Independent Evaluation of the Rapid Response Mechanism (RRM)

United Nations Office for the Coordination of Humanitarian Affairs (OCHA)
and
United Nations Children's Fund (UNICEF)

Democratic Republic of Congo

October 23 – December 12, 2006

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Abbreviations

ACF – *Action Contre la Faim*
ADF/NALU - Allied Democratic Forces/National Army for the Liberation of Uganda
AVSI - Association of Volunteers in International Service
CERF - Central Revolving Emergency Fund
CESVI - *Cooperazione e Sviluppo*
CPIA – *Comité Provinciale Inter-Agence*
CRS – Catholic Relief Services
CTC – Cholera Treatment Center
DDR – Disarmament, Demobilization and Reintegration
DFID – Department for International Development
DPKO – Department of Peacekeeping Operations
DRC - Democratic Republic of Congo
FARDC – *Forces Armées de la République Démocratique du Congo*
FDLR – *Forces Démocratiques de Libération du Rwanda*
HAG – Humanitarian Advocacy Group
HAP – Humanitarian Action Plan
HIV/AIDS - Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICRC – International Committee of the Red Cross
IDP – Internally Displaced Person
INGO – International Non-Governmental Organization
IPS - Inspection Provinciale de la Santé
IRC – International Rescue Committee
MONUC – United Nations Mission in the DR Congo
MSF – *Médecins Sans Frontières*
NFI – Non-Food Items
NRC – Norwegian Refugee Council
OCHA - United Nations Office for the Coordination of Humanitarian Affairs
ORS – Oral Rehydration Salts
PEAR – UNICEF Program of Expanded Assistance to Returnees
RRM - Rapid Response Mechanism
RRF – Rapid Response Fund
SGBV – Sexual and Gender-Based Violence
UN – United Nations
UNHCR – United Nations High Commission for Refugees
UNICEF - United Nations Children's Fund
VAM – Vulnerability Assessment Methodology
WASH – Water, Sanitation and Hygiene
WFP – World Food Programme
WHO – World Health Organization

Acknowledgments

Performance evaluations by independent experts produce optimal results when client institutions decide that they have nothing to hide, and a spirit of constructive, critical analysis prevails between evaluator and client. Senior staff may demonstrate their commitment to transparency by organizing an evaluator's itinerary well in advance, preparing the relevant data and reports for review, arranging field visits to remote sites, creating time for long interviews and generally making themselves and their subordinates as available as possible. Such a degree of support and cooperation is uncommon today, however.

The evaluator would therefore like to emphasize his appreciation to the organizers of this multi-agency evaluation for their exceptional support and facilitation, in a country renowned for its logistical challenges. In particular, UNICEF staff in Kinshasa, Goma, Bukavu and Lubumbashi facilitated the evaluation process at every stage by organizing transport, lodging, administrative support, office space and access to RRM field sites. OCHA, International Rescue Committee, and Catholic Relief Services were also available and forthcoming with information and responsive to follow-up queries. Solidarités were exceptionally accommodating and helpful in North Kivu and Ituri, committing their limited resources and time to ensure a fruitful visit despite challenging working conditions and a volatile security environment.

EXECUTIVE SUMMARY

The Rapid Response Mechanism (RRM), a program partnership between OCHA and UNICEF operating through select international non-governmental (INGO) partners, has provided immediate short-term assistance to victims of rapid onset emergencies in the Democratic Republic of Congo since October 2004. Its interventions aim to serve populations made critically vulnerable by three forms of crisis event: mass displacement due to recent conflict, natural disasters, and epidemic outbreaks. Its provinces of activity include but are not limited to North and South Kivu, Ituri District (Orientale Province), Katanga and Maniema.[1]

Large-scale civilian displacement has been a frequent feature of unrest across the country, beginning with the violent *refoulement* of the Kasai Luba from Katanga in the early 1990s. In the months immediately following the Rwandan genocide in April 1994, a vast influx of Rwandan refugees settled in Congo's eastern provinces, creating a large-scale humanitarian disaster. In late 1996, with Rwandan backing, Laurent Kabila's military campaign succeeded in ousting Zairian President Mobutu Sese Seko but left a path of civilian trauma and mass displacement in its wake. A second war to overthrow President Kabila exploded in 1998, during which humanitarian indicators plunged as civilians, particularly in the east, were targeted and displaced by diverse armed groups, many organized along ethnic lines. Despite a 2003 peace accord and the formation of a transitional government, civilians continued to bear the brunt of targeted violence leaving them little recourse but to flee for safety. RRM thus arose in 2004 not in response to the onset of a new crisis, but rather as a new strategy to assist victims of long-existing cycles of conflict and displacement.

