also enables the Tearfund agronomists to give technical assistance to vulnerable farmer groups, collaborate with technicians from the Provincial Department of Agriculture and to manage provincial seed warehouses. (both programs - seeds multiplication and warehouses- designed and supported by FAO TCEO). In 2006, seeds fairs will be implemented in Makamba with Concern. However, FAO knows that the distribution may be burdensome for some of our partners, but implement them because the beneficiaries need it and within agreed partnerships. Distribution of seeds and tools are relief operations, and they are not comparable to the seeds multiplication programs FAO has developed with Belgian funding. There is no shift in this case, both programs answer different needs.

FAO is reviewing its contracts with partner NGOs every year.

Security:

The security situation is having consequences for seeds and tools delivery. It has been very difficult to deliver supplies due to the existence of a security level IV classification by UNSECOORD in the provinces over the last years. However, those areas are hosting important numbers of IDPs and returning people from Tanzania. UN organizations have to travel with military convoys in those "security level IV" provinces, making supervision missions very difficult and NGOs sometimes face

difficulties in distribution because of security reasons. As of 2004, those provinces have become more accessible for the FAO and the number of households serviced has increased.

The example of World Vision's Kirotshe Health Programme in Eastern DRC:

In spite of these adverse conditions, the commitment of the agencies has been admirable. WVI for example has been operating in the areas along the Rwanda and Uganda border, which count among the most explosive in eastern Congo. Statistics demonstrate the positive impact of WVI's activities in reducing the rate of malnutrition in areas of intervention. Both the therapeutic and supplementary feeding activities have noted an improvement since late 2002: in Rwanguba health zone the reduction in global malnutrition went from 29.4 % in October 2002 to a current prevalence of 5.1 %, and in Kirotshe health zone the reduction in global nutrition is from 20 to 5 % respectively – in both locations, well below the WHO mark of 10 %. Severe malnutrition rates currently hover around 2 %.

However, this impact has come at a cost. Analysing WVI's total budget requirements divided by the number of direct beneficiaries for each year, the project phase costs per capita are as follows:

Project phase	Direct beneficiaries	Cost per capita	Cost per capita covered by the NL
01.10.01-30.09.02	7,440	US$91.6	US$38.2
01.04.02-30.03.03	6,960	US$111.9	US$36.7
01.11.02-31.10.03	6,192	US$127.3	US$60.0
01.07.03-03.07.04	12,716	US$83.6	US$40.5
01.07.04-31.12.05	9,231	€182.3	€79.2

These per capita costs are high in the context of Africa. Food and vaccination inputs are provided by WFP and UNICEF respectively, so these high value aspects of the project cannot be attributed to part of the programme costs, while staff costs represent fully half of the budget submitted to the Dutch government. On the other hand, it can be reasoned that project activities require high labour inputs (assisted feeding, vaccinators needed for campaigns, training personnel, etc.) relative to other assistance sectors that WVI is not engaged in. Also, if one reads per capita costs in terms of the number of *indirect* project beneficiaries, these could be considered much more reasonable, e.g. €14.6 overall, and €6.36 attributed to the Dutch contribution in the last phase of the project.

Observations at the project sites showed that at least the money appeared to be well spent. Sites were well ordered, clean, healthy in appearance and, most importantly, beneficiaries attested to the project's value to them in helping provide food for their families and in income-generation potential.

With regard to linkage between relief and transition phases, WVI's 18 month project in helping communities to become food sufficient is having an excellent impact on the communities, according to observations and the number of beneficiaries assisted. WVI, like many other agencies, is structurally stuck at a level of quasi-transition, unable to move fully into it due to continuing security uncertainties that keep beneficiaries living for the present and unable to plan their futures or make long-term

investments, and due to the weak capacity of the State to properly fund and control essential health and education functions. Thus the most it can do is, in consultation with beneficiaries, provide them with small-scale assistance to protect them from becoming targets of looters.

A case in point is the provision of small animals as a source of protein. Rather than provide IDPs with high-value animals such as goats and cattle, which would normally be the animals of choice, the beneficiaries themselves chose to receive small animals such as rabbits and guinea pigs. The rearing of animals is supported with veterinary services to the beneficiaries. WVI has also observed that communities are adopting coping mechanisms with regard to looters – including Government soldiers - which is to negotiate with them so that they take some of their produce but leave them with enough for the community. This shows how unstable the situation is, and how small-scale assistance is still the only possible option for Goma province. The IEC approach (information, education and communication) is another possibility being employed by WVI and used for future project strategies.

The example of the drugs supply chain and ASRAMES:

ASRAMES has plaid a leading role in delivering essential drugs in remote areas in the North Kivu. The availability of drugs makes a significant change in health centres' performance. Value of drugs delivered to the 19 health zones and financed by the EU has increased from less than US$200,000 in the first trimester of 2001 to US$350,000 in the last trimester of 2003.

There are many causes of drugs supply rupture, which are not all imputable to ASRAMES. In the absence of an operational and dynamic IPS, ASRAMES invited all relevant stakeholders in the Health Sector in a meeting that aimed at setting a norm for drugs supply rupture of 5 % in December 2002: In March 2003 the real indicator was at 14 %.[49] Most important causes are:

- The transfer of the preparation of drugs orders to the IPS in 2004, resulting in a rupture of 3 months at health centres; slow transmission of orders by Health zones in previous years.
- Health zones are not capable to do an appropriate estimation of drugs needed, because not taking into account seasonal trends in drugs use.
- The unpredictability of orders coming from NGOs working outside the Province. As of 2002, these orders have become more important than the orders done for the Health Zones. In 2004, the value of drugs ordered by NGOs represented 67 % of all orders and those of the Health Zones in the North Kivu 24 %. Health zones are complaining that NGOs get a better treatment because they pay cash. This to the detriment of in time delivery of essential drugs and equipment to the Health zones in North Kivu.
- Delayed delivery of essential drugs by international provider IDA on several occasions, who delivered 64 % of all drugs in 2003, but whose proportional contribution has decreased in 2004. Another cause of delay is the Tsunami in the end of 2004 that made it impossible to procure mosquito nets on the international market.
- ASRAMES is increasingly urged to improve its stock management, because its volume of drugs delivered, increased from US$1,000,000 in 2000 to more than

[49] This example shows that the IPS, the official and governmental lead agency, was not capable of setting norms and standards and monitoring them. Therefore, other stakeholders in the health sector took over these responsibilities by combining efforts.

US$5,500,000 in 2004. The volume of drugs in the warehouse that have passed the expiration date or that are not on the essential drugs list set by the Ministry of Health is increasing and is becoming an issue of concern in 2004, while already monitored since 2001 without significant action.

Promoting the rational use and prescription of drugs and improving health structure performance by ASRAMES is not fully effective. The public health department of ASRAMES, later CIF-Santé, has organized short courses in the field of rational drugs prescription (685 persons during 5 days in 4 years), management of health committees (822 persons during 5 days in 4 years), financial management, stock management and public health management. Training activities have been limited to 7 out of 19 Health Zones since 2001, partly due to the lack of funding, partly due to limited accessibility.

CIF-Santé was also in charge of supervision missions until 2004 and organized important studies in the field of accessibility to health services, performance of health centres and prevalence of malaria. The impact of those courses and supervision missions on the performance of health is mixed.

The average number of drugs prescribed per consultation dropped from 3.3 in 1995 to 2.7 in June 2001 and remained the same in December 2004. CIF-Santé did not manage to get the number of drugs prescribed to the expected level of 2 per consultation.

Many of the prescriptions are not medically implied. This is why ASRAMES and CIF work for rationale and well balanced prescription practice. Positive results are seen in a decrease of the prescription of antibiotic drugs and percentage of injections administered. CIF-Santé explains the stagnation of the prescription practices by the fact that CIF intervened in only 7 out of 19 health zones since 2001.

6.3 Accountability Levels and Responsibility

6.3.1. Long management chains

The inability to respond flexibly to the longer term structural issues is attributed by the evaluators to the long management chains which separate the programming processes at the project level and the actual delivery. It is not rare to see that resources pass through the hands of four agencies before reaching beneficiaries. These create a preference for long established, tried and tested systems, rather than a responsiveness to changing circumstances. Relying on past practice leads to rigidities in some cases, and a very good match in others.

The example of CARE/SAEU - Providing Community Mobilisation and Education to two Kibondo Refugee Camps in Tanzania:

In the case of CARE Netherlands, the decision to fund the assistance programme to refugees through a Dutch NGO, which works through a local implementing partner can be questioned with regard to problems and delays this set up caused, delays which are attributed by CARE to weak capacity in the local NGO structure.

The failed hand-over process to Caritas Kigoma and the long hand-over process to SAEU caused delays in project implementation and seemed to have consumed most of the energy of stakeholders from 2000 to 2003. In the meantime the programme activities continued as in the years before but with limited attention and guidance from the implementing organisations. This has contributed to the rather static programme implementation.

The failure of the hand-over to Caritas was due to the fact that Caritas did not manage to find a qualified financial manager in time. Local NGOs in western Tanzania have difficulties in finding qualified staff and compete with UN organisations that seem to pay higher salaries.

Finally SAEU was selected in a competitive bidding process but it is not clear to the evaluation what the proposed added value of SAEU in this bidding was. SAEU did not submit a proposal or methodology related to the content of the programme. The protocol of the steering committee meeting, which decided whether the competing organisation or SAEU would be selected, stresses the fact that SAEU is not a strong institutional partner but has an eagerness to learn.

DRA handed over all equipment, furniture, vehicles and other assets financed by the programme and SAEU also took over all of DRA's programme staff except for two international experts, which were replaced by Tanzanian staff (Project Coordinator and Financial Coordinator). One of these positions was taken over by the present Project Coordinator, who has worked for Caritas Kigoma before. After SAEU took over the programme the only baseline data available were hand written notes kept in the programmes camp offices.

SAEU and Care Tanzania staff participated in various workshops and trainings (Policy analysis and advocacy, Guidance and Counselling, Opportunities and Obstacles to Development, Fundraising). Although the institutional weakness of SAEU was known and the eagerness to learn (which still exists today) was recognized, the capacity building of SAEU was delayed in different occasions and has still not progressed to a satisfactory level. Even four years after handover to the local partner there are still deficits in systematic information management. There is a risk that the investment in the capacity building of the organisation will be lost as the future of SAEU after repatriation and the end of funding through the international community is very uncertain.

Whereas the capacity of SAEU has not progressed to a satisfactory level with regard to some capacities (e.g. a systematic information management system), capacity building activities have led to relatively stronger capacity levels of SAEU in other areas, for instance in community/social development work and in administrative & financial systems. Capacity was also built on proposal development in order to assist in marketing SAEU for future projects. The fact that funding opportunities for SAEU in Kibondo are limited is not due to their lack of capacity, but rather due to a lack of investment of donor agencies in the Kibondo area, who operate with other funding procedures and larger programmes for objectives beyond the refugee community.

In 2004 Care Netherlands faced internal difficulties. The Project Manager responsible for the Kibondo programme left and was replaced only after a long delay.

The long management chain has consequences for example for the reporting and the transfer of payments from MFA. The reporting goes through six main levels:

> Social worker ➢ camp programme coordinator ➢ programme coordinator Kibondo office ➢ SAEU office in Dar es Salaam ➢ Care Tanzania ➢ Care Netherlands ➢ Dutch government.

It became unclear where in this long chain a value was added regarding the monitoring and supervising of the programme. On Kibondo level the capacities and knowledge for good monitoring were not sufficient. The value added by the SAEU head office in Dar became not visible to the evaluation team at all, whereas the input of Care was important to the process. However, Care in Dar -and even more Care in the Netherlands- were fare away from the camps in western Tanzania and their input totally relies on the information provided by SAEU. Proper monitoring should take place on field level with technical support from well trained staff of Care, which has the resources to visit the field regularly and to transfer knowledge to the local partner.

The financial transfers are done in four steps and in three different currencies, which includes the risk of delays and currency fluctuations:

> MFA transfers to Care Netherlands in Euro ➢ Care Netherlands transfers to Care Tanzania in Euro ➢ Care Tanzania transfers to SAEU Dar es Salaam in US$ ➢ SAEU Dar es Salaam transfers to SAEU Kibondo in Tanzanian Shillings.

The example of UNDP's PCAC in Burundi:

This unclear added value is also apparent in other operational arrangements than for the refugee camp structure, i.e. also for reintegration programmes inside countries.

Although Dutch funding to UNDP PCAC in Burundi appears to have been considerable, none of the reports analysed have permitted a thorough overview of amounts contributed or disbursed. Figures presented are often contradictory and misleading. For example, the sum of all projects supposedly financed by the MFA in the period 2002-2003 is higher than the actual contribution of US$1,000,000), and the Jan-May 2002 progress reports shows the MFA contribution as only US$930,000 on page two while page 9 shows Dutch Trust Fund contributions as US$2.6 m.

This leads to a policy which is reactive to agency proposals. These proposals often do not originate from the immediate grantee, but emerge from closer to the field. This proximity often reduces the ability to think creatively about the response to needs, as agencies are often guessing, based on limited information, as to what donors will fund.

A structural flaw in the UNDP/PCAC project targeting has resulted in the programme being less needs-driven than supply-directed. In effect, it is dependent on suggestions from NGOs who tend to propose activities in sectors they are expert in and in regions where they already work. This did not pose a problem in the first two phases of the programme since needs were great everywhere and in every sector. UNDP has recognized that it is no longer an appropriate way of prioritising activities

for the next phase of the programme and intends to adjust it accordingly. This is examined below (see section 7.

The example of the added value of Health Net International in the aid delivery chain:

The Dutch NGO Health Net International (HNI) became an ASRAMES partner for the DMV0016985 project (2003-2004), but its added value has not been proven yet. HNI was not capable to assist ASRAMES in pre-financing the first 10 months of the project, and no traces have been found by the evaluation team of technical support.

The project proposal was submitted to the Ministry by HNI in March 2003 who decided positively in July (4 months delay). After that moment problems arose about financial disbursement procedures. HNI intended to transfer fund on the basis of 2 monthly activity reports, whereas ASRAMES was used to receive lump sums directly from the Ministry covering 12 months. HNI was not willing to take responsibility for repaying any possible unspent funds to the Ministry. HNI and ASRAMES only signed a collaboration agreement in September of that year, after which ASRAMES received funding. ASRAMES received its first funds on October 31.

HNI itself went through a difficult period recently and is now reorganized and merged with another Dutch NGO. During this process not much attention was given to the partnership with ASRAMES and CIF in Goma.

6.3.2 Institutional capacity and local partners

The evaluation has observed an extensive use of local NGOs and user committees that are directly servicing the target groups. Yet their institutional capacity is neglected by the humanitarian aid agencies, and this has been detrimental to the effectiveness of aid. There is a sense that where there is no direct responsibility for an operation, the local actors are neglected, or there are simply not enough resources to take them into account. In many cases the penetration of the aid programmes into the country is limited, for cultural and security reasons.

Some agencies, such as WFP or FAO, have even made themselves operationally dependent on the last link in the chain (whether they be international or local NGOs). This is because they hand over all control over resources at a delivery point, beyond which beneficiary lists, distribution and user monitoring are left to the local partner. These agencies are however not equipped to address problems when these are identified, for lack of human resources. In other cases the agencies are developing monitoring mechanisms (indicators) and contractual agreements with their implementing partners, but this is still limited to individual initiatives. Efficiency is considerably reduced.

The example of WFP in DRC:

WFP was visited in two locations where it carried out operations, in Goma and in Kalemie. In line with the approach of the agency worldwide, it carries out a complex logistical operation up to the Extended Delivery Point, usually its warehouse in the local hub. From there it operates through implementing partners, usually international NGOs and local NGOs. These are normally agencies carrying out other work, which places them in direct contact with the community leaders and some

form of community redistribution and accountability. This allows the local organisations to support general distributions (for example to returnees observed in the areas south of Uvira), supplementary and therapeutic feeding, and some food for work (usually linked to training as few agencies have the capacity to implement systematic work, for example on much needed access roads).

WFP depends for the elaboration of beneficiary lists, and for the implementation of distribution, on the capacity of the NGOs present. This varies considerably. Two difficulties emerge. The first is that WFP is effectively placed in a position of dependence *vis-à-vis* donors operating outside food aid: should an agency cease to receive funds for its main programmes, for example *Première Urgence* from ECHO in Kalemie, it will not be able to continue operating in support of WFP. As the agencies only receive funds for handling costs, there is little incentive to carry out food aid distribution as a core sector of activity.

Secondly WFP carries out only very limited monitoring of its implementing partners. This is due to the restrictions in faces in staff, as well as the fact that it has no resources for funding. The evaluation was given to observe that this is done indirectly through contractual agreements (case of the *Lettre d'Entente* in Kalemie where a clause is added by the NGOs to provide indicators of outcome).

However this ad hoc technical assistance provided willingly by WFP staff could not replace long-term support, designed to provide WFP with an operating base to reach the population. The logic of WFP interventions is to reach the groups which are facing food deficiencies, and this does not cover long-term work. The Protracted Relief and Rehabilitation Operations could nominally carry out such capacity building (this would fall under WFP's Strategic Priority 5), but donor resources are not allocated to this aim. The immediate consequence is that WFP's effectiveness is dependent on the funding and capacity building decisions of other donors. As these are increasingly declaring that the emergency phase is over (ECHO, OFDA), the risk is that performance is undermined, and WFP sees its indicators worsen.

The example of UNDP's PCAC in Burundi:

Although the PCAC project documents put great emphasis on building local capacity, the evaluators found scant evidence of it in practice. Despite the aim of bringing local committees and other authorities up to administrative and technical standards that would enable them to take over the projects when they are completed, the team observed that they are still weak – or at least, perceived to be weak. There may be a number of good reasons for this, which cannot be attributed to UNDP.

7 LEVEL 3: AGENCIES: BENEFITS IN TERMS OF CAPACITY AND COORDINATION

7.1 Human Resources and Preparedness of Agencies

7.1.1 Knowledge management (particularly about needs), and international and national human resource management, are affected by turnover and a drain of qualified personnel from public services to the agencies.

The length of the management chain in the case of some NGOs, and particularly in the case of the UN, has led to delays and a loss of coherence. The delays in financing have led to delays in implementation, and shortages in drug supply, as well as in the delivery of training and other activities in the cases of SAEU for example, which in turn have affected the beneficiaries. Management systems are oriented to delivery but not so much to control the programme performance and outcomes.

The example of Save the Children's Emergency Health Programme in DRC:

To illustrate this point we have first turned to Save the Children. Given Save the Children's long-term presence in the region and their experience in health programmes – funded by the Dutch government since 1999 – and in protection in eastern DRC, a considerable amount of expertise has been gained. Project teams have mastered the technical aspects of health programmes in general, and in the nutrition sector in particular.

Yet the evaluation observed weaknesses in terms of institutional memory. The evaluation team had difficulties in identifying respondents among the present Save the Children team who were capable of providing information about previous health programmes (the majority of respondents arrived in 2004). It was equally difficult to obtain relevant documents about previous programmes because the majority of records were destroyed during the eruption of the Nyiragongo volcano in January 2002.

Save the Children's capacity to ensure continuity and to monitor programme impact is compromised by poor institutional memory, which in part is caused by high staff turnover. When respondents were asked why turnover was so high, the main reason given was that emergency relief programmes tend to be short in duration, prompting staff to apply for new positions before their contract terminates, given the uncertainty of contracts being renewed. In areas of high insecurity, high staff turnover may be justified by the effects of intense stress (especially for expatriate staff), and in order to prevent burn out, agencies choose to recruit staff for short periods of time for these areas.

Yet there has been considerable work carried out to understand the local context. Save The Children has undertaken various household-level assessments – for example, 'The Household Economy Assessment' in 1999 which was subsequently updated in 2003 in the Masisi – which have had a bearing on the agency's capacity to understand livelihoods and identify survival strategies. The mechanism for updating these assessments is not necessarily built into the projects however.

Save the Children has also demonstrated a good ability to assess and question its programmes by means of monitoring and evaluation activities. Save the Children is open to self-criticism and is concerned about 'doing things well'. Agencies that are willing to allow external experts evaluate and call their activities into question are rare in the humanitarian sector. Lessons learnt from the first wave of reintegration of ex-child soldiers are currently being applied, an illustration of Save the Children's positive approach in this area and of its efforts to adapt to the local cultural environment.

Training and technical assistance, another form of knowledge management applied in the transition between emergency and development, is experiencing significant difficulties.

The example of Cordaid in Burundi:

Relations between private NGOs and public services, even when working in the same activities, are difficult to establish, requiring innovative solutions. To review this we have taken the example of Cordaid.

In terms of administration the staff from Cordaid is being complemented by the Ministry of Public Health through the province and the different health centres which had registered the leave (escape) by the personnel following the situation of insecurity that reigned previously. The personnel are still not motivated despite the bonuses that have been granted to staff in the health centres. The majority of the staff that the evaluation team met expressed their regrets in relation to the inadequate salaries and bonuses especially considering their great efforts and the way it is demanded that they are at service 42 hours per week, during the nights and at weekends. This situation has an impact on the reception of the patients that do complain about this effect.

The health centres and the governance have benefited from training and consequently better service in relation to the health care personnel, the governance of the supplies and the cashiers. The supervision should be strengthened in order to ensure that new knowledge is being used and that education will continue to be a priority. In average one midwife per Hillside is being educated in order to avoid birth at home and in order to guide the women giving birth towards the centres. This will still demand more supplementary involvement in order to reduce mortality of newborns and mothers.

Visits to the centres have increased since the rates have been reduced with 50% of the official rates. However the non respect of this rate by certain centres means that some patients chose a centre further away that do respect the reduced the rates.

The health committees have done a good job in identifying the groups in need that can have treatments free of charge. However the identification in terms of documentation should be clear either through their revenue card or by creating a specific column for groups in need in order to allow an effective control and to avoid confusion.

The resistance from certain staff members in the health centres towards interference from the community in the governance constitute a mayor obstacle in the development of the centres and their community governance. The Provincial Office

for Health should discourage this behaviour to the benefit of the beneficiaries (the population).

The supply and the governance of the medicine is a sensitive point. Especially the lack of supplies in different centres deserves special attention as it has a strong impact on the satisfaction of the beneficiaries and on the sustainability of the programmes supported. The explanations vary and stress on the one hand the non-control of the consumption in the centres themselves and on the other hand the heavy procedures the centres have to go through to require the medicine from the Ministry of Health. It is suspected that economic and political interests are at stake. Solving the problem is up hill considering all these difficulties. Good command of the supply mechanism is however a must and deserve special attention.

The functioning of the centres is based on the health committees that play an important role in relation to contact with the population. They sometimes act as mediators in relation to complaints from the population.

7.2 Targeting and Information Management

7.2.1 Communication and Needs Assessments

Information flow, from the field and to the field and concerning the outcomes of assistance provided, is good in terms of factual data, but not often systematic. Poor communications infrastructure has played a role in reducing quality, as well as a confused understanding by staff of what counts as important in monitoring for programming purposes and for donors.

In most agencies information flow tends to be bottom up, and overburdened with general narrative data. There is a lack of comparability and considerable impressionism in the analysis of situations and impact. Analysis is just not done for a few key indicators.

The evaluation notes that when access becomes possible, thorough and timely needs assessments are not always carried out. Technical indicators which can be used systematically are scarce, whether they be quantitative or qualitative. Some agencies do stand out again as exceptions, but these are not used at the inter-agency level. Stock taking is not taking place, or is inconsequential.

The example of OCHA and funding through the Consolidated Appeal Process:

At a system-wide level the role of the Consolidated Appeal Process (CAP) has been key to information flow. This was instated in 1991 in southern and eastern Africa as a result of the General Assembly Resolution 46/182, to facilitate joined up programming and presentation of resource requirements by the UN agencies. As these in turn fund NGOs, the mechanism of appeals and reviews is estimated to cover between 40 % and 60 % of the total humanitarian aid effort.

Observation shows that the CAP has evolved over time into a complete programming document, including a situation analysis, a framework for action, and requirements defined by sectors. This document is however not indicator-specific. Although figures concerning morbidity, mortality, and nutrition are included, these are drawn from sources difficult to compare, and more importantly are not tracked

over time. There is a prevalence of narrative explanation which tends to be very unspecific, and is apparently confused with qualitative data. The latter is not provided in the appeals, but rather by the agencies themselves in their donor reporting.

More worryingly, there is no link between the appeals process and evaluations. Evaluations, for example two recent ones by WFP in Congo, are commissioned, cleared and transmitted internally within the agencies and not reported in the CAP. In the case of WFP for example a summary of independent evaluation is written by the agency itself and presented to its Governing Board. The Mid-Term Reviews of the CAP present evolutions in needs, but not the impact achieved by projects which have been funded. Nor is there an explanation of the consequence of not funding fully certain projects, creating the possibly mistaken impression that appeal figures are naturally inflated. Hence the information tools of OCHA remain essentially beyond the realm of adequate knowledge management, i.e. analysis which could provide an appropriate basis for funding decisions.

The WFP evaluations reveal that it is suffering itself from a poor link between pipeline information (in other words information about the delivery of food) and food security conditions of the beneficiaries. The 2004 evaluation of the EMOP (Emergency Operation) states, in the section on performance in relation to objectives, that no acute hunger had been detected over the course of the operation, and that there was little evidence on the contribution the operation made to the reduction or stabilisation of the nutritional condition of the populations assisted. No nutritional survey was undertaken in conjunction with the operation. Similarly the only nutritional information collected by the present assessment in the area of Kalemie was from Première Urgence, a technically sophisticated nutritional survey which was itself only accessible from that NGO's office in Goma. Furthermore an evaluation of WFP assistance to Internally Displaced Persons (dated January 2004) states that there are no clear needs-based eligibility criteria used for inclusion or exclusion from WFP beneficiary lists. For this level of targeting the agency is dependent on its local partners.

The CAP is not the adequate vehicle to present problems for discussion among donors, and tends to be written in affirmative terms, with a focus on resource flows. Yet this may overlook significant issues. For example the CAP is based on a one-year cycle - a length of time indeed appropriate for conducting rapid impact evaluations in cases of acute emergency (e.g. food and nutritional crises; health emergencies). However, in contexts of protracted crises, such as DRC and Burundi, characterised by a mix of overlapping vulnerabilities/emergency pockets, and usually unaddressed structural poverty, impact evaluation methodologies tend to show an improvement of the situation: for example the reduction of acute malnutrition in Burundi below 10% emergency threshold in the period 2003-2005 could be seen as a positive development. However, at the same time chronic malnutrition remains above emergency thresholds.

This should trigger two types of questions:

a. for funding; should there be continued funding for nutritional programmes in Burundi if acute malnutrition is contained (focus on life-saving in humanitarian funding)?
b. for programming and response plans: are current nutritional interventions appropriate to address chronic malnutrition?

The posing of questions would facilitate donor programming, which instead tends to concentrate on project proposals which are examined mostly without reference to these broader issues.

It is clear that the CAP is tied to the information collection work of OCHA. This is primarily based on the inter-agency structures, patterned after the system-wide Inter-Agency Standing Committee of heads of agencies. Meetings in Burundi are organized weekly through a "Groupe de Contact", and information flows readily about the evolution of the situation and about operations. This is not a planning framework however, nor does it lend itself to evaluative work.

Decisions are consensual, if decisions are made, and implementation remains the province of individual agencies. Information related to needs-based evaluations, preparation of sector response plans, monitoring of plans implementation, early warning and surveillance is discussed at national (monthly meetings) and provincial sectoral coordination groups (meeting schedule varies according to the provinces). All coordination groups include UN Agencies, national and international NGOs, the ICRC and donors.

The example of UNDP's PCAC in Burundi:

The plan to undertake its own needs assessments in the provinces rather than allocate resources to NGOs to implement projects where they want to work, has a strong underlying logic: to ensure that future activities are needs-driven and that needs are uniformly assessed in each province. The new programme would then prioritise activities and put these out to competitive tender, resulting in the best NGO being selected to implement them.

This is a clear shift away from the PCAC I and II system whereby NGOs approached UNDP with a project they themselves wanted to implement. UNDP is concerned that this led to a supply-driven rather than a needs-driven approach, the NGOs being the entities driving the action in choosing where and in which sectors to intervene. Intervention was thus according to NGO priorities, which did not necessarily coincide with those of the country as a whole.

However, the new approach, while complying with UNDP's legal requirements, has certain risks:

- UNDP will require enormous time and resources to properly document and prioritise nation-wide needs without the NGOs to suggest areas of intervention, even if it is assisted in the task by local and national authorities;
- It will take away a sense of 'ownership' from the NGOs;
- It will further reinforce NGO sentiments of being treated as sub-contractors rather than partners;
- The entire process from needs identification to implementation may result in being so time-consuming that when the project eventually begins, the operational context, needs and beneficiaries may have changed character so as to render the project unrealistic.

The strategy risks being highly centralized, which goes contrary to the principles of local governance, 'strategic' partnership and multi-stakeholder 'ownership'.

Furthermore, the practice of obtaining authorization from UNDP HQ in New York for projects with a value over US$ 300,000 risks delaying the award of contracts and implementation even further. Such awards could take up to nine months – or more, based on UNDP's experience in 2004 and 2005. It would be difficult for the MFA to justify its funds being put towards 'extended emergencies' when a project may take up to a year between needs identification and commencement of implementation.

The example of ASRAMES in Eastern DRC:

The case of ASRAMES is an example for insufficient information flow between the field and the donor level. On several occasions, both ASRAMES and CIF-Santé, have deplored the fact that the Dutch Ministry of Foreign Affairs and its Embassy in Kinshasa, have hardly been visiting the ASRAMES project in Goma. Supervision and monitoring has been done on the basis of reports provided by ASRAMES staff, and by ASRAMES staff visits to The Hague and Kinshasa. To use the words of the ASRAMES-CIF expatriates: "*On peut tricher si on veut*".

Another striking issue is that the Dutch government has signed 11 contracts without any external evaluation commissioned and accepting external audits that all have been carried out by one and the same auditing agency, the BDEF Cabinet, who may have become very familiar with ASRAMES staff. All the external audits in the 2000-2004 period mention that the budget line departmental costs – "*coût des departments"* – needs further clarification to be made by the ASRAMES direction. MFA has not taken those reports as an opportunity to increase supervision or control.

The overall impression is that both ASRAMES-CAME and CIF-Santé are very professional organizations which are delivering high quality services. Although officially ASRAMES and CIF-Santé are the result of the joint effort of organizations, in practice ASRAMES is functioning as the result of individual persons both expatriates and national people – including a Dutch couple - who have been working with each other since the beginning of the 1990, in different organizations and occupying different positions, but continuously relying on Dutch funding. In fact both persons have received salaries and consultancy fees out of the project entitled DMV0016985. To outsiders such as the evaluation team, this raises questions with regard to the transparent and effective use of resources. The Dutch Ministry has never asked questions for clarification.

7.2.2. Analysis of information

The strategic analysis of information is missing at the upper echelons where the larger amounts of resources are managed (for example UN agencies handling many contracts), due to the fragmentation of ownership along the aid management chain. Nobody is in a position to plan according to the needs of the population because of operational risks that require continual adaptation, and because the priorities of donors are not always clearly perceived. There is only limited real planning on the basis of capacity and of past programmes.

Good Humanitarian Donorship:

In the preceding section the evaluation noted the weaknesses of the CAP in defining systemic issues surrounding humanitarian aid, particularly as regards information management. These have been acknowledged in the Conclusions from the 2003 Good Humanitarian Donorship (GHD) conference. The GHD Implementation Plan included piloting new approaches to more effective humanitarian outcomes in one or more crises. One such study was carried out in Burundi in 2004. Its findings were very critical, noting in particular that there has been little leadership in-country to make GHD become a reality over and beyond simple discussions.

The study notes that there is a tendency to oversimplify the objectives of the GHD by considering it an on-going process feeding on its own momentum. The GHD is a mix of a) objectives and definitions, b) general principles and c) good practices in donor financing, management and accountability. The GHD has a wider audience than donors and involves other humanitarian stakeholders as well. As such its process must be streamlined and clarity about which concrete objectives can be attained in Burundi. This has been confirmed by the Humanitarian Coordinator, who stated that the initiative had been an elephant that had given birth to a mouse. In both Burundi and Congo the concept of GHD was seen as abstract, while the flexibility and reliability of donor funding (particularly Dutch funding) was considered much more relevant to operations.

The example of UNDP's PCAC in Burundi:

The absence of clear notions of what is priority and what is not in donor funding is exacerbated as one moves away from the funding window, down the aid management chain. According to interviews with implementing partners (NGOs) and other stakeholders (UNHCR, FAO), UNDP's management with respect to the projects it manages under the PCAC, for example, is good, though rather slow, but with respect to actors outside the PCAC it is poor. One NGO partner interviewed in situ (CARE International) stated that it was not satisfied with its partnership with PCAC: it was not a true partnership between equals; it had suffered serious funding delays and there had been non-reconcilable disputes over the ownership of non-expendable property. CARE professed itself unwilling to undertake any further partnerships with PCAC. UNDP in turn reported difficulties with CARE: late submission of project reporting and a perception that UNDP was little more than a convenient 'mail box', since CARE had direct relations with its donors.

PCAC's reports leave much to be desired. They are well-presented but on closer inspection do not give clear information, especially with regard to funding chains, amounts requested, contributed and disbursed by donor and by project, and provide

little analysis on impact. These aspects have been noted by internal evaluations[50] conducted in 2002 and 2004 but not yet acted on satisfactorily. In fact, progress reports presented in the earlier phase are of better quality than the later ones. The two internal evaluations are the best source of analysis, well written and informative. The responsible staff at the Dutch Ministry informed the evaluation team that in its perspective from 2003 on there was no specifications in the progress reports. Financial information could be found in the certified statements. Generally speaking issues were found with format and timing (the 'most recent' report at the time of the evaluation covers the period January to June 2004) and as a result no contribution has been made in 2005.

Another deficiency of the project noted by previous evaluators as well as the current team is the lack of integral analysis given to project beneficiaries both in the project descriptions and the reports.

7.3 Coordination

7.3.1. Coordination and gaps

The ability to coordinate and address gaps in delivery has been good at the level of humanitarian assistance. It revolves essentially around the exchange of information about needs and activities, and the pooling of supply chains. It is when one moves beyond direct humanitarian operations that performance deteriorates considerably. The more long-term structural issues, particularly capacity building, are neglected.

The example of FAO in Burundi:

The example of FAO-TCOR, positioned literally in the driver's seat of the agricultural sector in Burundi, is particularly telling. FAO-TCOR has until now employed the most competent staff available in the agricultural sector in the country. The TCOR unit has close relations with national organizations, like the university and the research institutes, as well as with the ministry. This FAO-TCOR unit at the moment is taking the lead in setting policy agendas and in implementing agricultural projects, meanwhile ensuring collaboration with the ministry and the provincial departments. Provincial departments however, do not have the resources to be operational in the field and to carry out monitoring and evaluation tasks.

Due to the rapid phase of political transition at this stage in the country (a new Government was sworn in at the time of the evaluation, representing new forces), no public reflection has been carried out until this moment to prepare an exit strategy at the institutional level. This should enable the Ministry and its departments to take over FAO's current roles and responsibilities after the installation of the National Government. While Burundi is entering a pre-planning development stage, it is appropriate that FAO-TCOR take the initiative to facilitate the next phase towards development and assists the Ministry in taking the lead in policy formulation and implementation of agricultural policies.

[50] See for instance : Michel Gutelman et al, 2001. PCAC Evaluation finale: Résume analytique – leçons et recommandations, Bujumbura.

Such a handover of roles and responsibilities to the Ministry as well as a reinforcement of the competencies available at the Ministry and its Provincial Departments would require careful analysis and resource planning. This has not yet been carried out.

Coordination at national level however is effective. FAO collaboration of interventions at the national level is well done by the monthly or bi-monthly CCA meetings. The same applies for collaboration with the Ministry of Agriculture and Animal Husbandry, with the UNICEF and the WFP. Those four organizations make joint evaluations of the harvests, food aid and nutritional status in all provinces and for every season. Those reports enable FAO to intervene with the distribution of seeds and tools.

FAO project proposals are also incorporated in the Consolidated Appeals that are coordinated by the OCHA.

The same picture emerges in a very different context in North Kivu. Coordination mechanisms in the health sector are in place and functioning in North Kivu, according to several actors in the sector that were interviewed. National and international workers are in close contact and exchange information regularly. The security situation is improving, though still fragile.

The example of UNDP's PCAC in Burundi;

The evaluation team observed inadequate interaction with agencies such as UNHCR and WFP in terms of following refugees back home and putting in place targeted projects to help with their reintegration and absorption in the communities. UNHCR implements Quick Impact Projects for returnees to Burundi, yet were the PCAC to operate effectively, this parallel mechanism to the PCAC should not be necessary. UNDP would, by the interplay of mandates within the system, be 'the' UN-mandated agency to take over from the emergency phase with transitional projects leading to longer-term development.

Interviews with interested parties reveal that the PCAC appears not to liaise sufficiently with either UNHCR nor with WFP, who provide returnees with food rations for six months after their return. The link to the UN Peacekeeping Mission's DDR programme is due to be established in the next phase of the reintegration activities, which will have a conflict prevention objective, as well as infrastructure and economic security.