The rationale behind the RRM program is to enhance the capacity of the humanitarian community in DRC to assess and respond to rapid onset acute emergencies. This evaluation was commissioned in October 2006 in order to review the performance of RRM programming after two years of its novel arrangement between OCHA, UNICEF and INGO implementing partners. The evaluation also develops lessons learned and recommendations to strengthen the mechanism both in DRC and in light of future implementation in other countries.

According to the 2007 Humanitarian Action Plan, 1.1 million persons are currently displaced in the eastern provinces.[2] The United Nations estimates that 95% of the displaced flee in search of refuge and security to nearby communities, often within a day's walking distance from their places of origin.[3] From its inception, RRM has endeavored to respond to the challenge of recurrent displacement with specific strategies to identify and support the most acutely vulnerable with three core interventions: non-food items and shelter materials, water-sanitation assistance, and emergency education. To a lesser degree punctual assistance to existing medical facilities and actors as well as cholera response have also been part of the RRM program.

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[1] Maniema Province was covered by Solidarités from Kalemie in North Katanga for 2005, but the province is no longer actively covered by RRM. Stand-by intervention capacity in face of need is available from Lubumbashi and Bukavu, however.

[2] HAP 2007 was launched in November 2006: http://www.reliefweb.int/rw/rwb.nsf/db900SID/SKAR-6W2GRV?OpenDocument&rc=1&cc=cod

[3] "Action Plan 2006, Mid-Year Review," OCHA, July 18 2006: http://ochaonline.un.org/cap/webpage.asp?Page=1394.

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The RRM program has enjoyed a reputation of winning success within DRC since its inauguration in late 2004, with funding contributed by DFID, OFDA and Sweden (channeled through the OCHA-managed Rapid Response Fund, or RRF). Subsequent funding was received from the Pooled Fund, CERF and OFDA. A representative from DFID, RRM's single largest bilateral donor, claimed that "We cannot afford not to have RRM." Such is the general view among donors and other observers, with remarkably few exceptions: RRM is indispensable. RRM's success both as an operational model and a real-time program owes much to the simplicity of its coordination and operational structure, which integrates three basic requirements: pre-positioned relief supplies, prior funding to INGO partners to conduct assessments and interventions, and quick access to additional funds when needed.

As a relief program RRM is dedicated to responding within 72 hours and to intervening for no longer than three months. While the RRM program itself intervenes in limited sectors, the operational concept behind it is in principle limitless as a management solution to the need for rapid response capacity in other sector(s) as well. Funded to operate through May 2007, the current RRM program is the only multi-organization, multi-sector, emergency monitoring and response mechanism in the country.

The two basic components to the RRM program in DRC are (1) the INGO implementing partners funded and equipped with standby capacity and materials by UNICEF, and (2) support from an OCHA contingency fund for other emergency initiatives in areas outside those directly covered by the RRM program. Funds are channeled through OCHA's Rapid Response Fund to the three INGO implementing partners for the RRM program, although other humanitarian actors may also access this funding source. The OCHA contingency fund is also used to supplement RRM interventions when acute needs surpass the standing capacity of INGO partners.

RRM operations comprise four stages of intervention: (1) rapid multi-sector assessment as a crisis unfolds (within 72 hours, security and logistics permitting); (2) appropriate assistance in the area of non-food items (NFI), temporary shelter materials,[4] emergency education, medical supply kits, construction of cholera treatment centers and emergency water, sanitation, and hygiene facilities; (3) lobbying and advocacy based on first-hand reporting to mobilize a wider array of resources and interventions in remaining vital sectors, including food aid/food security, emergency nutrition, health and medicine, and protection; (4) ongoing monitoring and surveillance of evolving beneficiary needs and the impact of RRM interventions on affected populations.

Under the current arrangement, UNICEF covers operational costs, procurement of relief supplies and the provision of in-kind operating equipment to ensure that stocks of relief materials are adequately pre-positioned in five locations: Kinshasa, Lubumbashi, Bukavu, Bunia, and Goma. Three INGO implementing partners—Solidarités in Ituri and North Kivu, the International Rescue Committee in South Kivu, and Catholic Relief Services in Katanga—are thus equipped by UNICEF and prepared to deploy within 72 hours of an identified humanitarian crisis.

A primary concern identified by this evaluation (and highlighted in the 2005 RRM Annual Report) is that immediate and acute needs in other sectors—particularly food, health and protection—were not designed to be covered by the current RRM program.

[4] 'Temporary' or 'emergency shelter materials' typically signifies reinforced plastic sheeting that is distributed to families in need to serve as temporary shelter from rain, wind and cold.

For the sake of clarity, this is not a shortcoming of the RRM program per se, but an acknowledgment that unmet emergency needs exist in other vital sectors. The present evaluation defends the current configuration of the RRM program in DRC, whereby OCHA, UNICEF and three INGO implementing partners respond to acute needs in NFI/shelter, water and sanitation, and education. However, a central recommendation of this evaluation is that the RRM concept be adopted by the appropriate cluster lead agencies to ensure timely and appropriate response to acute needs in the food, health and protection sectors. In other words, the RRM concept is flexible and readily adaptable to satisfy the need for emergency response capacity in the food, health and protection sectors, where it is currently lacking. This is not to say that the current RRM program should assume the responsibility of providing emergency assistance in these three additional sectors.

Stand-by emergency response capacity will remain essential throughout 2007 in water and sanitation, NFI/emergency shelter, emergency education, food, health and protection. Gradual improvement of humanitarian indicators is contingent upon the effective pacification of non-state armed groups and the cessation of violations against civilians by the newly integrated national army. However desirable and necessary these developments may be for the progress of the country, neither is guaranteed, and the cycles of insecurity and displacement could continue to disrupt civilian livelihoods beyond 2007.

Evaluation findings

The evaluation sought to address the following five thematic issues:

1. **RRM process in the field**. How do RRM teams conduct their activities, what tools do they use, and how might these be improved?
2. **Beneficiary selection and RRM's three-month vulnerability criterion**. Are the current temporal vulnerability indicators and selection criteria effective and appropriate to the context, or do they wrongly discriminate between 'new' and 'old' displaced persons?
3. **Vital sectors outside RRM**. Are other needs being filled, particularly food, health and protection?
4. **Relations between RRM, other interagency initiatives, and the wider humanitarian reform agenda.** What are the precise roles of each RRM participant: OCHA, UNICEF and INGO Focal Points?
5. **Performance and impact of RRM**, including questions of exit strategy and possible replication of the mechanism in other emergency contexts.

In its current configuration, the RRM program ensures accountability in NFI/emergency shelter materials, education and water and sanitation—clusters for which UNICEF is cluster lead and the 'provider of last resort' in the DRC.[5] As mentioned, RRM as a concept or model for emergency programming need not be limited to the current three clusters. An RRM-like program model could be readily adapted by other cluster lead agencies or NGOs to provide emergency response capacity in other clusters where rapid onset emergencies are common, and which do not receive the same degree of funding as do NFI/shelter, watsan and education under the present RRM program.

[5] UNICEF is also responsible for nutrition. It should also be noted that UNHCR is the global cluster lead on NFI/emergency shelter materials. Only in DRC does UNICEF have this cluster lead responsibility.

In addition to the qualitative, thematic components of the evaluation noted above, the study also analyzed available quantitative data in order to gauge overall output of the RRM program to date. [Detailed quantitative data are presented in the Annex section.] Process or output indicators are important because they demonstrate that the program is going as planned and without undue delay or obstacle. For the purpose of this evaluation, statistics regarding program output presented below are not sufficient to assess program impact on beneficiaries, however. Gauging impact on program recipients requires qualitative data, which the evaluator obtained through focus group discussions with beneficiaries, interviews with RRM staff and partner agencies in the field. Project monitoring and impact surveys conducted by RRM teams with beneficiaries following field interventions were also incorporated into the present evaluation.

- **RRM I**, from October 2004 to August 2005, reached almost 417,000 persons.
- **RRM II**, from September 2005 to May 2006, reached slightly over 339,000 persons.
- **RRM III** to date (five months between June and November 2006), has already reached over 744,000 persons, more than double the total number of beneficiaries for RRM II.[6]

In terms of NFI/shelter, emergency education and water and sanitation, of the 1.5 million beneficiaries since October 2004:

- 815,000 persons received NFI packages and/or emergency shelter;
- 693, 500 benefited from emergency water and sanitation projects;
- 13,500 children received emergency education kits.[7]

Select recommendations

These and other recommendations and lessons learned are elaborated further in Section IV, p. 25, of the report.