In general, UNDP has not yet addressed transitional coordination with all concerned agencies the same way that OCHA coordinates activities in the emergency relief phase, yet it has both the mandate and the means to carry out this function. Indeed, there is a manifest need for it, expressed universally. The new and broader thrust of UNDP planned 2006 programme in Burundi is intended to cover the number of global relief operations that are currently hovering between relief, rehabilitation and development phases (DRC, Uganda, Liberia, Indonesia, Sri Lanka), which would be very timely.

The example of Cordaid in Burundi:

Considering all this the office of Cordaid in Makamba plays an active role in terms of coordination in this zone of action. Cordaid participates actively in meetings with "the contact group" which has been launched by OCHA. OCHA has suggested a weekly information meeting devoted to analysing the humanitarian situation. This network is looking at the summaries from the quarterly meeting that are being held in each province guided by an NGO that acts as "focal point" and assembles all the partners that are active in a province. Since 2004 Cordaid has been the principal NGO in the province of Makamba.

Cordaid participates in the coordination meetings of the medical sector held twice a week under the guidance of WHO called "health exchange". Cordaid is also a member of "Réso" a body representing all international NGOs in Burundi.

The example of World Vision and Save the Children in DRC:

World Vision shows evidence of close coordination with other agencies on planning and implementing their activities. For example, when planning its intervention in Kirotshe, WVI noticed that the lack of clean water was a very big health threat and liaised closely with OXFAM to intervene in the same area. Save the Children undertook a study in Masisi and found malnutrition rates were high in certain areas. Save the Children and WVI now work in the same activities in different "aires de santé" in Masisi. The scarcity of clean water in Masisi was raised by both agencies in the coordination forum, which has led to the ICRC considering intervention in this sector and area. Such complementarity and good practice in coordination appears widespread in Goma, as attested to by agencies other than WVI, though it is thought to be less performing in certain sub-sectors such as agriculture. Gaps are mainly due to resource insufficiency rather than lack of coordination.

Where coordination, complementarity and linkages between relief and development are problematic is in the handover of programme activities after the MFA funding ends in December 2005. Therapeutic feeding and supplementary feeding are emergency activities with low sustainability. Training of local staff in nutrition is important for the continuation of nutrition activities.

The problem is not one of coordination *per se*, because WVI was observed to be in very close contact with communities and in touch with realities, needs and insufficiencies on the ground. It has put in place good training mechanisms with multiplication effects among the local communities.

Save the Children has also undertaken significant coordination efforts with other actors working in the same sector, such as World Vision for health and UNICEF, MONUC, etc. for the reintegration of ex-child soldiers. Save the Children participates in the various coordination initiatives implemented by OCHA, WHO, etc. However, coordination appears to be limited to 'who does what where'. There is a need to improve coordination of different approaches and strategic thinking, and improve dissemination of basic information that determines programme definition. The publication of the results of household assessments or of Save the Children strategies for the reintegration of ex-child soldiers is important to this effect.

Save the Children also collaborates with the Ministry of Health at a district level (Inspection Provincial de la Santé) and at health zone level (Bureau Central de Zone de Santé) for its health programme and with local partners (PAMI, UPADERE, DIVAS) for the child protection programme. This collaboration is somewhat

compromised by the weak capacity of Ministry of Health infrastructure, despite the improvements introduced by various capacity building processes that are currently underway.

8 LEVEL 4: POLICY: BENEFITS IN TERMS OF CONNECTEDNESS AND COHERENCE

8.1 Strengthening Institutional and Mandate Linkages

8.1.1. Internal and external coordination

There is no incoherence between different foreign policy directions in Dutch supported actions. However there remains a gap between institutions dealing with peacekeeping and peace-building (which also touches on the reconstitution of public administration in war ravaged areas) on the one hand, and the humanitarian aid field on the other. The connections take place through security related issues (staff security, broader Security Council mandate implementation), but not at the level of the programming of aid for the transition.

The aid community, in the form of its coordination meetings (absent in Burundi for example) and resources deployed on the ground (for demobilisation in Congo) lags behind the political process.

The most significant interaction noted between the aid agencies and the peacekeeping forces on the ground in Burundi and in Congo concern security of personnel and of facilities. This is carried out through the exchange of information, and occasional escorts and securing of assets.

The need for the peacekeepers to operate with very limited means, and in cooperation with local authorities in as much as possible, meant that this protection was not always available. Thus in June 2004 the WFP offices and warehouses in Kalemie were comprehensively raided and looted, while peacekeepers established road blocks to contain the crowds about a kilometre away. The ability of the agencies to access MONUC logistical services, in particular flights, is highly useful, even if a little constrained (for example NGO vehicles are not allowed to enter airstrip perimeters, for example).

Coordination meetings between MONUC and humanitarian aid agencies are not very systematic however. It was noted that in Kalemie this is increasingly taking place concerning the demobilisation and reintegration of armed groups. In Burundi it remains a completely separate process. There is a monthly forum in which issues of DDRR and rule of law can be discussed. However the programming of emergency rehabilitation and governance still is not coordinated. On the other hand, as has been noted elsewhere, this coordination highly developed in the area of humanitarian aid, with weekly meetings of the contact group. The Resident Coordinator noted in the interview that humanitarian assistance would have to ensure that assistance keep pace with the political reforms and the expectations of the population.

This is not necessarily the fault of the peacekeeping side of international operations. Much progress has been achieved in the procedures of UN peacekeeping contingents, as compared to the inability of UNPROFOR in Bosnia or MINUAR in

Rwanda[51] to ensure the security of personnel, or even to establish operational humanitarian affairs units. Some of the blame for the lack of dialogue rests with the agencies.

On the one hand the integrated structure of the UN central office in Burundi is highly advanced, where the aid coordination wing is under the authority of the UNDP Resident Representative, who effectively wears four hats: that of Resident Representative, Resident Coordinator for the UN agencies, Humanitarian Coordinator, and Coordinator for security (UNSECOORD). On the other hand there is little translation of the potential that this brings to link the demobilisation process to emergency rehabilitation.

The example of UNDP's PCAC in Burundi:

UNDP's PCAC intervention strategy in Burundi for example, since 1999 to the present, has been to bridge the transitional phase between emergency relief and development, a highly relevant policy given the political, social and economic situation of the country throughout this period. Through a community-based participative approach it aims at building peace and reconciliation by 'assisting the Burundian populations to rebuild their economic social and material lives'.[52] It professes to do this through strategic partnerships, but it is unclear from project documents how partnerships are chosen, with whom they are strategic, or what the strategies actually are.

Just as important as the links to peacekeeping and peace-building are the links to capacity building programmes. These would appear to be the most relevant form of action apart from humanitarian aid. Eastern DRC for example is currently in a state of endemic crisis – persistent instability and uncertainty as to whether security conditions will improve in the near future – highlighting the importance of building the community's capacity to withstand shocks and strengthening resilience beyond periodic emergency relief.

Mobilising the affected population's own resources is a respectful and effective approach. However it is not easily put into practice. Its strength lies in the fact that people emerge from a state of 'learned helplessness', or. aid dependency, and take on an active and participatory role. This enables them to adopt a more positive attitude to their future. Furthermore, if the affected population has been under threat over an extended period of time, it may be functioning on a survival basis and social fabric may have been weakened.

In this case, prolonged interventions are required in terms of psychological support and strengthening of existing coping strategies. However, investment in social capital and psychological support requires a medium- to long-term commitment. Unfortunately, these activities are not considered by the agencies to be as liable to be funded by most donor agencies, and they are thus often overlooked by humanitarian actors and donor agencies alike.

The example of ASRAMES in Eastern DRC:

These conundrums are addressed in their own ways by some of the agencies with the longer lasting programmes. ASRAMES for example, is the lead agency in the Health

[51] Reference is made here to the personal experience of the evaluators in those operations.
[52] PCAC Progress Report, January-May 2002.

System in North Kivu and is a role model for setting up Health Systems in eastern DRC. It is unique in combining business principles, a quasi-public status, and pure charity work. This is materialised in a web of agreements and interconnections.

- ASRAMES is still very important in setting the policy agenda. It has 5 founding members and itself represented in the steering committee of IPS, one of its founding members –CEMUBAC– is directly assisting IPS and at the same time in the ASRAMES board. Another ASRAMES partner, Novib, is also assisting IPS in setting up cost recovery policies and improving drugs delivery systems within the health system.
- In the drugs supply market, ASRAMES is holding a monopoly position in the Eastern Congo. As of 2005, ASRAMES has been recognized by EU as the humanitarian partner for drugs supply, meaning that all NGOs who use EU funding have to purchase drugs with ASRAMES. ASRAMES has also an official status *vis à vis* the government of DRC and is exempted from paying taxes.
- As of 2006, the European Development Fund programming process intends to replicate the ASRAMES experience, which it considers successful, in other provinces.

ASRAMES-CAME is financially viable, but in fact the entire health sector is depending on one donor. ASRAMES is not receiving direct donor funding anymore as of April 2004. Its main sources of income are the drugs supply to NGOs (67 %) and IPS (24 %). However, most orders are indirectly financed by the European Commission as they are financing both the NGOs and IPS, making the whole health sector very dependent on only one channel and is hence vulnerable.

As of 2002, ASRAMES has rationalised its operational costs and increased its own capital by 370,000 Euro. Currently it is building its own warehouse at one of the biggest building sites in Goma.

CIF-Santé has turned into a well performing organization, however not financially viable at the moment. CIF-Santé transformed into a training, consultancy and applied research organization, while at the same time intending to continue with the direct implementation of development projects. The quality of their services is highly appreciated by all Health partners but they cannot charge fees that enable them to operate on the basis of cost recovery.

There is a unique constellation of professionals who are working together within the structure, in very trying circumstances. The overall impression is that both ASRAMES-CAME and CIF-Santé are very professional organizations which are delivering high quality services. Although officially ASRAMES and CIF-Santé are the result of the joint effort of organizations, in practice ASRAMES is functioning as the result of individual persons both expatriates and national people – including a Dutch couple – who have been working with each other since the beginning of the 1990, in different organizations and occupying different positions, but continuously relying on Dutch funding.

This mechanism for achieving substitution to the state in the public interest is admirable in many ways. It however raises real issues of accountability. An example is the partnership between CIF-Santé and MDF-ESA. MDF is a Dutch training and consulting foundation specialized in public health and development issues. MDF and

CIF are jointly organizing training courses in North Kivu. MDF is also hosting CIF's web site. In fact this relationship is based upon a personnel relationship, where both persons have received salaries and consultancy fees out of the project entitled DMV0016985. To outsiders such as the evaluation team, this raises questions with regard to the transparent and effective use of resources. The Dutch Ministry has never asked questions for clarification.

The multi-annual funding applied by the Dutch government is hence definitely a strength in this perspective of it is exercised knowing the particular requirements of endemic crises. This multi-annual nature of Dutch funding is based on a recent extension of the duration of projects from one year to two years, but also on a willingness to continue funding an institution which has proven to be reliable.

In the context of prolonged conflict this is highly relevant and enables a certain degree of inter-institutional links to be established.

The example of Save the Children in Eastern DRC:

The Dutch government financed a series of Save the Children programmes lasting six to eighteen months, and according to the Dutch Ministry of Foreign Affaires, this timescale will be extended to two years in the near future. The importance of strengthening social capital and providing psychological support (see sections above) raises questions about the relevance of short duration programmes which may be the root cause for high staff turnover and compromise the programme continuity.

The Dutch government's decision to continue funding Save the Children's health programmes since 1999, as well as Save the Children's efforts to ensure continuity in these programmes is commendable. However, in order to increase programme impact and ensure that social capital is strengthened in the long-term, further thought needs to be given to ways of ensuring medium- to long-term commitment by the Dutch Ministry of Foreign Affairs and Save the Children, whilst ensuring that programmes are capable of adapting to context changes.

8.1.2. Humanitarian Space

The peacekeeping missions have had a globally positive effect on the sense of stability among the population, with the exception of Ituri since 2004 where evidence collected in interviews points to the fact that the peacekeeping mission is one of the forces engaged in military action.

Humanitarian space is naturally very limited by insecurity, but well negotiated through a structured process. The UN has drawn the lessons from integrated missions in Congo and Burundi, with improvement in coordination.

Progress in the peace process in both Congo and Burundi, and the deployment of integrated UN operations, is having a direct and positive impact on humanitarian conditions on the ground.

The evaluation was struck by the progress made between 2003 and 2005 in many of the regions visited, be they in Tanzania (from where the refugees are repatriating), in Burundi where most areas are now safely accessible during the day and the elections have passed without major disruption, and more specifically the field situation in

Congo. In this latter case the region south of Uvira has opened up since the establishment of a relatively strong Pakistani peacekeeping presence. In all these cases there is a clear link to international peace support efforts. The population repeatedly informed the evaluation team that this change is not so much the result of effective monitoring of the outlying regions, but rather that the presence of MONUC deterred the larger rebel forces (in particular the RCD), and eliminated the justification for *Maï Maï* militia checkpoints.

However the eastern part of Congo is still wracked by a high degree of insecurity. Security incidents involving aid staff are daily reported in the Goma area, where exactions and armed violence are visible, even if in an ill-defined form. It is reported by aid agency staff that in Ituri the conflict continues, directly involving MONUC.

8.2 Ability to Address Both Situational and Structural Vulnerability

8.2.1. Instruments for emergency response

The instruments available in the emergency response sector (i.e. significant logistics, short projects, outcomes designed in a return to "status quo ante") are effective for emergency interventions (which the team was not given to observe) but of low relevance for situations of structural vulnerability.

These structural factors cause severe hardship in the communities, and sow the seeds of future crises. Within the organisation of the Dutch government this problematic is effectively delegated from the Humanitarian Aid Division to development cooperation. But often engagement comes too late or not at all.

The example of UNDP's PCAC in Burundi:

UNDP in Burundi has deployed the PCAC under an intervention strategy which is persuasive to the evaluation team. The 2004 evaluation undertaken by UNDP points to the lack of proper objective-setting but, this criticism notwithstanding, the project's main objective *de facto* is: that of alleviating poverty in areas that have seen destruction of livelihoods due to years of conflict and insecurity by assisting the return and resettlement of populations displaced by the conflict and by strengthening the capacity of return communities to improve the livelihoods of their most vulnerable people.

Such short-term responses certainly falls both within the scope of UNDP's global aim of poverty reduction under the Millennium Development Goals (MDG) as well as its role in post-crisis situations, and within the Dutch strategy of extended emergency (*urgence élargie*) funding. In fact, the PCAC fits the definition of a response to a chronic emergency in light of the ongoing political instability in Burundi that has left much of its population in poverty and in need of targeted interventions.

The example of World Vision's Kirotshe Health Program in Eastern DRC:

The situation of endemic crisis in North Kivu requires simultaneous interventions in relation to humanitarian aid, rehabilitation and development. The Dutch Humanitarian Aid policy is not providing such a framework where interventions can

be combined, nor do Dutch policies in the Great Lakes provide emergency strategies into adaptive forms of assistance oriented toward increasing the ability of the population to withstand crises. This is reflected in the shortcomings of the implementing agency programming.

The fundamental problem faced by agencies such as World Vision is a structural one that affects much of the humanitarian community, and is due to the lack of national infrastructure and services in certain sectors – particularly health. Thus, as noted above, handover of the feeding programmes to national authorities may lead to a renewed increase in malnutrition rates because the latter do not have the capacity to access essential nutritional inputs such as those currently provided by UNICEF and WFP.

Even if there is a certain internal coherence in developing garden and animal husbandry activities for each "zone de santé" where WVI is phasing out supplementary feeding, it is questionable as to whether communities are sufficiently advanced in their small gardening and animal husbandry skills and experience to ensure food security on their own. This means that other, longer term, forms of adaptation have not been explored and phasing out is here done because there is a perception that the emergency phase must give place to normalisation. On the ground it is much too early to do so.

This situation calls for an exploration of the very concept of humanitarian aid, as formulated in the Netherlands Ministry of Foreign Affairs: the relief of life-threatening needs. This is not necessarily premised on the transitory nature of humanitarian aid. Humanitarian aid should also allow the populations to move away from life-threatening conditions before development assistance is allowed to intervene.

8.2.2. Grey Zones and Linking Relief Rehabilitation and Development (LRRD)

In spite of recent changes in funding instruments (in particular longer funding cycles and the creating of TNF, the transitional fund for security sector actions) there is not yet an appropriate Dutch policy about cut-off points for humanitarian aid in grey zones. There is only a gradually emerging awareness of the possibility of a two track approach (situational and structural) and the possibility of passing from one to the other.

Linking Relief, Rehabilitation and Development, which is considered good practice in humanitarian aid, is still not ensured for lack of funding and of an ability to access the appropriate resources. Linking Development, Rehabilitation to Relief (in other words a shift back from development to relief) is not foreseen by donors, yet occurs on the ground.

The example of ASRAMES in Eastern DRC:

Yet beyond the policy discourse, a certain degree of flexibility exists *de facto*. It has never been the intention of ASRAMES, nor of CIF-Santé to provide Humanitarian Aid to their beneficiaries. All interventions have been oriented towards setting up a Health System on the basis of partial cost-recovery practices, following the international Health Policy framework, the Bamako Initiative. Both structures have shown to be very relevant for the improvement of health services and the Health system in the North Kivu.

In the strict sense of humanitarian assistance, MFA-NL should not have funded the MFA 8-11 projects. The projects implemented seem to be more eligible for rehabilitation funding or development oriented funding, which are not yet deployed in Congo (development), or not seen as a priority funding for health services (TNF which is more oriented to security sector reform).

The example of FAO in Burundi:

The existence of critical needs is not linked only to the existence of civil conflict. FAO notes that in Burundi, in areas not affected by the current rebel activity, the percentage of chronically vulnerable households is increasing and requires other intervention strategies. The percentage of households that are chronically vulnerable is estimated to be at 16 % in September 2004, whereas this percentage used to be lower in previous years (13 % in 2000). This structural problem cannot be attributed solely to the consequences of conflict, but also to high population density, high dependency on the agricultural sector for making a living, lack of a labour force, and decrease of agricultural produce.

Rather than continuing with the distribution of seeds and tools, this problem requires more structural interventions that aim at stimulating off-farm employment in order to address land issues and chronic vulnerability. Other ministries than the MFA might possibly be involved in trying to stimulate off-farm livelihood strategies. It is generally accepted that development aid is not apt at dealing with pockets of severe vulnerability which often have cultural or social roots. Even from the point of view of development aid there is a need to continue the targeted form of humanitarian assistance, even when the overall emergency figures have improved. Yet it is considered that it should be gradually phased out.