- **To UNICEF, OCHA and INGO implementing partners:**

Develop appropriate indicators to track and measure progress. RRM generates a large quantity of documentation, particularly its assessment and intervention reports, and monitoring questionnaires. The bulk of this reporting serves real-time decision making by documenting remaining or additional needs and recommending immediate action in other sectors. A weakness noted by this evaluation is that very little of this accumulated monitoring data is synthesized, quantified or fed back into a formal evaluation framework, with established performance indicators, in order to measure the overall impact of RRM interventions over time. This evaluation suggests a set of basic indicators

[6] These statistics were calculated using the summary intervention tables received from RRM managing agencies, and are presumed complete. Data received for phase II lacks statistics from Ituri and South Kivu, however. Phase II data is also not representative of the entire period (only January to June 2006 was available). Data for phase III is ongoing, but is presumed complete from June to November 2006.

[7] Figures compiled from summary intervention tables representing the number of beneficiaries per sector, per province, per phase of RRM. Education beneficiary number appears low; see possible explanation on p. 11 in the 'Limitations and challenges' section.

to be shared by the three INGO partners, which will also be relevant for the future creation of a database for RRM and PEAR.[8]

Two types of data collection require attention. First, basic process data tabulating beneficiary numbers, number and sector of interventions (number of families receiving NFIs, water points rehabilitated, schools assisted, etc.). Second, formal monitoring data from post-intervention monitoring visits to be compared with program indicators and performance targets, to be harmonized among all RRM implementing partners. These needs were identified during the February 2006 Goma workshop, but have seen little subsequent progress. Concrete steps are now planned to further develop RRM's monitoring and evaluation activities, and harmonize performance indicators at a UNICEF-led workshop in early 2007.[9]

The three month criterion should be retained as a flexible indicator of vulnerability. In the wake of a crisis, RRM assesses the degree of vulnerability and selects its beneficiaries according to how recently they were displaced. Those displaced within the last three months are eligible for assistance. The RRM experience in DRC illustrates the utility of this criterion as a prioritization tool in situations of chronic displacement, its limits, and the occasional need for other eligibility criteria. In some areas, such as North Kivu where pre-emptive displacement is a common civilian self-defense strategy, the three month criterion is no longer reliable as an indicator of acute vulnerability. Instead, RRM teams assess vulnerability in purely material terms: prior possession of NFIs, shelter, access to water, health care and education. Alternately, vulnerability could be indexed by employing Sphere standards as initial baseline indicators against which basic measurements of the beneficiary group (access to liters of water per day, nutritive intake per day, etc.) are compared before and after an intervention. Doing so could facilitate the quantitative component of post-intervention follow-up, by providing a baseline against which progress and impact could be measured.

- **To cluster lead agencies in health, food and protection:**

Emergency preparedness and reactivity should be developed by the cluster lead agencies in health, food and protection. The current RRM configuration of OCHA, UNICEF and INGO implementing partners has demonstrated positive impact in the three sectors in which it specializes. Acute unmet needs persist in the food, health and protection sectors, which exceed the specialized mandate of the current RRM program.

RRM program activities in HIV/AIDS are limited (by design) to raising awareness of HIV/AIDS issues in emergencies among partner agencies and beneficiaries. In protection matters, RRM's role consists in collecting information on specific cases in communities where RRM intervenes, which is then transmitted to the protection cluster for further action. In neither instance are RRM's efforts intended to substitute for cluster responsibility for action in these sectors, which would be better served by the specialized

[8] The UNICEF Program for Expanded Assistance to Returnees (PEAR), initiated in early 2007, supports the return process for tens of thousands of displaced families spread across eastern Congo. It provides a relief package not unlike that of the current RRM program, with additional emphasis on reconstruction materials for those returning to destroyed and abandoned villages. PEAR and the RRM program assist the same group of beneficiaries during the two most critical, phases of their crisis: displacement and return. PEAR and the RRM program are thus complimentary efforts. Discussion of PEAR and RRM commences on p. 59.

[9] This workshop took place on February 23-24 in Goma.

agencies comprising the protection and health clusters. Given that the RRM model is not 'owned' by OCHA, UNICEF or their INGO partners, nothing precludes the adaptation and application of the RRM concept by cluster lead agencies to meet emergency needs in food, health and protection clusters as and when they arise.

- **To UNICEF, OCHA and other cluster lead agencies:**

Introduce measures to ensure the validity and utilization of RRM assessment findings by cluster leads in food, health and protection. RRM teams voiced the recurrent frustration that multi-sector assessment recommendations made in their assessment reports are rarely accepted and acted upon by cluster lead agencies in the relevant sectors. The solution is not for other sectors—food, health and protection specifically—to duplicate RRM assessments by conducting their own. Two solutions are available. First, cluster leads in other sectors may accept the results of RRM assessments by actively engaging in the process, providing RRM teams with tools and training as needed. Second, RRM teams may collect only the most basic information in health, food and protection. Specialized actors in these other sectors are encouraged to consider adopting a similar operational model to allow for similar standby capacity to evaluate and respond to acute, rapid-onset needs in their respective sectors.

Baseline vulnerability study at program outset should precede other RRM interventions elsewhere. Traditionally with project proposals for large-scale emergency programs, donors require baseline vulnerability data because it establishes an objective denominator against which donor and agency can track a project's progress, or lack thereof. Without baseline data, cumulative impact of a project on beneficiaries is difficult to measure, and yet donors require statistical evidence of performance, the most basic form of accountability for public monies spent. At the inception of its operations in 2004, RRM did not conduct a baseline needs assessment against which it could establish output targets and subsequently measure performance. Instead, RRM re-conceived needs assessment and prioritization according to a real-time model that evaluates vulnerability as each crisis unfolds. Such a model is practical and adapted to DRC field realities, but it does not provide the necessary benchmark against which the impact of the RRM program as a whole can be measured. Should RRM be replicated elsewhere, it is encouraged to document baseline vulnerability (using basic Sphere indicators for water, nutrition, etc.) against which its progress and impact may be measured over time.

- **To OCHA:**

Advocacy undertaken by OCHA on behalf of RRM concerns should be systematized for greater accountability. RRM teams operate on the front lines of rapidly unfolding emergencies; their eyewitness accounts and real-time assessments of affected populations form a primary source of information for the wider humanitarian community, in particular its advocacy and lobbying initiatives. While OCHA and UNICEF are engaged and quick to respond to perceived advocacy needs, RRM teams in the field expressed disappointment with the follow up and outcome of these initiatives, which require sustained attention and continued effort. OCHA's provincial information officers could document and track such efforts, overseen by the sub-office OCHA head, so that other RRM members could stay abreast of initiatives as they evolve and learn of their eventual outcome. By documenting and systematizing the advocacy initiatives that it undertakes on behalf of RRM, OCHA's role in this domain could be better measured and thus evaluated. Quantifying the success and failure of inter-cluster advocacy efforts

would bring greater accountability to the cluster system as well. A mechanism to ensure clearer documentation and accountability tracking was proposed and adopted at the RRM meeting in Bukavu in December 2006.

II. Evaluation scope and method

An independent evaluation was commissioned in October 2006 to assess the performance and impact of RRM to date, to propose recommendations for improvement and towards the possible replication of the mechanism in other emergency contexts. The evaluation sought to address the following five thematic issues:

1. **RRM process in the field**: How do RRM teams conduct their activities, what tools do they use, and how might these be improved?
2. **Beneficiary selection and RRM's three-month vulnerability criterion**: Are temporal vulnerability indicators and beneficiary selection criteria appropriate?
3. **Vital sectors outside RRM**: Are other needs being filled, particularly food, health and protection?
4. **Relations between RRM and other interagency initiatives** (clusters, PEAR), including the wider humanitarian reform agenda. What are the precise roles of each RRM participant: OCHA, UNICEF and INGO Focal Points?
5. **Performance and impact of RRM**, including questions of exit strategy and replication elsewhere.

Following the Executive Summary, the Introduction explains the core components, rationale, and genesis of RRM. Section IV follows with a presentation of lessons learned, categorized according to the above five areas, and includes recommendations. In the main body of the report (Section V), each of the five guiding questions above are addressed with a summary of core findings, including relevant views or experiences of the actors involved (INGO partners, OCHA, UNICEF, donors, beneficiaries, and other agencies).

Field visits and interviews for this evaluation commenced on October 23 in Kinshasa and ran through November 23 in Goma. The evaluator visited RRM partners and several project sites in all provinces of activity, with the exception of Katanga, which was limited to interviews and group discussions in Lubumbashi. An RRM workshop held in Bukavu from December 5-8 allowed the evaluator to present preliminary findings to representatives from OCHA, UNICEF and INGO partner agencies in order to incorporate their feedback into the study. Details on the evaluator's itinerary, persons and places visited, and documents consulted are found in the Annex.

The methodology for this evaluation combined qualitative and quantitative approaches, drawing primarily from beneficiary interviews and focus group discussions, interviews with actors in the wider humanitarian community, local authorities and civil society, field visits, and document reviews.

Limitations and challenges

The evaluation encountered few challenges or limitations during the study, although two are enumerated here. First, the evaluation of RRM activities in Katanga was compromised due to the inability to visit remote field activities given irregular flights and a tight itinerary. Useful information was obtained in the regional capital but could not be corroborated by field visits and interviews with beneficiaries.