A targeted adaptive approach in the recovery phase would however require more in depth analysis of the situation than is currently found in the files. We note for example that the MFA has always financed seeds and hoes projects. This is despite the fact that other project proposals have been submitted to the Humanitarian Department in early 2000. No information has been obtained that makes this choice explicit in relation to other actions developed by FAO-TCOR in Burundi, such as seed multiplication and home gardening. At the time of writing the FAO-TCOR is recommending to the Dutch Government to finance projects that contribute to the improvement of input markets (fertilizers), to animal husbandry development for organic fertilizers and for home gardening. Those activities can be justified under the Humanitarian Department, because they are still targeting the most vulnerable people and trying to improve the access to seeds and fertilizers on local markets.

FAO-TCOR is targeting the most vulnerable households with its seeds and tools program and with its programs of local seed multiplication, home gardening, vocational training and eventually small animal husbandry (rabbits, birds, piglets, goats). The target groups are in theory the most vulnerable households. But the FAO-agricultural development department in fact addresses the specific needs of the better off households, who have access to different livelihood capital available to engage in agricultural production and marketing. The consequence is that no exit strategy has been developed for the assistance to the FAO-TCOR target group.

The MFA-NL has not developed a handover strategy to development either. There are no bilateral development relations between Burundi and the Netherlands, which makes it very difficult for the Humanitarian Department to prepare an exit strategy with Dutch funding.

These issues are not limited to food security, but are found in other sectors such as health, with Cordaid. The high level of and the rise in the vulnerable part of the population in need as well as a population that is fragile after the war, displacements and an almost total absence of measures dealing with the mental health of this population is a risk factor. The stability of a country and the population depends directly on the quality of life. The quality of life is dependent on the satisfaction of primary needs as well as a psychological balance.

The programmes of prevention in terms of vaccines, nutrition, water and protection against malaria and other diseases (HIV/AIDS, STI etc.) are being implemented and allow prevention that have a impact on the health condition of the population. The issue of mental health is however not included in the programmes and it risks being a "bomb of setbacks". A problem neglected is not a problem solved.

The Dutch Ministry does not have a strategy for the link between relief, rehabilitation and development. This poses a great risk in terms of maintaining the existing structures in the province of Makamba. The transfer of responsibility is not easy and the health centres will probably become autonomic with great difficulties or maybe they will never become autonomic at all. A transparent governance of the services and the finances as well as a good functioning in general could eventually convince future agencies.

8.3 Regional Dimensions, Links to Peace Processes

8.3.1. Cross-border effects

Regional planning for programmes does not take place at the level of the Embassies, nor among the agencies, with the exception of some of the UNHCR activities in relation to repatriation.
The reduction in food rations in Tanzania, for example, is acting as an encouragement to repatriation even though there is no official policy of encouragement of repatriation.

The example of Care/SAEU Providing Community Mobilisation and Education to two Kibondo Refugee Camps:

Within the Dutch government the field monitoring of the SAEU programme falls within the responsibility of the Dutch embassy in Dar es Salaam whereas the responsibility for monitoring the Burundi programme was shifted in 2002 from Dar es Salaam to Kigali. While this arrangement does not constitute a problem when the activity monitored is one of care and maintenance in the Tanzanian camps, it risks creating a disconnection between what should become a joined-up programme of repatriation to and reintegration in Burundi.

On the agency level there is no cross-border approach followed by Care Netherlands or Care Tanzania although Care is a world wide network and through this network also operating in Burundi. The local implementing partner has over the years established a good relation with the refugees in the camps but has difficulties in dealing with Burundi directly. It should however be noted that this situation is not unique to SAEU. A previous evaluation ("Evaluation of the Tanganyika Christian Refugee Service" commissioned by Danchurchaid) noted that this issue pervaded all the NGOs operating in the camps.

Given the renewed likelihood of increased repatriation in the coming months because of the peace process, it would be more coherent to reorient current strategies to strengthen the cross-border link and communication between and within agencies. Care/SAEU could initiate contacts with UNDP in Burundi to find out how it may be able to link up with the new phase of the PCAC in this respect.

The evaluation also notes the degree to which the refugees are more tuned to events across borders than the agencies. The upcoming (September) election registration in Congo acted as a magnet for the Congolese based in the camps to the north-east of Kigoma in Tanzania. Even though UNHCR had not encouraged repatriation, because of continued insecurity and occupation of houses, the repatriation was running steadily. It seemed to be linked to the desire of the refugees to gain electoral registration cards (which are considered by public rumour to entitle the holder to an identity card), but also to the reduction in the WFP rations in the Tanzania camps. This would appear to be linked to pipeline difficulties, but has the net effect of contributing to a sense of rapid transition in Congo. This coincidence is not the result of careful regional coordination.

The regional planning strategy drawn up by the MFA responds to concerns that the attempts at resolving the crisis in Rwanda and Burundi in the mid-nineties had been too country based. It was believed at the time that cross-border security issues, and the tasks of repatriation, had to be considered jointly to achieve more results in a return to stability. The current document remains general in its terms. The regional approach is limited to the political and security sector level, does not include humanitarian aid programming, and is not supported by an organisational structure. This has not had negative consequences for humanitarian assistance, as the planning and delivery remain focused on agencies and on countries, rather than being cross-border.

9 FINDINGS AND RECOMMENDATIONS

9.1 Key Findings

The balance of performance in humanitarian assistance is good in as much as the emergency needs are concerned, but is not convincing as regards structural vulnerability. Considerable suffering is being experienced by pockets of population which are not reached by traditional humanitarian assistance, and more targeting of vulnerability is required. The danger is that the population will enter a phase of prolonged loss of human and social capital. This will inexorably lead to continued instability, even if the political and governance frameworks are being adequately addressed in Burundi and Congo.

The evaluation has focused on two key concerns.

1. The first is that there is a need to create a new centre of gravity for knowledge management in the humanitarian aid management system. This must be situated closer to the field in a physical sense, and have the time and personnel needed to penetrate the complex local reality. It should also have contacts with the Embassies and the Ministry in The Hague to ensure that information collected can be acted upon. This would make the upper echelons of the aid management chain more focused on contractual and delivery issues. It could complement the role of OCHA in resource mobilisation.
2. The second is that the Ministry should explore ways of increasing the funding to its transitional funding windows. TNF is currently 60 million € annually, which cannot cover the needs identified as well as those of DDR in the region. Alternatively the Humanitarian Aid Department could loosen its strictures in the interpretation of the policy mandate. This would allow it to cover capacity building, support to local administration in health and social services, and psycho-social needs of a protracted nature.

9.2 Implications for the Ministry of Foreign Affairs

The policy framework for Dutch Humanitarian Assistance in general and for the Great Lakes region in particular is relevant and sets the right priorities. The concept of a three track approach combining peace negotiations, stability through Security Council mandated peacekeeping in the region, accompanied by life-saving humanitarian activities, is a relevant and coherent approach, reflecting connectedness.

The implementation however does not always achieve the goals of this approach. Deficits are in particular that:

- There is still a gap between relief and rehabilitation, and Dutch policy and financing opportunities does not allow for a strategic "adaptive" perspective for the population caught in a prolonged conflict, especially when there is no long-term bilateral development

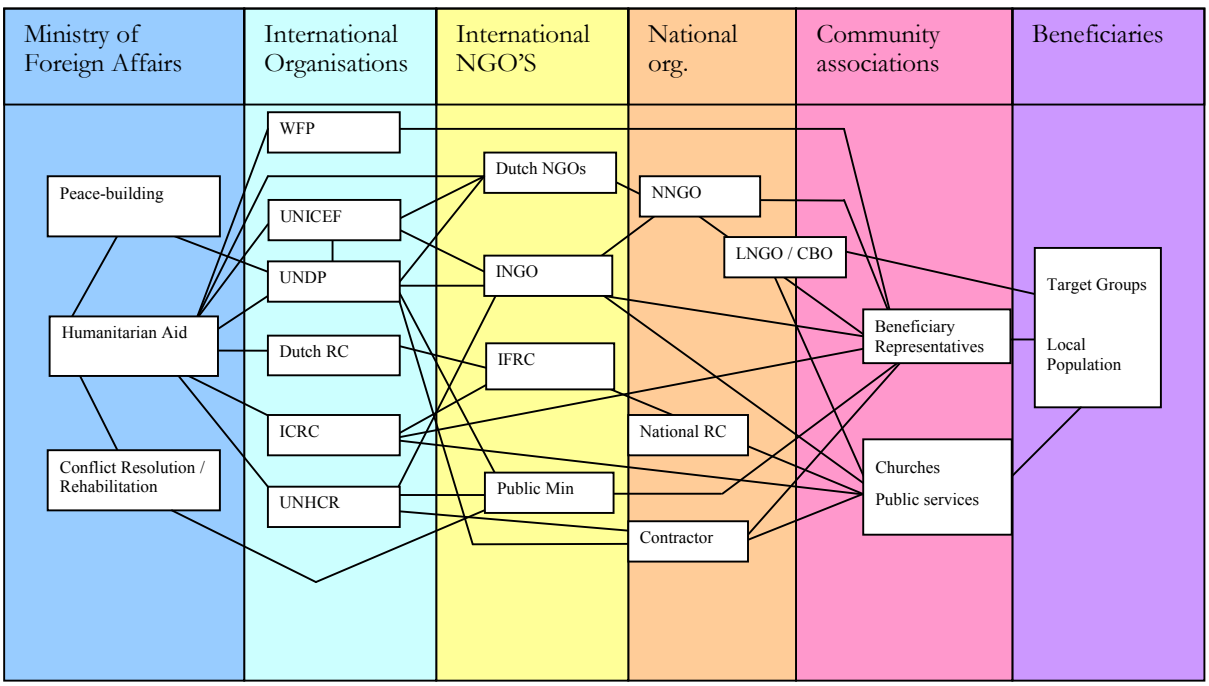
programme, or when there is a disconnect between the Embassies and the Humanitarian Assistance Department.

- Going through a prolonged aid management chain (choice of multiple sub-contracting processes with the UN and NGO partners) is detrimental to information flow and to a responsive aid system. It leads to an excessively conservative programming, to poor controls, and delays. The evaluation has not examined the issue of cost-effectiveness, but, as suggested by some of the agencies that have commented on the draft report, would merit some attention.[53]

Dutch policy establishes that the State's aid programmes cannot be limited to the more high profile cases in public relations terms (those receiving most coverage in the Netherlands), and should not be liable to be used as a weapon in the hands of any of the armed groups. This has clearly been respected.

Furthermore, the overall aim is to follow the direction of the efforts of the populations concerned to find and adopt the solutions which will help them escape from life threatening conditions. This has not been implemented systematically, and clashes with the relatively conservative project proposals put forward by the agencies. There is simply an absence of analytical capacity that can understand all levels of decision making, from the local delivery organisations to the Ministry in The Hague.

There is strong evidence throughout the evaluation that policy decisions are made on the basis of general principles which establish an appropriate overall framework, but do not enhance agency performance due to the remoteness of policy makers to the population most in need. The key difficulty is attributed by the evaluation team to the long chain management in the Great Lakes, and the limited capacity in the MFA to handle the contractual and analytical complexity of humanitarian aid. This long chain can be represented in the following way, where each box represents an agency (itself often better represented in two to four sub-boxes):



[53] It can for example be assumed that four levels of implementation lead to overhead expenses of more than 40 % if each level uses 10 % of the funds for administrative expenses.

Beyond the immediate contracts, drawn up here as lines linking the agencies in the management of financial resources, Dutch funded projects must also deal with a complex institutional fabric in the region. This fabric includes impoverished public service delivery organisations, community based organisations, church organisations and non-governmental organisations, as well as other bilateral and credit agencies. There is also a strong regional dimension because of the significance of refugee and rebel movements across borders on local conditions. Decisions are shared between missions in three capitals, separated by one to three days' travel from the field, and the capital in the Netherlands.

The responsibility for knowing and planning civilian crisis response sits uneasily in the Ministry. This is due to the limited staffing in the Humanitarian Aid Department. For the period May 2003 to now the Great Lakes files changed hands two times in a short period of time (end 2002 and end of May 2003). Due to a shortage of manpower delays in the processing of applications had built up. There were also significant delays in the payment of instalments due to the introduction of '*Piramide*' (The Ministry's administrative software package) in the spring of 2003.[54] Many of the agencies experienced delays in receiving instalments from the MFA. This has impacted negatively on their programme implementation (for CARE/SAEU, UNDP, World Vision).

The Ministry meets most of the INGOs concerned twice a year on a bilateral basis and every time insists upon a timely introduction of new proposals. The funding to the UN agencies passes through the Consolidated Appeal Process. There are also good connections between the Humanitarian Aid Division and other units of the Ministry in charge of specific issues.

In the case of WFP programming there are regular contacts by email and telephone with the staff representing the Netherlands at the Governing Board, at least weekly, sometimes more often. Preparation for the WFP Governing Board meetings is carried out in very close consultation between the officials in The Hague and in Rome. In the Ministry several departments are involved in preparing for the WFP Governing Boards, namely the United Nations and Financial Institutions department, the Humanitarian Aid Division and the division that is responsible for international markets. A representative from the Humanitarian Aid Division joins the delegation to the WFP Governing Board on a regular basis, but not always (depending on the agenda and timing). The WFP Governing Board is always attended by a representative of the UN department and representatives of the Netherlands in Rome. The Humanitarian Aid Division is actively involved in bilateral consultations with WFP.

Yet the burden of analysing the results is left on the very limited staff of one in the Humanitarian Aid Division in The Hague. The evaluation has showed that the Dutch embassies in the region (Kigali for Burundi, Dar Es Salaam for the Tanzania refugee camps, and Kinshasa for eastern Congo), even if they are interested, are much more heavily involved in security and diplomatic issues than in humanitarian aid. Visits, when they occur, are mostly to institutions in the capitals, and infrequent in the field.

[54] At the time of writing, the evidence given to the team points to considerable improvements. However from time to time there are still some delays because the applying INGO has not fulfilled all requirements or has submitted its proposal too late. The processing period for applications is still short: in 95% of the cases applications have been processed within the time limit of 13 weeks (according to Grant Regulations).

The MFA is dependent on oral briefings and monitoring by the agencies, which the evaluation has found of limited usefulness.

The implementation modalities are hence an important factor in the results achieved. At a time when the focus on transaction costs for development aid has led to the launch of sector support and budget support modalities, the selection of implementation modalities in humanitarian assistance should naturally come under scrutiny.

This affects programming orientations and the management of knowledge within the agencies and between agencies. It places a heavy burden on the MFA to provide a developed and well informed management and planning framework. For example the recent IDP Synthesis Report[55] noted that donors can have an overwhelming influence on what degree needs assessments are carried out, on the quality of collaborative approaches amongst agencies, and on when and how phasing out takes place in humanitarian aid.

Donors have a fiduciary responsibility toward their own tax payers and toward the populations to be assisted. The aid management chain acts as a complex delivery mechanism, but it has so far not acted as a conduit for accountability in terms of impact and outstanding needs.

A policy of directly financing such units of greater accountability located at an appropriate level of the implementation chain should be envisaged. In other words, this will increase the management of knowledge and inform better decision making within the humanitarian and rehabilitation sphere of aid. This is not only a matter of legitimacy of the aid effort and an issue related to the Netherlands Ministry of Foreign Affairs trying to 'economise' on its own management costs.

Dutch Humanitarian Assistance for the Great Lakes region is relevant. It is coherently inscribed in the Ministry's concept of a three track approach combining peace negotiations, stability through Security Council mandated peacekeeping in the region, accompanied by life-saving humanitarian activities. There is a strong connectedness between humanitarian aid and conflict resolution.

Dutch policy establishes that the State's aid programmes cannot be limited to the more high profile cases in public relations terms (those receiving most coverage by the press and in public discussions in The Netherlands, and should not be used as a weapon in the hands of any of the armed groups. This is in line with humanitarian principles and has clearly been respected.

There are however two key systemic weaknesses which could be addressed through the development of new positions and structures within the Ministry:

- There is a continuing gap between relief and rehabilitation. Humanitarian aid is of a palliative nature and is based on the assumption that "normal conditions" of stability will return. This is not on the horizon in eastern Congo and Burundi. Current Dutch policy and financing do not allow for a strategic "adaptive" perspective to help in a lasting way the population caught in a prolonged conflict and collapsed public services. This may be because

[55] Borton, J., M. Buchanan-Smith and R. Otto (2005), *Support to Internally Displaced Persons: Learning from Evaluations.* Summary Report. Stockholm: Sida.

there is no long-term bilateral development programme, or maybe because there is not enough flexibility in the stability and TMF budgets (which at this time is dedicated to security sector issues only).

- Going through a prolonged aid management chain (choice of multiple sub-contracting processes with the UN and NGO partners) is detrimental to information flow and to a responsive aid provision. The critical success factor is at the last stage of the chain, where relations to the beneficiaries are established, and this is precisely the least visible link. Agencies situated in the middle levels are not aware of the flexibility they may have in programming, and tend to propose projects which replicate what has been funded in the past. The transfer of funds is characterised by an extremely large number of sub-contracts, and the agencies inter-facing with the Ministry are the least able to provide information on impact. The current system leads to poor programming, to poor ownership, and to significant delays.

The overall aim of the programmes supported by the Netherlands is to support the efforts of the populations concerned to find and adopt the solutions which will help them escape from life threatening conditions. This has not been achieved in many of the projects because of the gap, and because of the relatively unimaginative project proposals put forward by the agencies.

To compensate for these two weaknesses there is simply an absence of analytical capacity and resources that can penetrate all levels of decision making and redress the balance, from the local delivery organisations to the Ministry in The Hague, and that can formulate the challenges faced by the population by relating it to project financing. Instead there is a strong evidence throughout the evaluation that policy decisions are made on the basis of general principles which establish an appropriate overall framework, but do not enhance agency performance due to the remoteness of policy makers to the population most in need.

Remoteness is the key constraint. Beyond the immediate contracts, drawn up as lines linking the agencies in the management of financial resources, Dutch funded projects must also deal with a complex institutional fabric in the region. This fabric includes impoverished public service delivery organisations, community based organisations, church organisations and non-governmental organisations, as well as other bilateral and credit agencies. Decisions are shared between missions in three capitals, separated by one to three days' travel from the field, and the capital in the Netherlands.

This situation highlights the critical role which the Embassies are not playing fully. It is not compensating for the long management chain which has been put in place for assistance in the Great Lakes region, and the limited capacity in the Ministry of Foreign Affairs to handle the resulting contractual and analytical complexity.

The burden of analysing the results through these multiple levels is left to the very limited staff resources (one person) in the Humanitarian Aid Division in The Hague. The evaluation has showed that the Embassies in the region (Kigali for Burundi, Dar Es Salaam for the Tanzania refugee camps, and Kinshasa for eastern Congo), even if they are keen, are much more heavily involved in security and diplomatic issues than in humanitarian aid. Visits by diplomats and Embassy staff, when they occur, are mostly to the big cities, and infrequent in the field. The Ministry in The Hague is dependent on oral briefings, monitoring and reporting by the agencies, due to the lack of staff.