The second limitation concerns the quality of statistical data on beneficiary numbers made available to the evaluator. RRM appears to lack a coordinated and centralized

mechanism to register and update beneficiary numbers based on cumulative reporting from its ongoing interventions. This results in certain anomalies. For instance, the figures for beneficiaries of education interventions presented in the 2005 Annual Report appear unsubstantiated: the overall number of education beneficiaries is given as 36,700, yet the statistics intended to corroborate this figure add up to a mere 3374 students. Summary tables of education interventions carried out during 2005 and provided to the evaluator by RRM administrators, also add up to 3374 beneficiaries, not the 36,700 figure cited in the 2005 report.

In the other two sectors, watsan and NFI/emergency shelter materials, the overall figures are consistent with the summary tables included in the 2005 Annual Report, and cohere with data provided to the evaluator by RRM managers. The above-mentioned discrepancy indicates the lack of a well-coordinated data centralization system not only for beneficiary numbers and interventions according to sector, but also documenting annual costs per province, for example, which could then be used to estimate cost per beneficiary.

III. INTRODUCTION

The Rapid Response Mechanism, an interagency partnership between OCHA and UNICEF, operates through INGO partners in four regions of eastern and southern DRC: Ituri (Orientale), North Kivu, South Kivu, and Katanga. The mechanism responds to three forms of acute crisis common to these areas. The most common form of RRM intervention concerns sudden population movements that have occurred within the last three months, or for displaced groups who have only become accessible within the last three months. In some instances, assistance was also extended to recently returned populations. It also responds to natural disasters such as flooding and landslides. Finally, it reacts to epidemic outbreaks, such as cholera and malaria.

The RRM program has enjoyed a reputation of winning success within DRC since its inauguration in late 2004. A representative from DFID, RRM's single largest bilateral donor, claimed that "We cannot afford not to have RRM." Such is the general view among donors and other observers, with remarkably few exceptions: RRM is indispensable. Donors and UN agencies not involved with RRM maintain that its primary value is the increased geographical coverage it offers, in view of Congo's vastness and logistical complexity. Second is RRM's ability to jumpstart a response without having to negotiate questions of what/who/how with the wider humanitarian community. Reaction time lost to coordination efforts at the breaking point of a crisis is drastically reduced, because assessment teams and relief supplies are already in place.

RRM success owes much to the simplicity of its coordination and operational structure, which integrates three basic requirements: pre-positioned relief supplies, prior funding to INGO partners to conduct assessments and interventions, and quick access to additional funds when needed.

RRM program design departs from conventional emergency programming in several significant ways. First, RRM does not use the traditional logistics framework to establish intervention parameters and output targets at the outset, supplemented with baseline vulnerability data. Instead, as a crisis unfolds, RRM's multi-sector assessment teams register acute vulnerability in seven different sectors (NFI/emergency shelter materials, water and sanitation, emergency education, food aid/food security, nutrition, health, and protection), and convey this data to the wider humanitarian community. Assessments in the three core sectors (NFI/emergency shelter, watsan, and emergency education) are systematic, and minimize the risks associated with supply-driven response by identifying specific needs and then tailoring the RRM intervention accordingly. While assessment reporting is valuable and the teams generally capable of identifying vulnerability in sectors outside their core competencies, complications arise in securing the commitment of relevant actors to intervene in other vital sectors, particularly food and health. The evaluation has recommended solutions to this impasse.

Second, RRM maintains full-time emergency response capacity, providing temporary shelter materials and NFIs, water and sanitation services and structures, emergency education kits and school rehabilitation. Basic health kits are also provided to local dispensaries and health centers directly or through operational medical NGOs, where needed. This flexibility allows it to tailor its response in terms of one, two or all three of these sectors, as dictated by its assessments. A large store of pre-positioned stocks and sufficient advance financing allows INGO partners to respond immediately by not having to submit individual project proposals and budgets for each proposed

intervention. At weekly meetings between UNICEF, OCHA and implementing partners at the field level, there occurs an informal approval discussion prior to each operation. Results from previous or ongoing interventions are also discussed, including decisions on real-time strategy as specific crises continue to evolve.

All implementing partners, IRC, Solidarités and CRS, also carry out protection evaluations where conflict and protection-related issues are most likely to have occurred—less likely after a landslide, for example. A set of action points and recommendations for intervention by sector are usually, but not always, fed back to the cluster system in order to trigger the appropriate response from key actors in these five other sectors. With its rapid mobility and frequent assessments, RRM offers multi-sector monitoring and surveillance capacity ('eyes and ears') to the wider humanitarian community.

Given its predominant attention to assessing emerging crises and intervening within 72 hours, RRM has invested relatively little in measuring the impact of its interventions—a primary reason for the present evaluation. Yet RRM teams carry out extensive post-distribution interviews, using random sampling techniques and detailed questionnaires, in order to gauge the appropriateness of the response relative to beneficiary needs. Although this data is yet raw and unfiltered, it constitutes an essential qualitative and quantitative resource for a final evaluation of RRM performance. The three RRM INGO partners—Solidarités, Catholic Relief Services, and International Rescue Committee—plan to undertake their own impact evaluations as the third phase of RRM concludes in May 2007. The present evaluation will propose a set of relevant indicators and method, drawn from RRM's own ongoing monitoring practices, with which a standardized evaluation tool may be developed.

For those unfamiliar with the Congolese operational context and the RRM program in particular, it merits mention that in Katanga, RRM's implementing partner (CRS) does not possess the same degree of multi-sector response capacity as do partners operating in the eastern provinces. In Katanga, RRM teams provide NFIs, shelter materials, medical kits, education kits, and minimal classroom rehabilitation assistance. There is no provision of water, sanitation facilities, or hygiene assistance. Given the presence of other actors in water and sanitation in Katanga, the RRM partner's lack of response capacity in this sector does not constitute a major weakness for the program there. Because of vast distances, the absence of a viable transport and communications infrastructure, and its recent start-up (May 2006), the assessment and surveillance capacity of RRM Katanga is less extensive than in the eastern provinces.

1. RRM components

The effectiveness of RRM's current activities is due in large part to the program's uncomplicated, practical focus on multi-sector assessments and three-sector delivery. As an operational model for rapid response to emergency needs, the RRM concept need not be restricted to its current set of sectors, but can be adapted and applied by cluster leads to meet needs in food, health even protection. The RRM model is based on three core components: pre-positioned relief supplies, prior funding to INGO partners to conduct assessments and interventions, and quick access to additional funds when needed.

- **Pre-positioned relief supplies and equipment**. Non-food items, clothing, plastic sheeting, mosquito nets, high nutrition biscuits (BP5s), basic medical kits,

Ringer lactate and ORS for cholera, and watsan equipment are procured—most internationally but some locally, such as jerrycans and soap. Those procured abroad are transported and pre-positioned by UNICEF in five strategic locations: Bunia, Goma, Bukavu, Lubumbashi and Kinshasa. The procurement process can be lengthy, from three months to over a year, depending on distance, cost and availability of materials. UNICEF orders supplies and materials from its logistics centers in Denmark, Kenya, and South Africa, although vehicles and other forms of in-kind support to INGO partners may be sourced elsewhere.

- **Prior funding to INGO partners to conduct assessments and interventions**. Operational agreements (Memoranda of Understanding or MOU) exist between the RRM managing partner UNICEF and three international relief agencies: Solidarités in Ituri and North Kivu, International Rescue Committee in South Kivu and Catholic Relief Services in Katanga. Each receives advance funding to conduct systematic assessment and monitoring of vulnerable populations and emerging crises, and to intervene with essential assistance within 72 hours. RRM partners work with teams composed of national and international staff, and are supplied with transport (cars, trucks, flights), communication equipment (computers and internet, HF, VHF, satellite phones), and administrative equipment, staff and training (office equipment, training in UNICEF accounting procedure, funding for hiring of additional administrative staff).

- **Quick access to additional funds when needed**. OCHA manages a contingency fund to facilitate rapid assessment and intervention in other provinces where full-time RRM teams are not immediately present. The fund also covers additional needs that surpass INGO partner capacity, such as transport costs. This fund is open to all humanitarian agencies and in the last two years has enabled rapid transport solutions by air (air drops), the positioning of Field Coordination Units in remote areas of extreme vulnerability, and the rehabilitation of roads and bridges to increase access to affected populations.

2. Beneficiary profiles

RRM's overriding objective is to serve as 'first responder' in emergent crises. Doing so requires RRM teams to prioritize the acutely vulnerable over others also affected by conflict, natural disaster or epidemic. In eastern Congo, populations have been fleeing violence for over a decade. Displacement has become the most common form of self-protection, with many preemptively fleeing anticipated attacks, or even rumors of attack. Given this quasi-permanent state of displacement for much of the population, livelihoods and food security are weakened; material indigence is widespread and debilitating, resulting in higher morbidity and mortality.[10]

[10] Mortality surveys conducted by IRC and MSF across the eastern provinces have repeatedly documented the causal link between high mortality and lack of access to primary health care. As these surveys show, Congo's "four million war dead" are not the direct victims of combat but perish for circumstantial reasons, the primary being a lack of available health care (See "DRC: Access to healthcare no better now than during the war": http://www.irinnews.org/report.asp?ReportID=50094). See also http://www.theirc.org/news/latest/inside-congo-an-unspeakable.html.