5.6.2 Recommendations

The implementation modalities are the most important factor in improving the results achieved. At a time when the focus on transaction costs for development aid has led to the launch of sector support and budget support modalities, the selection of implementation modalities in humanitarian assistance should now come under scrutiny.

This places a heavy responsibility on the Ministry of Foreign Affairs to provide a better developed and well informed management and planning framework. For example the recent IDP Synthesis Report noted that donors can have an overwhelming influence on to what degree needs assessments are carried out, on the quality of collaborative approaches amongst agencies, and on when and how phasing out takes place in humanitarian aid.[56]

Donors have a fiduciary responsibility toward their own tax payers and toward the populations to be assisted. The aid management chain acts as a complex delivery mechanism, but it has so far not acted as a conduit for accountability in terms of impact and outstanding needs.

A policy of directly financing such units of greater accountability located at an appropriate level of the implementation chain should be envisaged. In other words, this will increase the management of knowledge and inform better decision making within the humanitarian and rehabilitation sphere of aid. This is not only a matter of legitimacy of the aid effort and an issue related to the Netherlands Ministry of Foreign Affairs trying to 'economise' on its own management costs.

The evaluation has focused on two key areas of future institutional and policy development:

- The first is the need to unify knowledge management in the humanitarian aid system. This must be materialised as a capacity situated closer to the field, understood in a physical sense, and have the personnel (with time) needed to penetrate the complex local reality. It should also have contacts with the Embassies and the Ministry in The Hague to ensure that information collected can be acted upon. This would make the upper echelons of the aid management chain more focused on contractual and delivery issues. It could complement the role of OCHA in resource mobilisation, as this agency is currently playing the role of one of the links in the management chains, and is not providing adequate information.

- The second is that the need to explore ways of increasing the funding to its transitional funding windows. Alternatively Humanitarian Aid should loosen its strictures in the interpretation of the policy mandate. This would allow it to cover capacity building, support to local administration in health and social services, and psycho-social needs of a protracted nature.

[56] Borton, J., M. Buchanan-Smith and R. Otto (2005), *Support to Internally Displaced Persons: Learning from Evaluations.* Summary Report. Stockholm: Sida.

The broader issues, flowing from the above two, and in order of priority would be the following:

(1) Beyond a threshold of funding in a country, there should be a mechanism attached to the Ministry for monitoring of performance of programmes and of the local situation. The inability to generate a large civil service to handle the significant funds is not the only option. DMV could for example rely on existing resources, such as ECHO's network of technical experts in the country. It could also fund a selected agency to do independent monitoring of outcomes and audit of management systems. Alternatively it could take the form of a service contract akin to what is done in development aid (technical programme management units), focusing on monitoring and evaluation. An other option might be to investigate the possible value added of reinforcing the analytical capacity at the Embassy level, to supplement the resources available. Sufficient resources should be given to ensure both closer monitoring of projects in Burundi and eastern Congo, to allow the Ministry to have not only a clear picture of its contributions over a given period but also to allow it better follow-up to problems encountered by the agencies funded. Such an action could lead to the re-prioritisation of funding and favour the support of better-run projects, possibly cutting out some layers of implementation. Should the Ministry of Foreign Affairs decide against this, it will have little choice but to continue funding agencies that at least have nominal accountability to donors and a higher degree of transparency.

(2) There is a need for the new types of funds created by The Netherlands with an explicit mandate to deal with connectedness and structural issues during emergencies, including in particular multi-annual funding and handing over resources to local bodies while putting in place strong results based accountability[57]. Alternatively, the parameters defining which types of interventions are to be financed from the humanitarian aid budget may be reconsidered, in order to allow the funding of activities that focus on capacity building, structural support to health and social services, and psycho-social needs of a protracted nature. There are clearly limited resources to distribute in relation to needs, but also limited strong local capacity. The agencies could obtain a clearer mandate to negotiate conditionalities with local partners (i.e. selection of partners and control of resources in the field), and to work in a detailed and long-term manner with community organisations and local NGOs. There should also be an improved understanding about households, population structure, local care mechanisms, survival strategies and population mental health, to ensure that programme content is appropriate for strengthening population resilience.

(3) The Netherlands should intensify the efforts to strengthen the regional and integrated approach to the Great Lakes Region by better linking humanitarian assistance to simultaneous support for peace building and stabilisation, nation building, reconstruction and economic development. Such an approach would

[57] One such approach has been developed by Cordaid for a programme in Rwanda. It relies on the use of funding allocated in tranches to the agency responsible for services in the long term (usually a public structure at the level of Municipality). Each tranche is allocated on the basis of the achievement of certain targets, exemplified by carefully pre-selected performance indicators. This approach is being embraced for budget support assistance in development aid, and there is no clear reason why it could not be applied in a decentralized and micro-level for rehabilitation assistance.

entail designing a comprehensive and flexible package of support consisting of humanitarian and other types of assistance in order to avoid gaps in programming for emergency relief, rehabilitation and development. The definition of a medium term regional strategy for the rehabilitation phase in Burundi and Congo, will significantly increase the likelihood of programme success. The promotion of preventive initiatives, such as public awareness campaigns (on matters such as hygiene, child nutrition, or even peacekeeping etc.), population participation in the design and targeting of assistance, as well as all other activities facilitating ownership and dissemination of good information to the local public and to the public in the Netherlands are to be encouraged. The same applies for awareness campaigns and advocacy about the demobilisation of child soldiers, with a special focus on girl soldiers and the issue of sexual violence.

(4) The Ministry of Foreign Affairs should encourage population-based as opposed to sector-based approaches. This should be translated into the appeal mechanisms, in particular the CAP. Population based approaches would include all groups based in an area, or particularly vulnerable groups, rather than provide resources for a particular form of need (water, health, etc…). This should overcome the blinders (in particular a neglect of structural causes or less visible population groups) which a sectoral focus creates. This would cover groups which are less easy to target, and justify the additional expenses this requires. This analysis should also include situational and structural risks/problems for these populations, and how these evolve over time.

10 ANNEXES

10.1 ANNEX 1: ToR (abbreviated)

1. Purpose of the evaluation and evaluation questions

1.2 Purpose

The purpose of the evaluation is to carry out an independent assessment of the results of Dutch humanitarian assistance to Burundi and the Eastern DRC in the period 2000-2004. The evaluation will focus on the implementation and results of humanitarian activities supported by the Netherlands, as well as review Dutch humanitarian policy and administrative procedures for the implementation of humanitarian assistance.

By providing an account of the humanitarian support, the evaluation will also provide lessons for policy and programme improvement. It will focus on results whilst also taking into account processes involved in the planning and delivery of humanitarian assistance in Burundi and the Eastern DRC. The evaluation will examine relevance of the humanitarian support, its effectiveness in terms of outputs, outcomes and impact, as well as its efficiency, notably in terms of connectedness, coherence and co-ordination.

1.2 Special issues

The evaluation will take into account the following pertinent issues.

Security, protection and humanitarian access

The extent of violence, especially perpetrated against women and children, is one of the defining features of both conflict and post-conflict environments in the Great Lakes countries. The sub-region is characterised by the use of under-age combatants, child abductions, rape as a weapon of war and merciless attacks on civilian populations. Protection — particularly for vulnerable civilians — is increasingly understood as an essential element for providing a minimum of assistance to affected populations[58].

Destruction and violence in day-today life reduces civilians' access to education, healthcare and income generating activities, while obviously limiting possibilities for humanitarian assistance. Humanitarian access is severely hampered by security considerations. One of the major questions is if Dutch humanitarian policy has been effectively geared to maximising and safeguarding humanitarian access.

Considering that the region is undergoing processes towards peace and reconstruction, it is further important to review how humanitarian assistance has articulated with other concerns of foreign policy. The humanitarian strategy for the Great Lakes of the Netherlands has partly been geared to the strengthening of civil society and peace building capacities. This is in line with the notion that Dutch humanitarian assistance in conflict situations should be part of an integrated strategy aimed at the provision of humanitarian assistance, conflict containment and mitigation and promotion of peace, which may encompass political,

[58] *CAP Great Lakes*, United Nations, 2005.

economical and -if necessary- military resources. Without aiming to evaluate these wider policy concerns, the present evaluation wants to shed light on the question how humanitarian access was affected by other policy interventions.

The gap-issue: Linking relief, rehabilitation and development

The gap-issue deals with the transition from emergency to development assistance. Ideally, emergency assistance programmes in developing countries should be phased out and (sustainable) development assistance programmes recommence once a crisis situation has ended. However, because of the rise of intrastate conflicts, the distinction between a conflict situation and post-conflict situation has become blurred. This complicates decisions to phase out emergency assistance (exit strategies), to commence rehabilitation and to revert to the provision of development assistance.

The Netherlands emphasises the connection between different types and phases of assistance. This applies to the international level, the inter ministerial level in the Netherlands and the level of departments in the Ministry of Foreign Affairs. At the operational level the Netherlands strives to only finance activities that, where possible, have paid attention to the (future) transition from relief to development assistance.

In the Great Lakes Region the Netherlands has particularly aimed in this respect at ensuring the hand-over of medical emergency facilities to local authorities (Burundi) and small-scale rehabilitation of the health sector (Eastern DRC). The evaluation aims to review the results of this approach.

Co-ordination and coherence of humanitarian assistance

Issues of co-ordination and coherence of humanitarian assistance arise at both the operational and the strategic level. At the strategic level, coherence and co-ordination imply harmonising humanitarian, developmental and political action. An important question is how coherence and co-ordination work out at the implementation level in the Great Lakes Region. At the operational level, humanitarian actors are increasingly finding themselves working alongside other developmental, military and political actors. The question is how to resolve potential conflicts between the mandates and principles of these different actors. Co-operation between civilian and military actors (CIMIC) in particular may have far-reaching consequences in terms of security of aid workers and securing humanitarian access.

With respect to co-ordination on the ground, three factors are important. In the first place the extent in which co-ordination is affected by organisations having their separate mandates and freedom of action. Second, it is especially important to review co-ordination between international and national actors in Burundi and Eastern DRC. The Netherlands emphasises that the local population must have a prominent role in food programmes, and that local civil society and health structures must be strengthened (Burundi), and support to civil society and grassroots initiatives for the reduction of contrasts in society and ethnic tensions (Eastern DRC). Finally, it needs to be established whether concerted and co-ordinated action in politically complex situations may be at odds with the humanitarian principles of neutrality, independence and impartiality.

Quality, Accountability and Good Humanitarian Donorship

The Netherlands supports a number of initiatives to enhance quality and accountability, and encourages the use of the Code of Conduct and other quality instruments by agencies implementing humanitarian programmes. To address the equally important issue of donor accountability, the Netherlands is actively involved in forwarding the so-called Principles and Good Practices of Humanitarian Donorship, that were formulated in Stockholm in June 2003.

Adherence to the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief, Inter-Agency Standing Committee guidelines and

principles on humanitarian activities and Sphere standards is part of the issues to be covered in the evaluation. The evaluation is also expected to come up with observations and recommendations about constraints and possibilities to enhance the Principles and Good Practices of Humanitarian Donorship for the case of the Great Lakes Region.

1.2 Criteria and evaluation questions

The following evaluation criteria and main questions will be covered by the evaluation.

Relevance

Was the humanitarian assistance provided to Burundi and the Eastern DRC in line with the humanitarian policy and procedures of the Netherlands, as well as the needs, priorities and rights of the affected populations?

The evaluation will *inter alia* take into account the following issues:

- At the level of policy development:
- Attention paid at the national, regional and local level to needs, priorities and rights of affected populations;
- Interaction and consistency with International Humanitarian Law and humanitarian policy at the international level, including responsiveness to new developments.
- At the level of policy implementation:
- Consistency of supported interventions with Dutch humanitarian policy, including basic principles such as impartiality and independence;
- Provision and distribution of assistance based on assessment of needs, priorities and material and non-material rights of affected populations. An example of non-material rights is the right for protection against sexual exploitation and abuse;
- Type of activities supported and modalities of implementation (channels, implementing partners, agreements);
- Level of access secured to needy groups.

Effectiveness

To what extent did the humanitarian assistance provided to Burundi and the Eastern DRC achieve its purpose?

Issues to be addressed:

- Realisation of the immediate material and non-material needs of the affected populations (coverage and timeliness of support provided);
- Provision and distribution of assistance taking into account gender and generation, including specific material and non-material needs of women, children and the elderly;
- Adherence to the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief, Inter-Agency Standing Committee guidelines and principles on humanitarian activities and Sphere standards;
- Influence of and response to security and humanitarian access.

What have been the wider effects of the Dutch humanitarian interventions in Burundi and the Eastern DRC?

Wider effects, also called impact, can be immediate and long-range, intended and unintended, as well as positive and negative. In this evaluation, it is tried to establish the immediate wider effects of the support provided. The following issues will be addressed:

- Effects of humanitarian assistance in terms of reducing the immediate material and non-material vulnerability of the affected population and fostering preparedness and people's coping mechanisms;

- Effects of humanitarian assistance on the emergency situation or conflict, including relations between recipients of aid and other vulnerable groups.

Efficiency

Were the financial resources and other inputs efficiently used to achieve results?

Issues to be addressed:

- Aid management (programme and project cycle, staffing, tasks and responsibilities of ministry departments and embassies, inter-ministerial co-operation including civil-military co-operation);
- Criteria used in the selection of implementing partners (comparative advantage or other);
- Organisation and costs of aid delivery at field level (diversion, security, creating humanitarian access);
- Use of monitoring of progress and achievements for programming, learning and accountability.

Connectedness

To what extent have the humanitarian activities taken into account the specific context in Burundi and the Eastern DRC with its longer-term and interconnected problems?

Issues to be addressed:

- Policy developments and intradepartmental collaboration to address the gap between relief and development;
- Conflict analysis informing the choice and the design of interventions;
- Institutional capacity building as part of assistance provided;
- Decision making to link humanitarian assistance, support for rehabilitation and development aid where appropriate (timeframes of assistance and the use of exit strategies).

Coherence

Are humanitarian policy and programming at field level in Burundi and the Eastern DRC coherent with those of other actors?

Issues to be addressed:

- Coherence with policies and interventions other than humanitarian support;
- Possible effects of diverging interests;
- Relation between basic principles of humanitarian assistance and coherence.

Co-ordination

How effective has co-ordination at policy, strategic and implementation levels been?

The following issues will be addressed:

- Involvement of the Netherlands in co-ordination mechanisms and processes;
- Encouragement of operational partners to engage with co-ordination mechanisms and processes;
- Trade-off between co-ordination and humanitarian principles (humanity, neutrality, impartiality, independence).

2. **Scope of the evaluation**

The evaluation of Dutch humanitarian assistance to the Great Lakes region will consist of a sample of completed and ongoing humanitarian assistance operations in Burundi, as well as in eastern DRC (see table 7 and 8, as well as Annex 3). The activities to be covered by field analysis have been selected on the basis of an inventory of activities. The selection represents a cross section of sectors and organisations involved in implementation (UN, ICRC/Red Cross, international NGOs, national NGOs and where appropriate local NGOs). It is not statistically representative, but provides a sufficiently illustrative sample of humanitarian activities supported by the Netherlands.

In view of the expected difficulties in gaining access to many parts the region, specifically eastern DRC, it is aimed to largely conduct field investigations of activities which are located in the same geographical areas.

10.2 ANNEX 2: List of Persons Interviewed

Netherlands Ministry of Foreign Affairs		
Date/Time	Person and Title	Organisation and location
9.05.2005	Ted Kliest, IOB Thea Hilhorst, External Consultant IOB Mariska van Beijnum, IOB	The Hague
8.06.2005 11:00	Jan Remijn, Desk Officer for DRC, Burundi (and Tanzania) Humanitarian Aid Division (DMV/HH)	The Hague
8.06.2005 14:00	Jelte E. van Wieren, Senior Policy Advisor, Peace Building and Good Governance Division (DMV/VG)	The Hague
10.06.2005 11:00	Frank van Pelt, Policy Advisor Africa Department, Section Central and Eastern Africa, responsible for DRC (DAF)	The Hague
15.06.2005 11:00	Wouter Vidlung, Policy Advisor Africa Department, Section Central and Eastern Africa, responsible for Burundi (DAF)	By Telephone
08.08.2005 09.30 – 17:00	Mr. Gert Jan Tempelman, Deputy Ambassador Mr. Robert Jan Siegert, First Secretary	Embassy of the Netherlands, Kigali, Rwanda
11.11.2005	Ms. Ellen Ch.W. van der Laan, Ambassador Ms. Joke Zuidwijk, Deputy Ambassador Mr. Roy Hans, Chargé d'Affaires	Embassy of the Netherlands, Kinshasa, DRC

UK DFID & USAID		
Date/Time	Person and Title	Organisation and location
12.08.2005	Sue Hogwood, Representative	DFID Bujumbura
12.08.2005 9:00	Tyrone Gaston, Country Representative	Office for Transition Initiatives, Bujumbura
13.08.2005	Mr. Jay Nash	USAID/OFDA

Various Donors/International Organisations		
Date/Time	Person and Title	Organisation and location
17.08.05 13.30- 14.00	Dr. Victor Kibonge, Assistant Technique, Prog. D'Aide Transitoire de la Santé, ECHO	Kinshasa (by telephone)
14.00- 15.00 15.15-	Mr. Patrick Lavandhomme, Head of Office Ms. Sarita Bingeman, HAO, OCHA	Kinshasa (by telephone) Goma

17.00	Ms. Ruth Kottmann, Head of Sub-Office, ICRC	Goma
17.08.2005 15:00 – 16:30	Yasmine Thiam, Senior Political Affairs Officer, Mrs. Francine X Anna Gallard Henk Bruyn, Humanitarian Affairs Officer	MONUC, Office Kalemie
16.30 – 17.00	Mrs Francine, Child Protection	MONUC, Office Kalemie
21.08.05 09.00- 10.00	Mr. Farah Barrow, Deputy Security Officer, MONUC	Goma Goma

CARE/SAEU Tanzania		
Date/Time	Person and Title	Organisation and location
05.08.2005	Kiki van Kessel: Policy and Programme Officer	CARE Nederland By Telephone
11.08.2005 9:00	District Commissioner	Kibondo
11.08.2005 9:30	Bayisa Wak-Woya, Head of Sub Office	UNHCR, Kibondo
11.08.2005 10:00	Ms. Fé Guevarra, Head of sub-office Florien Ngali, Programme Officer	WFP, Kibondo
11.08.2005 12:00	Godfried Pondamali, Assistant Camp Commander	Ministry of Home Affairs, Mtendeli camp, Kibondo
11.08.2005 12:30	SAEU staff meeting, Mtendeli programme staff: Mullenga Nyabarimba, Logistics and Construction Officer Angelina Ndayikje, Child Protection Officer Samuel Maghimbi Elly J. Mgate, Micro projects Niyonshima Rukanda Abbas Nsanjugwanko Daniel Joy Beda Nwanakulya, Gender/SGBV Christopher Nkwezi, Project Coordinator	SAEU, Mtendeli camp
11.08.2005 13:00	Group meeting with refugee teachers (2 women, 8 men), primary and secondary schools	Mtendeli camp
11.08.2005 14:30	Group meeting with social workers (3 women, 4 men)	Mtendeli camp
11.08.2005 16:00	Group meeting, skills training tailoring (7 women, 3 men)	Tailoring workshop, Mtendeli camp
11.08.2005 18:00	SAEU staff meeting Lawrence Mallawa SAEU Director Christopher Nkewzi, Project Coordinator Caroline Mutayabamva, Technical Officer Education, Care Tanzania	SAEU Office, Kibondo
12.08.2005 9:00	Mrs. Penina Samgiwa	Officer-in-Charge Unicef Kibondo

12.08.2005 10:00	Edson Yoyeye, Lead Focal point Joseph Audax, Ahadi zone coordinator	Refugee Education Trust (RET)
12.08.2005 11:00	Terry Rafael, Field Coordinator	TCRS
12.08.2005 13:00	Group meeting (9 women)	Nduta Camp, weaving group
12.08.2005 14:00	Nora Noyayenzana, social worker Agnes Nzegimana, social worker	Nduta Camp
12.08.2005 15:00	Group meeting Valentin Ndaymiye, Responsabile Centre des Jeunes John Nyongere, Outreach Officer, IRC Social Worker (2 female, 3 male)	Youth Centre, Nduta Camp
12.08.2005 17:30	Caroline Mutayabamva, Technical Officer Education	Care Tanzania
12.08.2005 18:00	Christopher Nkewzi, Project Coordinator Lawrence Mallawa SAEU Director	SAEU, Kibondo office
12.08.2005 21.30 – 22.00	UNHCR team in Tanzania and cross-border team from Burundi	UNHCR Guest House (over informal drinks)
12.08.2005	Samuel Maghimbi –Community Based & Rehabilitation (CBR) Officer Elly J. Ligate Niyonshima Rukanda – Community Services/Education Coordinator. Abbas Nsanzugwanko – Community Services Camp Coordinator Daniel Loya- Programme Coordinator – SAEU HQ Lawrence Mallawa – Senior Finance Officer. Please also include: Daniel Loya-Programme Coordinator-SAEU HQ. Daniel Loya-Programme Coordinator-SAEU HQ.Lawrence Mallawa – Senior Finance Officer	SAEU
14.09.2005	Maria Maas, Former Care Project Manager	NOVIB (by telephone)

Cordaid		
Date/Time	Person and Title	Organisation and location
28.06.2005 10:00	Sara van der Weerd, Project Officer, Emergency and Rehabilitation Department	Cordaid HQ, The Hague
28.06.2005 10:00	Geke Verspui, Senior Programme Officer Emergencies & Rehabilitation Department	Cordaid HQ, The Hague
28.06.2005 10:00	Kees van der Broek, Senior Programme Officer Emergencies & Rehabilitation Department	Cordaid HQ, The Hague
09.08.2005 16:45 – 19:00	Mrs. Odile Joly, head of mission Mr. René Djamen, coordinateur des opérations	Cordaid Office Bujumbura
10.08.2005 09.00 – 20.30	Day trip to Makamba 1. Visit of Centre de santé Muguruka 2. Meeting responsible doctor of the hole district, *Dr. Canut* 3. Meeting titular of CDS	Centre de santé Muguruka and Nyanza-lac

	4. Interviewed two beneficiaries, *young women Agnes and mother* 5. Meeting the Committée de santé 6. Visit of Centre de santé Nyanza-lac 7. Meeting titular of CDS 8. Meeting with traditional midwifes 9. Meeting with the Commitée de santé 10. Meeting with nurses 11. Meeting with Dr. Canut	
11.08.2005 08:00 – 08.30 09:00 – 09.30 12:15 – 14:30	Day trip to CDS Bukeye Interview with midwife ; *Consolate* Interview with director of hospital Makamba 12. Visit of Centre de santé Bukeye 13. Meeting titular of CDS 14. Interviewed three beneficiaries, *Mr. Louis Burakuwye* 15. Interviewd traditional midwifes 16. Interview with nutritionist 17. Meeting with the Community leaders of Kibago	Centre de santé Bukeye and Kibago town
12.08.2005 08.30 – 09.00 09.00 – 09.30 10.00 – 10.30	Meeting with Dr. Canut Meeting with Midwife, *Consolate* Field visit with Twa-families	
13.08.2005 09:00 – 12:00	18. Meeting with Mrs. Odile Joly, head of mission	

World Vision		
Date/Time	Person and Title	Organisation and location
16.08.2005 16.30-18.45	Mr. Pierre Machiels, Programme Director	World Vision, Goma, North Kivu, DRC
08.30-10.30	Mr. Gauffe, Administrator, World Vision	Goma, DRC
10.30-13.00	Dr. Léonardo Shamamba, Health and HIV/AIDS Coordinator	World Vision, Goma, DRC
18.08.2005 08.30-17.00	Day trip to WV nutrition project sites at Saké and Kirotshe Meeting Saké Zone de Santé nutrition staff Meeting Dr. Isaac Tshamala, Nutritionist, WV Leonardo Shamamba, Health and HIV Coordinat. Mr. Jules Nsabimana, Commodities Officer, WV Mr. Kabikwa Ngango, Agronomist Group of 70 beneficiaries, Saké community fields Interviewed 6 IDP women and 3 women from	Goma North Kivu locations

	host community Dr. Bisimwa, Kirotshe Provincial Hospital Therapeutic feeding programme staff Interviewed 3 women with children in TFP.	

Save the Children		
Date/Time	Person and Title	Organisation and location
12.00 – 14.00	Field visit to CTO PAMI, child soldiers Responible infirmier Meeting with 13 beneficiaries (former child soldiers)	CTO Goma
20.08.2005	Ms. Rose Bubuye, Coordinatrice de la Protection de l'Enfance pour le Nord Kivu, Save the Children Visit to Transit Centre for Child Soldiers	
17.08.2005 8:30 – 10:30	Mrs. Marion Turmine, Chef de mission Mrs. Penninah Mathenge, Chef de programme Santé	Save the Children, Goma
17.08.2005 16:00 – 18:00	Mrs. Penninah Mathenge, Chef de programme Santé Health Program team members	Save the Children, Goma
18.08.2005 08.00 – 18.00	Day trip to Masisi and Nyabiondo Visit of Masisi centre Hospital Visit of CNT Masisi centre Visit of Nyabiondo Health Centre, Visit of Masisi centre Health Centre, Interviewed "Infirmier Titulaire Adjoint", *Ndoole Msafiri* Interviewed Nyabiondo Health Centre team Members (Chargé de petite pharmacie, aide accoucheuse, etc.)	Beneficiaries, Masisi health zone
19.08.2005 08:00 – 10:00	Mr. Bavon Mwabilwa Lumande, Ancien coordinateur santé, puis conseiller santé à Save The Chilidren. Administrateur Adjoint Chargé de la Protection des filles vulnérables et du VIH/SIDA, UNICEF	Unicef, Goma
19.08.2005 11:00 – 12:30	Mrs. Marion Turmine, Chef de mission Mrs. Penninah Mathenge, Chef de programme Santé (Restitution of preliminary finding)	Save the Children, Goma
19.08.2005 15:00 – 16:30	Dr. Baabo K. Dominique, Médecin Inspecteur Provincial	Inspection Provinciale de Santé, Goma
22.08.2005 09:00 – 10:30	Mr. Simon Levine, Consultant, author of "Missing the point: An analysis of food security interventions in the Great Lakes"	Save the Children
22.08.2005	Mrs. Marion Turmine, Chef de mission	Save the Children

WFP		
Date/Time	Person and Title	Organisation and location
11.08.2005	Zlatan Milisic, Country Director and Representative, Burundi	WFP Bujumbura

	Guillaume Foliot, WFP Programme Coordinator Pierre Subille, Security Officer	
14.08.2005 12:30 – 14:30	Group meeting with staff in Uvira	WFP Sub-Office Uvira
16.08.2005 13:30 – 14:00 18.00 – 19.00	Romuald Lucas, HoSO Kalemie Amadou Sidibe, Logistics Officer	WFP Sub-Office Kalemie
17.08.2005	Romuald Lucas	WFP Kalemie
18.08.05 18.00-21.00	Meeting with Ms. Aya Shneerson, Head of Sub-Office Goma	WFP, Goma ville
18.08.2005 08.30 – 10.00	Debriefing with Romuald Lucas	WFP Bukavu
19.08.2005	Herminio Porras, Logistics Officer	WFP Bukavu
18.08.2005	Mr. Eunice Smith, Logistics Coordinator	WFP Goma
19-23.08.2005	Ms. Aya Shneerson, Head of Sub-Office Goma Theo Kapuku, Programme Assistant	WFP Goma

UNDP Burundi		
Date/Time	Person and Title	Organisation and location
09.08.2005 15.00 – 17.30	Mr. Adama Coulibaly, Assistant Representative Mr. Louis Nduwimana, Assistant to the Representative, Poverty, HIV/AIDS Mr. Gérard Nkurunziza, PCAC Programme Assistant	UNDP, Bujumbura, Burundi
10.08.2005	Day trip through Burundi Visit to CARE: Ms. Cassie, Country Director Interviewed four beneficiaries of Goat project Visit with host community	Beneficiaries, Village Heads
11.08.2005	Mr Ibrahima Fall, Resident Representative, Resident Coordinator, Humanitarian Coordinator, UNSECOORD	UNDP Burundi
12.08.2005	Mr. Adama Coulibaly, Assistant Representative	UNDP, Bujumbura, Burundi
17.08.2005	Zenaïde Gatelli, Reintegration Expert Harouna Dan Malam, Provincial Adviser Reintegration	UNDP DRC, Kalemie

FAO/ ACF		
Date/Time	Person and Title	Organisation and location
16.08.2005 08:30 – 10:00	Mr. Dieudonne Katusi, Chargé de programme urgence Mr. Phemba Phezo, Consultant national Mr. Culotte Kabeya, Chef d'antenne FAO Baraka	FAO, Bukavu,

09.08.2005 14:30 – 16:30	Mr. Jean-Pierre Renson and colleagues	FAO Office Bujumbura
13.08.2005 09.00 – 10.15	Mr. Jean-Pierre Renson and colleagues	FAO Office Bujumbura
16.08.2005 10.00 – 10.30	Mrs Yvette Gonzales, chef de mission	Action Contre la Faim, Bukavu

OCHA, Burundi, Congo		
Date/Time	Person and Title	Organisation and location
11.08.2005	Gloria Fernandez, Country Coordinator	OCHA Burundi
15.08.2005	Telephone interview: Mr. Jahal de Meritens, Head of Office, OCHA	From Bukavu, DRC
16:15 – 17:45	Mrs Anne Edgerton, Humanitarian Affairs Officer, Chiara, United Nations Volunteer	OCHA Field Office Kalemie
11.11.2005	Mr. Jahal Rabesahala de Meritens, Head Mr. Bernard Leflaive, Humanitarian Affairs Officer Mr. Mark Cutts, Senior Humanitarian Affairs Officer (OCHA Geneva visiting OCHA Kinshasa)	OCHA DRC

UNHCR		
Date/Time	Person and Title	Organisation and location
14.08.05 09.00-09.45	Mr. Alberto Carlos Cabeia, UNHCR Repatriation Officer	Bujumbura, Burundi
15.08.05 09.00-10.00	Mr. Magatte Guisse, Head of UNHCR Sub-Office	Baraka, South Kivu, DRC

ASRAMES/CIF		
Date/Time	Person and Title	Organisation and location
28.06.2005 12:00	Rolf van der Maas, Programme Officer Central Africa Maria Maas, Programme Officer East and Central Africa	NOVIB HQ, The Hague
28.06.2005 16 :00	Jacqueline Lemlin, Senior Health Advisor	Health Net International HQ, Amsterdam
20.08.2005 09.00 – 18.00	Day trip to Mweso 18. Visit of Mweso Hospital 19. Meeting "Comité de gestion du Bureau Central de Zone", *Mujyrugumba Jean-Pierre, Katengo, Lolis, Gakunde Joseph, Rev. Nzamuhabua Gahima, Nzonbo Kajongo, Ndagilimama Fidel.* *20.* Meeting « Bureau Central de Zone »	Beneficiaries, Médecin Chef de zone, Membre de Comité de gestion du Bureau Central de zone et bénéficiaires, Membre de

	members, *Dr. Claire Majone (Medécin Chef de Zone), Kazungu Mwezi Silas, Bura Bambaga* 21. Visit of Kithsanga Health Centre 22. Meeting with "Infirmier titulaire" 23. Meeting with "Comité de Santé" members and Community health Workers (Relais communautaires)	Comité de Santé, Relais Communautaires
20.08.2005	Mr. Baganda Fakage, Responsible department formation et conseil (il a accompagné la mission dans la zone de santé de Mweso)	CIF
20.08.2005 18:00 – 19:00	Mr. Dany Bulondo, administrateur à l'IPS (il a accompagné la mission dans la zone de santé de Mweso)	IPS

Various

Congolese Organisations		
Date/Time	Person and Title	Organisation and location
15.08.2005 09.00 – 18.00	Day trip to FIZI Visit of CNT-Fizi Meeting with Mr. Nzee Amouri, Animateur ACF, Assemde Mbuto, responsible CNT-Fizi, Obedi Bwendwa, Assistant de Programme de nutrition ACF Interviewed 18 mothers at CNT-Fizi Visit with host community	Beneficiaries
15.08.2005 10.30-11.00	Team of Communauté d'Eglises Libres de Pentecôte (CELPA) distributing WFP food rations to vulnerable individuals in community Mr Keyeka Kalonda –	Baraka, DRC
17.08.2005	Nkozo Village Gilbert Kasangu, Caritas Coordinator Sergeant Major Florentin Mufite, Salvation Army Parish Pastor Captain Jean Mutombo, , Salvation Army	Kalemie District
14.08.2005 20.30-21.00	Mr. Mathias Caharya, Norwegian Church Aid	Baraka, South Kivu, DRC
17.08.2005 13:30 – 14:30	Dr. Mireille Kiungu, responsible for women's health and victims of sexual violence	General Hospital
18.08.05	Personnel and patients from the General Hospital, Kalemie (nutritional centre and TB wards)	Kalemie
19.08.05 09.30-13.00 15.30-18.00	Mr. Mukanirwa Migabo, Infirmier Titulaire, Centre de Santé, Saké Mr. Jannes van der Wijk, CIF/ASRAMES	Kirotshe Province
20.08.2005	Sr Dominique, Caritas Poland	Rutshuru Nutritional Centre

20.08.05	Mr Bruno Matsundo	CEPSOPA, Rutshuru
14.08.2005 15:30 – 16:00	Mrs. Bissa Bisashiabwe, president of AFSVEO, and Mr. Mutendele, supervisor	Nundu
14.08.2005 18:30 – 19:30	Mrs. Chantal, head of organisation, SOFIBEF	SOFIBEF Paroisse Baraka
15.08.2005 09:30 – 10:00 10.00 – 10.30	Head of office of CEFAS Interview one beneficiarie, Mariamu Eca, 45 years, widow	Office Fizi
17.08.2005 08:30 – 09:30	Mama Bea, and Beneficiaries Maison de femmes of Kalémie	Maison Kalemie
17.08.2005 10:00 – 11:00	Mr. Raoul, programme responsible and Mr. Augustin, Programme assistant	IFESH Office Kalemie
19.08.2005 08:30 – 10:00	Soeur Pilard Delgado, responsible of maison de femmes Kalemie, CDJP (Comission diocésaine Justice et Paix) Sœurs Missionaires d'Afrique	Couvent Bukavu
11.08.2005 14:30 – 16:30	Mr. Herman Ndayisaba, director and Ir JosephNduwumwani, coordinator	TPO Office Bujumbura
22.08.2005 16:00 – 17:00	Mrs. Justine, coordinatrice de la synergie des femmes and Mrs. Germaine Chighiri, counsellor, Synergie des Femmes	Synergie des femmes, Goma Stella Mattutina

Search for Common Ground		
Date/Time	Person and Title	Organisation and location
12.08.2005	Danielle Lustig, Representative	SFCG Bujumbura
11.08.2005 17:00 – 18:30	Mr. Alexi, responsible for programme "Victimes of torture"	SFCG Office Makamba

Solidarités		
Date/Time	Person and Title	Organisation and location
17.08.2005	Jeanne Vogt, Human Resources Coordinator	Goma
22.08.2005	Fred Meylan, Chief of Mission	Goma

Congolese Administration		
Date/Time	Person and Title	Organisation and location
16.08.2005 15:00 – 15:30	Administrateur Kalemie	Congolese Ministry of Interior, seen at home, Kalemie
16.08.2005 15:30 – 16:00	Pierre Kamubu Commissaire of Kalemie	Congolese Ministry of Interior, Kalemie

10.3 ANNEX 2: Background Considerations on Gender, Children and Psycho-social Issues in DRC

Une population traumatisée

La population dans la région visitée vit depuis une longue période des violences, une situation d'instabilité et de guerre civile, avec des intensités différentes suivant le pays et l'endroit. Nous en connaissons les faits.

Quelle est l'influence d'une situation si instable et donc carrément menaçante pour la population en générale et l'individu en particulier?

La violence
La violence omniprésente durant un long laps de temps ne permet pas aux personnes de s'y « habituer » mais plutôt d'en devenir indifférentes, c'est-à-dire, d'en être dépassées ou « blasées » (comme un mécanisme d'adaptation), l'on pourrait aussi l'appeler une personne détruite. On peut parler de stress cumulatif qui amène les gens à ne plus fonctionner de manière « normale », mais à appliquer des stratégies de survie, par ex. à être dissocié : la peur est si chronique, que les sentiments nécessitent à être dissocié du vécu. Ainsi, la violence subie ou observée devient supportable. Sans ça, les personnes deviennent inadaptés (« folles », comme elles disent souvent).

Toute personne exposée à des formes de violence, soit en tant que témoin (aussi par l'intermédiaire des médias) soit directement affecté, soit éventuellement même en tant qu´agresseur, est à considérer comme victime de violences. Les formes de violences étant multiples, la plupart des personnes ont subis, vus ou entendus des violences (tueries, viols, vols, destruction des biens acquis dans la vie, torture, incarcérations etc.).

Ce fait a un impact considérable sur la manière de considérer la vie : il y a du danger partout et les personnes deviennent vigilantes et sont effrayées au moindre bruit. Les gens sont aux aguets tout le temps. Cette situation peu sûre les amène à une vigilance accrue et parfois démesurée. Le système d'action qui entre en ligne de compte est la protection et la prévention de violences contre soi-même ou contre ses proches. Assister à des scènes de violence, directement ou indirectement, peut laisser des traces intenses et difficilement gérables par la personne concerné. Les troubles d'Etat de Stress Post-Traumatique (ESPT) sont multiples, et pour les plus graves, les états de dissociations avec leur panoplie de symptômes sont souvent ingérables (voir plus bas).

Les recherches menées à travers toutes les populations et toutes les ethnies nous montrent, que les symptômes qui font les suites à des violences sont universelles et générales chez toute personne victime de violences, indépendamment de sa provenance, son sexe, son âge et ses ressources. L'intensité, la durée et les spécificités individuelles peuvent varier, mais sont généralisables.

Une étude menée par de Jong et al. (Joop de Jong et al; JAMA 2001, 286 : 555 – 562) en quatre pays pauvres (Algérie, Cambodge, Ethiopie et Gaza) portant sur la santé mentale de la population en phase de post-conflit a pu identifier une variance de

l'Etat de Stress Post Traumatique (l'ESPT, voir plus bas) entre 15,8% et 37,4%. Dans les pays occidentaux on compte avec une prévalence de l'ESPT de 5 – 10% due aux traumatismes « normaux » de la vie humaine (accidents, pertes, catastrophes naturelles etc.)

Pour la jeunesse, on observe un drame tout particulier dans la perte d'années de scolarité, d'apprentissage d'un métier ou d'études. Laissant ainsi une population avec des moyens réduits et une perte au niveau du capital social. Beaucoup d'enfants sont par le fait illettrés.

Il est à noter aussi, que dans la population, il n'y a pas que des personnes victimes, mais aussi des agresseurs (dissimulés) ou personnes ayant eu des activités militaires ou politiques douteuses. Cette part de la population souffre souvent par après de sentiments de culpabilité et de honte. Dans l'hôpital psychiatrique au Rwanda, nombreux sont les ex-combattants et bourreaux de la guerre de 94.

Pour les combattants de guerre, (ex-enfants soldats, vétérans et personnes toujours affectés dans les groupements armées), il en est de même : la ligne entre agresseur et victime étant parfois très mince.

Pour obtenir une population « saine » au niveau mental, il est essentiel de tenir compte de tous ces troubles afin d'assurer aux pays un développement vers une stabilité intérieure. Une population traumatisée n'est pas une population stable et une détérioration de la situation économique peut vite les amener à utiliser les mêmes moyens qu'auparavant, c'est-à-dire la violence.

Une population déplacée

Des personnes déplacées ont du quitter leur foyer dans la hâte en laissant tout derrière eux, ne sachant pas quand ou même si un jour elles pourront y retourner. Au déplacement précède une situation d'instabilité, d'angoisse et de menaces plus ou moins intenses. Leur itinéraire les amenant à une nouvelle structure n'est pas forcément rassurant. Un trajet souvent pénible et long les attend, accompagné de structures minimales, pas d'accès aux soins, pas de nourriture, etc. les affaiblit et les éprouve considérablement avant même d'arriver dans un lieu sûr. Les femmes notamment sont souvent dans des situations particulièrement précaires, étant souvent seules avec leurs enfants (maris disparus ou tués ou encore affectés dans les groupes armés), et elles deviennent facilement victimes d'agressions multiples.

Le **passé** de ces personnes est parsemé d'événements terribles laissant des traces profondes et une personnalité traumatisée, le **présent** dans le camp est précaire et peu sûr du à différents phénomènes psychologiques entre autres, la proximité qui empêche tout intimité du fait de camps surchargés et bondés, des déprivations en tout genre, la rupture de communautés sociales et du support social, un manque de moyens en tout genre, une aggravation de la pauvreté, une morbidité et une mortalité accrue, peu de perspectives, un sentiment d'être inutile, de pas savoir quoi faire. On observe aussi beaucoup de problèmes de couple ainsi que de séparation de couples et des grossesses fréquentes. Le **futur** de ces personnes est incertain entraînant des angoisses existentielles.

Les droits humains sont violés massivement. L'expérience d'événements traumatiques comme des pertes, de la violence et des tueries, la torture, le viol, la détention etc. affectent le comportement et le vécu des personnes.

Selon la WHO, il est établi que plus de 50 % des populations réfugiées et déplacées souffrent de problèmes de santé mentale allant d'un grand nombre de maladies psychosomatiques, de réactions au stress et troubles chroniques dues à des événements traumatiques. Vivre ainsi durant des années sans aide particulière au niveau psychologique est très difficile. Des situations d'instabilité et de dysfonctionnement prolongées causées par des événements traumatiques restent dans la mémoire individuelle et collective d'un peuple pour longtemps.

La problématique de la femme : les femmes dans les pays pauvres, mais tout particulièrement dans les pays en guerre, rencontrent une situation extrêmement difficile : le planning familial n'est pas appliqué (donc trop d'enfants en peu de temps), un affaiblissement de la santé par des accouchements répétés et encore par des accouchements souvent mal accompagnés (accouchements traditionnels) et des conditions d'accouchement précaires au niveau sanitaire et physiologique, avec une mortalité infantile et maternelle élevée (au Burundi, le taux de mortalité maternelle est de 0,85 %, la mortalité néonatale de 3,19 % et la mortalité infantile de 12,9 %) laisse la femme dans une situation très difficile. En plus, d'avoir comme stratégie de contraception un allaitement prolongé (quoique peu efficace quand même) les femmes s'affaiblissent d'avantage et disposent de ce fait moins de résistances, elles sont ainsi plus sujettes aux maladies. Les femmes veuves ou femmes chefs de ménages dans les conditions de guerre sont très fréquentes.

La situation de la fille n'est pas moindre non plus : dans l'école de Manono on compte 758 élèves, dont seulement 51 filles. D'une part, la scolarité n'étant pas gratuite, les garçons sont privilégiés, mais les filles arrêtent leur cursus scolaire la plupart du temps pour des grossesses précoces. Le premier accouchement étant souvent entre 12 – 15 ans, les filles se retrouvent avec des déchirures au niveau vaginal ou de fistules, pour celles n'ayant pu bénéficier de césariennes (indication très élevée par l'âge et la taille de la fille). Combien ont été forcé aux rapports sexuels ? Nous ne connaissons pas les chiffres.

Les violences faites aux femmes

Dans un pays en guerre, tout particulièrement dans la région des grands lacs, le viol de filles et de femmes par les soldats est devenue une stratégie de guerre, non seulement pour humilier l'ennemi, mais pour l'infecter et le rendre infertile (la stérilité ou infertilité est une chose terrible pour la population africaine). Ainsi un nombre énorme de femmes (au Nord Kivu, de mai 2003 à avril 2005, 3551 femmes étaient recensées victimes de violences sexuelles) ont été violé, régulièrement par plusieurs militaires d'affilé, voire par toute une troupe, souvent encore devant les yeux de son mari (avec le fusil sur la tempe) et de ses enfants. Le viol n'étant pas suffisant pour les agresseurs, la femme est souvent mutilée par la suite par l'introduction d'objets ou d'armes dans le vagin, avec la volonté de la rendre infertile. Si elle est « épargnée » de la mutilation, fréquemment elle présente des fistules vaginales ou urinaires ou de prolapsus du vagin suite à la brutalité et la durée de l'acte. Et ce n'est pas fini pour la femme : si elle a de la chance, elle n'est ni séropositive, ni enceinte et n'a pas été infecté par des infections sexuellement transmissibles (IST), mais nombreux sont les cas contraires. Indépendamment de son état post-viol, mais quasi certainement si elle est enceinte, elle est chassée du foyer et de la communauté par son mari. Le viol a rendu la femme « impure ». Ces femmes rencontrent alors le triste sort d'errer dans la nature, de chercher un abri, souvent encore au risque et péril de leur vie, car la situation demeure instable. La création de la synergie des femmes à l'est du Congo pour accueillir ces femmes dans des maisons d'écoute où elles trouvent de l'appui a

apporté une aide importante, mais largement insuffisante en vu du nombre et de l'intensité de la problématique (environ seulement 150 femmes sur les 3551 ont pu être à l'heure actuelle réinsérées dans leur famille). La marche pour accéder à ces maisons d'écoute, souvent pendant des jours, expose les femmes à de nouveaux viols.

Beaucoup de femmes sont devenues victimes de viol, unique ou multiple, en cherchant du bois ou en travaillant dans les champs, mais aussi durant le sommeil la nuit ou les forces armés font irruption dans la cabane en violant, volant et tuant. Un grand nombre de femmes, surtout les jeunes et belles, mêmes encore filles, sont emmenés par les troupes pour esclavage sexuel. Ces femmes sont ainsi à la disposition des soldats, ou d'un chef particulier qui « l'a choisi ». Elle doit alors servir son « mari » mais surtout être à sa disposition la nuit. Dans le cas de E. M., 22 ans, elle a été durant 8 mois « le matelas du soldat » comme elle dit, avec des viols 5 – 6 fois par nuit, avant de pouvoir finalement s'échapper. D'autres atrocités sont rapportées par des femmes capturées qui doivent, par exemple préparer à manger les entrailles et la chair humaine de leurs proches tués devant leurs yeux, pour les servir aux militaires.

Les croyances aux fétiches, tout particulièrement dans les troupes des Mayi-Mayi, a augmenté de manière dramatique le viol des femmes, plus particulièrement celles des petites filles. Le fétiche procure au soldat la protection contre les balles de l'ennemi (« mayi » veut dire « eau », et le fétiche leur assure que les balles de l'ennemi leur coulent sur le corps comme de l'eau). Pour activer et maintenir la force du fétiche, un soldat mayi-mayi doit violer une fille ou une femme. Sinon, le fétiche ne le protège donc pas et il mourra.

Un phénomène déplorable rapporté par beaucoup de personnes travaillant avec les femmes victimes de violence sexuelle ou les observateurs du terrain est le fait, que le viol est devenu un phénomène social. N'étant pas un thème avant la guerre (peut-être un thème tabou quand même), le viol est devenu chose commune, il est devenu un phénomène habituel. Les viols sont devenus une « pratique commune » dans la population (on déplore aussi de plus en plus de victimes de violence sexuelle hommes) de la région des grands lacs, commis par des hommes non armés. L'impunité de la majeure partie de ces actes est une problématique qui facilite le viol. Malgré le fait que la synergie des femmes fait d'énormes campagnes de sensibilisation avec même une demande de changement de loi auprès du gouvernement de la RDC à Kinshasa, le phénomène persiste et très peu d'hommes sont punis. Quelques cas de condamnation sont connus au Burundi, mais la corruption est telle que le condamné sort souvent le jour même ou peu de jours après son incarcération. La femme ou la fille vit alors encore en plus du viol l'angoisse de la persécution et de nouvelles agressions de la part de l'agresseur.

Certaines pratiques sont décriées par les intervenants (congolais eux-mêmes) : des arrangements parmi les partis dans des tribunaux traditionnels en cas de viol sur les petites filles, comme ceux rapporté dans la région du Nord Katanga notamment. Un homme ayant violé une fillette peut se faire « blanchir » et « blanchir » la fillette en offrant à l'enfant :

- une poule blanche
- un litre d'huile de palme ou un verre de sel ou encore une robe blanche
- ainsi que 1000 Francs Congolais (env. 2$)

Cette Kusubula (purification) dans la tradition congolaise est en soi compréhensible et louable. Des actes symboliques peuvent aider une victime à intégrer un vécu traumatique, mais ils ne tiennent pas suffisamment compte des besoins et du traumatisme psychologique de l'enfant et invite sans autre l'agresseur ou d'autres à répéter l'acte, la sanction étant plutôt mineure. Des viols de fillette ou de jeunes femmes restent une problématique liée en partie aussi au croyances erronées et misogynes qui disent que le viol procure pouvoir, disparition ou encore immortalité, fortune etc. Des activités de sensibilisation, d'advocacy et de médiation familiale sont d'une haute importance pour remédier à ce fléau. Chez les femmes reprises par leur mari, on observe de graves problèmes de couples dues à une non envie de rapports sexuelles de ces femmes, un état dépressif et les troubles de l'ESPT (voir plus bas).

La problématique des enfants soldats : **Entre victime et bourreau**

La problématique des enfants soldats relève des défis particulièrement pointus. En effet, le nombre d'enfants soldats en RDC encore aujourd'hui est extrêmement difficile à estimer (certains chiffres parlent de 25'000 – 30'000, voire 40'000 enfants affectés dans des troupes armées, les Nations Unies estiment que 15 – 30 % des combattants nouvellement recrutés sont des enfants en dessous de 18 ans, beaucoup ont même moins de 12 ans. On a déjà trouvé des enfants à partir de 5 ans dans les forces armées), mais beaucoup d'enfants ne figurent pas dans ces estimations, notamment beaucoup de filles, présentant une problématique encore plus grave. Les filles ne sont souvent pas considérées comme enfants soldats par les chefs des groupes armés (sensés recenser les enfants et les démobiliser), mais elles ont plutôt un statut de domestique, de porteuse de messages ou de concubine, d'épouse voire de prostituée : l'exploitation sexuelle sous toutes ses formes est extrêmement répandue. Ainsi, beaucoup de filles ne sont donc pas « visibles » dans les statistiques en tant qu'enfant soldat. Si les quatre ONG internationales (Save the Children-UK, CARE, IFESH et IRC) présents dans la région des deux Kivu ont pu démobiliser de décembre 2003 à septembre 2004 1718 garçons, seulement 23 filles y figuraient. De 1998 à 2003, seulement 20 fillettes ont été libérées contrairement à 1522 garçons. Il ne faut cependant pas croire que les filles sont tellement minoritaires dans les groupements armés. Selon les garçons ex-enfants soldats, 30 – 40 % des enfants sont des filles. Une étude menée par Save the Children-UK et les partenaires (CARE, IFESH et IRC) laisse croire que les filles sont tout autant recrutées par les forces armées, mais une minorité de filles est atteinte par le PNDDR (Programme National de Démobilisation, Désarmement, Réintégration). En plus, une fille ayant été « épouse » d'un militaire ou ayant eu des contacts avec les forces militaires, spécialement une fille célibataire, a d'énormes difficultés de réintégration, du fait qu'elle n'est plus vierge (considéré comme chose évidente par la communauté) et qu'elle « appartenait » à un autre. Souvent, les filles sont enceintes ou ont déjà des enfants. D'ailleurs, une des raisons de mobilisation des filles était clairement exprimée : « pour rehausser le moral des troupes ». Les filles ayant démobilisées volontairement ou clandestinement ne sont pas prêtes à révéler leur vécu, craignant une forte stigmatisation – avec raison. Lorsqu'une fille a eu des relations sexuelles avec un homme, que ce soit de manière volontaire, par viol ou par présomption du fait d'avoir été prise par un groupe armé, en dehors du système de mariage et de dot, elle est considérée comme « n'ayant plus aucune valeur » par la société. Les filles « épouses de soldats » connaissent ces opinions publiques et ne cherchent pas forcément à être démobilisées. En plus, avec la charge d'enfants elles se retrouveraient seules et stigmatisées. Une forte crainte dans la population se focalise

aussi sur le fait que ces filles sont porteuses de maladies et infections sexuellement transmissibles (VIH/IST) ainsi que d'autres maladies (tuberculose etc.) et qu'elles auraient subies un abrutissement. Des stratégies évitant une stigmatisation des filles sont donc primordiales.

Il est à noter aussi qu'un certain nombre d'enfants sont devenus adultes (>18ans) entre-temps et sortent ainsi des statistiques. En plus, certaines régions (Nord Kivu, Ituri et Nord Katanga) sont toujours en conflit et continuent un (ré-)recrutement de soldats, tout âge bienvenu (spécialement chez les forces des Mayi-Mayi et des Interahamwe). Des cas multiples de ré enrôlement d'ex-enfants soldats sont rapportés par le rapport de « l'Initiative Congolaise pour la Justice et la Paix » pour les régions de l'est-congo en 2004. Des milliers d'enfants, appelés parfois « kadogo », se battent depuis 1996 dans la guerre en RDC.

Le recrutement des enfants soldats s'est fait pour les uns de manière forcée et pour d'autres sur une base volontaire (souvent par naïveté ou endoctrination ou encore motivé par leur parents qui voulaient soit remplir leur quota, soit profiter du gain promis). Néanmoins, grâce au programme PNDDR qui a été entamé après la réunification du pays en décembre 2003 et a commencé à être opérationnel en avril 2004, et grâce à beaucoup de travail de sensibilisation et d'advocacy, la **démobilisation** et le **désarmement** des enfants soldats avance constamment.

Il est à noter que Save the Children-UK par exemple a un grand mérite dans le début des actions notamment dans la province de Nord Katanga de décembre 2001 à janvier 2003 déjà, lorsque la province était toujours en guerre civile intense. Save the Children a répondu à un appel de la MONUC pour sensibiliser les chefs des forces armées à relâcher les enfants soldats. La réponse à alors été rapide et adéquate. Un projet pilote en décembre 2001 et fortement appuyé par UNICEF et le gouvernement congolais portait sur 280 enfants ex-soldats. Différents ONG's locales, nationales et internationales ont pu depuis réintégrer 1 279 enfants dans les deux centres de Goma et de Bukavu jusqu'en décembre 2002. Le Désarmement et la Démobilisation (DD) se font par les forces armées et la MONUC, les différents NGO's s'occupent de la Réinsertion (R) en suivant le cadre opérationnel conçu par le gouvernement. Différents partenaires (Save the Children, PAMI, UPADERE, DIVAS, IFESH etc.) interviennent au niveau des Centres de Transit et d'Orientation (CTO) où les ex-enfants soldats sont recueillis avant d'être rendus à leurs familles. Ceci peut durer que quelques jours ou peut aller jusqu'à plusieurs mois pour des enfants dont la famille ou des proches sont difficiles à trouver ou qui rejètent l'enfant (notamment dans le cas d'enfants soldats chez les Mayi-Mayi qui ont souvent été forcé à commettre des atrocités contre leur propre famille ou leur communauté, soi-disant pour activer les fétiches qui les rendraient invincibles et invulnérables aux balles des fusils de l'ennemi). Certains ont commis des atrocités contre leur propre famille (souvent sous l'influence d'alcool et de drogue, comme p.ex. manger un bout du sein de sa propre mère, encore une fois pour activer les fétiches. Pour beaucoup d'entre eux, on constate une endoctrination et un lavage de cerveau qui leur rend la vie difficile par la suite (p.ex. ne se lavent plus à l'eau de pluie car elle est sensée désactiver les fétiches, ou ne pas manger certains aliments comme la courge par exemple, pour les mêmes raisons).

La **réinsertion** des ex-enfants soldats se fait avant tout au niveau socio-économique, c'est-à-dire qu'on leur trouve une place d'apprentissage, les plus jeunes étant réinsérés dans le système scolaire. Le suivi des enfants n'est souvent pas assuré, par manque de

moyens ou manque de conscience de la part des partenaires. Ainsi, « L'Initiative Congolaise pour la Justice et la Paix » déplore un grand nombre d'échecs à la réinsertion et un taux élevé d'ex-enfants soldats se reconvertissant en voleurs à mains armées pour avoir de quoi vivre, semant ainsi l'insécurité dans leur milieu.

L'état de santé des ex-enfants soldats et déplorable. On relève notamment une grande fréquence des dermatoses (galle), des scarifications, des amibiases, des hernies scrotales ou discales, de la malnutrition aiguë, des infections IST (syphillis, VIH) etc.

Un *suivi psychologique* des ex-enfants soldats est totalement absent ou très rudimentaire. Il se situe avant tout au niveau de discussions et d'entretiens avec des personnes de référence (assistants sociaux ou infirmiers) ne disposant pas de la formation requise en matière de traumatismes sévères. Les enfants soldats sont en même temps victimes (pour beaucoup) et agresseurs quoique la limite entre les deux est très floue. Sachant que beaucoup d'entre eux étaient sous l'influence de la drogue ou de l'alcool, mais aussi victimes d'un lavage de cerveau et d'endoctrination, les enfants sont innocents, mais restent quand même agresseurs ou acteurs. Des ONG, parmi lesquelles Amnesty International, demandent à ce que les ex-enfants soldats en général ne puissent être condamnés à la peine de mort, à des châtiments physiques ou à d'autres traitements cruels et inhumains en quelque circonstance que ce soit. Le Traité des Nations Unies sur les droits de l'Enfant datant de 1989 constitue pour cela un important soutien. Ce traité impose que les États qui le signent s'engagent à prendre toutes les mesures nécessaires pour que des enfants de moins de 15 ans ne puissent être impliqués dans des conflits armés. Le Protocole facultatif au Traité sur les droits de l'Enfant qui s'appuie sur un certain nombre de traités internationaux, a été adopté le 25 mai 2000 par l'Assemblée générale des Nations unies. Ce protocole interdit la participation à des conflits armés et le recrutement d'enfants de moins de 18 ans (également connu en tant que point de vue « straight 18 »). Le protocole est entré en vigueur le 12 février 2002. Ce protocole facultatif énonce que l'utilisation d'enfants soldats est inacceptable en quelque circonstance que ce soit.

La république démocratique du Congo (RDC) a, comme le Rwanda et l'Ouganda, ratifié le protocole facultatif au Traité sur les droits de l'enfant. Mais cela ne signifie pas que la situation s'est améliorée pour autant pour les enfants ou pour les ex-enfants soldats.

Les enfants rencontrés dans le CTO de PAMI (Programme d'Action contre la Misère) à Goma présentaient des troubles du comportement social très net (agressivité aiguë, incapacité de vivre dans une société civile, inactivité, arrogance etc.) et selon les sources de la MONUC (child protection), beaucoup d'entre eux sont traumatisés. Chacun a tué, le nombre exacte reste leur secret (ce qui fait penser à des sentiments de culpabilité, voire de honte chez les enfants, chose qui devrait être géré et non refoulée). Il est à noter que sur les 46 enfants présents dans le CTO de PAMI, 43 ont vécus des relations sexuelles, c'est-à-dire qu'ils étaient avant tout violés ou violeurs (le viol active et maintien la force des fétiches). Quatre d'entre eux avaient attrapés la syphilis. Des enfants ayant pour un grand nombre vécus des années dans des conditions de violence, une réinsertion qui ne tient pas compte des blessures ou de l'abrutissement de l'âme ne peux être couronné de succès. En plus, d'autres recherches sur des vétérans de guerre (Viêt-Nam, Dhiên Biên Phu, Kosovo) montrent que les séquelles à long-terme posent de problèmes majeurs et les ex-combattants ne sont que partiellement capables de réintégrer la société. (Dans les années 1990, les premières expériences avec la méthode de détraumatisation EMDR

sur des ex-combattants du Viêt-Nam ont pu démontrer un effet positif sur la réinsertion de ces vétérans, jusqu'alors considérée comme un échec). La psycho traumatologie reste un domaine plutôt négligé par un grand nombre de partenaires dans l'aide humanitaire ou est associé à une « écoute » de quelques séances qui est censé permettre de « clore » le chapitre psychologique, malheureusement à un degré totalement insuffisant.

Par une remise en question des actions menées à travers du monitoring et par l'évaluation des interventions il est possible d'améliorer la condition des ex-enfants soldats. La remise en question des interventions à travers l'engagement de spécialistes est chose plutôt rare dans le domaine de l'aide humanitaire. Mais il existe chez Save the Children-UK une forte adaptation des pratiques comprenant l'intervention de spécialistes, ce qui permet une amélioration nette des pratiques. Les « lessons learned » des premières réintégrations des enfants sont en voie d'application actuellement par SC, mais pas par beaucoup d'autres organismes.

C'est-à-dire, la réinsertion aujourd'hui porte surtout sur une nouvelle approche qui cherche à renforcer le capital social à travers la « dette sociale », un concept qui veut réintégrer les enfants dans leur milieu naturel lui permettant de se situer dans la communauté en rendant les ex-enfants soldats « EGAUX » aux autres enfants, chose qui n'était pas le cas auparavant : les ex-enfants soldats étaient privilégiés par rapport aux autres enfants restés hors du circuit des groupes armés.
Les ex-enfants soldats se sont retrouvés avec des biens de valeur trop élevée (machines à coudre, chèvres ou vaches, rabots, vélos etc.) qui sont inaccessibles pour les enfants issus de familles « normales », même pour beaucoup d'adultes. Ceci a provoqué des jalousies de la part des autres enfants et une certaine arrogance de la part des ex-enfants soldats, se sentant supérieurs aux autres et refusant d'exécuter certains types de travaux habituellement demandés aux enfants les considérants comme « abaissants ».

Cette pratique de donner des biens à l'enfant renforce la mentalité « donnez-moi » au détriment de l'auto prise en charge. Le fait d'être « privilégié » par rapport aux autres enfants est en plus particulièrement dangereux en cas de nouvelles flambées de violence, où l'affectation dans un groupe armé pourrait devenir un attrait particulièrement fort, autant pour les enfants que pour des parents désireux de gagner des biens à travers la « mobilisation » de leurs enfants (et oubliant que les enfants sont envoyés en première ligne dans les combats).

La nouvelle politique de réinsertion des ex-enfants soldats porte aujourd'hui comme cité plus haut, sur le principe de la « dette sociale », c'est-à-dire, par exemple, l'enfant est pris en charge par un maître d'apprentissage qui l'accepte sans être forcement payé (en cash), mais que la famille se porte garant pour lui offrir de temps en temps une poule ou des vivres. Ou comme autre exemple, un enfant peut regagner l'école sans payer les primes de scolarisation, mais le programme de Save the Children l'aide à acquérir une tondeuse mécanique (<10$) avec laquelle il va couper les cheveux aux enseignants et aux élèves durant sa scolarisation. Ce principe cherche avant tout à tisser et renforcer les liens sociaux pour recréer les réseaux qui soutiennent habituellement les enfants. La famille doit fortement s'impliquer pour son enfant et le travail des ONGs porte plutôt sur les partenaires que sur l'enfant lui-même. La « dette » reste « à vie », mais créé un réseau social qui peut aussi être activé en cas de problèmes. Ce programme promet plus de succès pour la réinsertion, mais Save the Children reste un pionnier en la matière, ce qui crée de nouveaux problèmes aux ex-

enfants soldats : ils ne veulent pas être un enfant de « Save », car les autres reçoivent des biens plus attirants – à court terme bien sûr. De là l'importance de travailler en réseau et la coordination des actions avec les autres intervenants.

Les populations oubliées

Nous avons rencontrés des familles de Pygmées, les Twa au Burundi. Bien qu'étant une population extrêmement pauvre, donc indigente, ils n'ont jamais bénéficié de l'aide humanitaire et ne peuvent se payer les soins de santé par exemple. Bien que connus par les ONGs locales, ils ont un statut de « sauvage » et sont dénigrés par la population. Cette communauté aurait besoin d'une aide importante. Un père de famille nous a communiqué que trois de ses enfants sont morts en bas âge, ne pouvant pas demander de l'aide au centre de santé tout proche, faute de moyens financiers. Ils ne sont pas recensés par la population locale et les comités de santé en tant qu'indigents, du fait qu'ils ne sont pas indigènes (les twa sont toujours semi-sédentaries et ne sont donc pas considérés comme population locale). Il est important, que des poches de populations oubliées deviennent au plus vite bénéficiaires de l'aide humanitaire.

Quelques notions sur le concept du traumatisme

Il est important de rappeler que les réactions suite à des traumatismes sont des réactions normales à des situations pas normales, hors du commun. L'être humain ne sait pas ou que difficilement gérer des situations si dramatiques et si menaçantes.

Les effets sur le psychisme d'une population traumatisée et les suites possibles sont à comprendre dans le concept de l'ESPT (Etat de Stress Post Traumatique), de personnalités dissociés, donc des personnes « fonctionnant », mais plein de problèmes somatoformes graves traités médicalement sans succès (the body remembers). Les personnes à travers le monde entier réagissent de manière assez similaire aux situations traumatiques. **L'ESPT** comme il est décrit par le ICD-10 (International Classification of Diseases and Related Health Problems, WHO 1992) les troubles suite à un stress traumatique étant des **Intrusions** (images et pensées intrusives, cauchemars, flash-backs etc.), un **évitement** de situations et déclencheurs de souvenirs souvent accompagné d'une surdité affective et un état dépressif avec indifférence envers personnes ou situations ou encore activités auparavant importantes. En plus, comme troisième groupe de symptômes, une **activation végétative** accrue menant à une hyper vigilance (effrayabilité exagérée, troubles du sommeil, troubles nutritionnels etc.). En plus, on constate des troubles généralement sur quatre plans : sur le plan **cognitif** (troubles de la pensé, difficultés de concentration, idées noires, ruminations etc.), sur le plan **émotionnel** (mauvaise estime de soi, sentiments de culpabilité, de honte, angoisses et paniques, ou le contraire : pas de sentiments etc.), sur le plan **physiologique** (troubles dues à l'activation végétative, troubles des fonctions élémentaires comme de la nutrition, du comportement sexuel, des problèmes cardio-vasculaires, disposition aux maladies et infections etc.) ainsi que sur le plan **comportemental** (retrait social, abandon d'activités auparavant agréables, évitement de toutes situations potentiellement dangereuses etc.). Pour les cas plus graves, on observe des sentiments de dépersonnalisation et de déréalisation, des « absences », la personne ne se souvient pas de parties de sa vie, de sa journée ou ne sait pas où elle se trouve, dans quelle réalité, tout lui paraît irréel. Ses troubles sont souvent observés après des violences chroniques.

Il est d'une grande importance de tenir compte des croyances culturelles comme p.ex. les croyances par rapport aux esprits des morts. Certaines populations ont des croyances fortes, p.ex. que les esprits des tués restent présents parmi les vivants car ce sont des esprits non calmés, ils ne peuvent pas quitter la terre. Ainsi, les esprits poursuivent les vivants. Ce genre de croyances rajoute des symptômes contextuels supplémentaires à un tableau déjà bien chargé. En plus, les rituels culturels doivent être considérés comme d'une grande valeur pour le traitement du traumatisme et des troubles et doivent se rajouter aux traitements.

Les lessons learned dans le domaine des pays d'après guerre du siècle passé et la prise en charge de populations et d'ex-combattants devraient être appliquées dans ces pays. Malheureusement, actuellement ce n'est que très peu le cas. On sait qu'une prise en charge rapide après une expérience permet de diminuer considérablement l'apparition de symptômes décrits plus haut.

Les programmes humanitaires et le manque de prise en charge psychologiques

Les programmes humanitaires sont en effet focalisés sur l'urgence, c'est-à-dire ils procurent à manger, à boire et un toit et une place pour dormir, l'accès aux soins, un travail éventuellement ou l'accès à des terres. La santé mentale ne présente que peu d'intérêt, quoique la prise de conscience par rapport à ces populations traumatisées présentant de problèmes augmente heureusement. Il n'est que peu compréhensible pourquoi l'aide humanitaire se soucie si peu de la santé mentale des populations affectés par la guerre et la situation instable dans leur pays. On pense à une société dissociée qui veut avant tout fonctionner sans oser affronter la réalité affective, en la dissociant du reste.

L'état de santé des humanitaires

Nous avons constatés que la santé mentale des humanitaires n'est pas si bonne, il y a une grande surcharge de travail, souvent une absence de possibilités de se ressourcer, notamment dans des zones peu sures et instables, entraînant aussi des contacts limités. Des comportements dues à un stress cumulatif (les symptômes de l'ESPT, nervosité accrue, voire une agressivité envers les bénéficiaires, grosse rotation du personnel entraînant une perte de la mémoire institutionnelle, des dépendances au tabac et alcool, etc. sont fréquentes).

Recommandations principales

En vu du grand nombre de cas (plus de la moitié de la population ? On parle ici des déplacés, des réfugiés, des femmes et enfants victimes de violence sexuelle, les ex-enfants soldats et la population traumatisée tout court) nécessitant de l'aide pour l'amélioration de leur santé mentale, il est peu sensé de penser à des prises en charge individuelles. Celle-ci étant réservée aux cas les plus terribles ou les plus difficiles, pour le gros de la population il faut penser à des prises en charge communautaires. En plus, la plupart des infrastructures de la santé et de la santé mentale sont inexistantes ou ne sont qu'en voie de réhabilitation ou de reconstruction, avec une absence cruelle des ressources humaines (professionnels de la santé et de la santé mentale). Au Burundi, il y a un seul psychiatre, ne travaillant même plus dans la psychiatrie, et que très peu de psychologues. Il faudrait mettre l'accent sur la

formation du personnel capable de prendre en charge ces problématiques à une grande échelle, avec l'appui de spécialistes. Il est primordial que les concepts de formations doivent être adaptés au contexte culturel (croyances) et que les capacités de résilience et les stratégies de coping de la communauté (rituels) doivent être pris en considération. Ainsi, ça devient un travail plus volumineux demandant plus de ressources du fait que les programmes ne peuvent être « administrés » de manière universelle. La collaboration avec des personnes locales s'impose donc.

Le renforcement des capacités de résistance (inclus le capital social) et leurs stratégies de coping permettra à la population éprouvée l'intégration du traumatisme dans leur vécu, ils apprennent à « vivre avec ». Des techniques permettant à réduire les symptômes et de stabiliser les personnes traumatisées sont assez facilement accessible à un grand nombre de personnes et pourraient être enseignés de façon large. Des recherches menées sur des personnes traumatisées démontrent que beaucoup de personnes arrivent à bien vivre avec leurs souvenirs terribles (donc pas de travail sur le traumatisme, car nécessitant l'intervention de spécialistes) s'ils savent comment gérer les symptômes eux-mêmes. Ceci leur permet également de regagner une notion de contrôle sur leur vie et leur vécu, chose qui augmente le bien-être psychologique.

Malgré que la prise de conscience des acteurs sur le terrain grandisse face à cette problématique, les bailleurs ne sont que peu motivés à financer des projets de ce type. Il est plus séduisant de pouvoir afficher des chiffres attestant combien de personnes ont été sauvées de la faim, combien d'enfants ont été vaccinés, combien de tentes ont été dressés etc. Certes, ce sont les premiers besoins et ils nécessitent absolument une prise en charge immédiate dans l'urgence. Mais le retrait abrupte post-urgence et le non financement de projets concernant la santé mentale sont en déséquilibre par rapport à l'ampleur du problème. Il est reconnu que des personnes traumatisés ou encore des vétérans de guerre n'arrivent que très difficilement à diminuer leurs symptômes psychiques, et en plus, développent toute sorte de symptômes psychosomatiques, devenant ainsi une charge pour l'infrastructure de la santé : s'ils en ont la possibilité, ils consultent énormément de médecins sans jamais trouver l'aide appropriée. Leurs troubles étant des problèmes psychiques, on ne peut que difficilement les traiter avec la médecine (la pharmacothérapie n'est souvent qu'un travail sur les symptômes, p.ex. insomnies, mais pas sur les causes). Les programmes de santé mentale devraient être intégrés dans les structures de santé.

Concernant la prévention d'une trop grande rotation du personnel et la prévention du burn-out de celui-ci, ils est à recommander que des vacances fréquentes soient imposés aux collaborateurs par les organisations mères, en tout cas tous les deux mois.

Il faudrait mettre l'accent sur la formation du personnel pour le rendre capable de prendre en charge des problématiques psycho traumatologiques à grande échelle, ceci avec l'appui de spécialistes. Il est primordial que les concepts de formations doivent être adaptés au contexte culturel (croyances) et que les capacités de résilience et les stratégies de coping de la communauté (p.ex. rituels) doivent être pris en considération. Ainsi, le travail est plus volumineux demandant plus de ressources du fait que les programmes ne peuvent être « administrés » de manière universelle ou générale, mais demandent une adaptation contextuelle. La collaboration avec des personnes locales s'impose donc.

Le renforcement des capacités de résistance (inclus le capital social) et leurs stratégies de coping permettrait à la population éprouvée l'intégration du traumatisme dans leur vécu, ils apprennent à « vivre avec ». Des techniques permettant à réduire les symptômes et de stabiliser les personnes traumatisées sont assez facilement accessible à un grand nombre de personnes et pourraient être enseignés de façon large. Des recherches menées sur des personnes traumatisées démontrent que beaucoup de personnes arrivent à bien vivre avec leurs souvenirs terribles (donc pas de travail sur le traumatisme, car nécessitant l'intervention de spécialistes) s'ils savent comment gérer les symptômes eux-mêmes. Ceci leur permet également de regagner une notion de contrôle sur leur vie et leur vécu, chose qui augmente le bien-être psychologique de manière considérable.

Le manuel de l'OMS et du HCR par rapport à la santé mentale des réfugiés est disponible en 10 langues et informe sur beaucoup de savoir scientifique sur les besoins des personnes déplacées et réfugiées, incluant le développement de stratégies, de plans d'action avec un outil d'assessment rapide des besoins de santé mentale.

Il est hautement souhaitable que ces « lessons learned » vont être appliqués rapidement pour aider un grand nombre de personnes à augmenter leur état de bien-être et diminuer au plus vite leurs souffrances. Ceci leur permettra de retrouver leur dignité et leur équilibre psychologique perdu dans toutes ces années de guerre et d'horreurs, leur apportant un futur meilleur, des conditions de bien-être individuel amenant au développement et à la paix.