Field Code Changed

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Where displacement becomes the norm and not the exception, displacement alone loses its relevance as the defining characteristic of acute vulnerability. Among the displaced of eastern and southern Congo, RRM assesses the degree of vulnerability and selects its beneficiaries according to how recently they were displaced. A temporal criterion is applied: those displaced within the last three months are eligible for assistance. In theory, the most recently displaced (i.e., those within the last three months) are more acutely vulnerable than those who have suffered through initial displacement and established the necessary coping mechanisms in order to survive. In the Congolese context, this means integration with host families in non-displaced communities. IDP camps are rarely created in such a context.

As result, RRM beneficiaries often find themselves temporarily grouped on the outskirts of other villages, in varying degrees of organization. Some are entirely spontaneous, occupying churches, empty schools or rudimentary shelters from leaves and sticks. Longer term presence generally sees a degree of integration and accommodation by local inhabitants, where IDPs may sleep in the home of a host family, share meals, but otherwise fend for themselves. Rarely do such situations evolve into organized camp dynamics, typically associated with refugees and IDPs in contexts such as Darfur or northern Kenya. Where large scale, spontaneous groupings occur, as in Gety in southern Ituri, there is no 'camp manager, but rather diverse humanitarian agencies offering various services as local needs and agency resources allow.

The three month criterion also serves to delimit RRM interventions to the mode of acute emergency and 'life-saving' assistance, thus allowing other humanitarian actors to take over with programs aimed at reducing vulnerability in the short and medium term, or at supporting return and reintegration for IDPs in their community of origin.

RRM beneficiary profiles thus include:

- **Recently displaced populations.** Families, individuals and unaccompanied minors that have fled violence or for fear of violence within the last three months are eligible for RRM assistance. Displacement itself is not a criterion of acute vulnerability. Individualized, real-time vulnerability assessments are thus an appropriate strategy for identifying the most vulnerable and to tailor assistance to meet their specific needs.
- **Populations recently affected by conflict.** Victims of violence and systematic destruction (burning and looting of houses, destruction of fields and livestock), but who have not fled their communities.
- **Victims of natural disaster.** Examples include flooding, landslides, severe storms.
- **Victims of epidemics.** Examples include cholera, malaria and measles.
- **Returning IDPs, previously inaccessible.** Displacement does not always tend towards places of refuge that are accessible to humanitarian agencies. IDPs sometimes seek refuge deep in the forest or in areas known to be insecure. Once they leave these areas and return home, assistance can be provided within three months of their return, when emergency needs are most acute.
- **Other vulnerable persons in host communities.** A massive influx of IDPs can deplete local resources in host communities, increasing the number of acutely vulnerable persons. Emergency assistance for host communicates is sometimes warranted, and RRM teams try to find creative ways to include

acutely vulnerable local persons on their distribution lists for NFIs, for example. For more chronic, structural needs affecting the community, RRM's assessment and intervention reporting are used to alert the wider humanitarian community in order to mobilize possible response to meet the needs of non-displaced populations falling outside the scope of RRM's narrow temporal and vulnerability criteria.

3. The RRM relief package

In its initial formulation, RRM was designed for NFI distributions, which were delivered in bulk to qualifying populations. While transport and storage costs were reduced by the bulk format, NFIs are either assembled in individual kits or distributed individually in order to better tailor the response according to specific needs. NFI items selected for distribution are intended to reduce morbidity due to the physical strains of displacement, particularly exposure to the elements, and restore a minimum of dignity and autonomy to beneficiaries by reducing their total dependence on host families for shelter, food and essential household instruments (pots, jerrycans, blankets, soap, etc.).

NFI kits and other components of the RRM relief package include:

- The **NFI kit** is composed of the following materials: a 4x5m sheet of tarpaulin for emergency shelter, two blankets, one collapsible 10 liter jerrycan, one cooking/eating set (two pots, spoons, forks, knives, kitchen knife, set of stainless steel plates and cups), two 800gram soap bars, and, since late 2006, a mosquito net. NFI kits do not systematically contain mosquito nets (high altitude areas are non-malarial), however, and may be supplemented with used clothing. A quantity of concentrated energy biscuits for immediate nutrition (BP5s) are also provided as needed. The average cost of the kit, excluding international and local transport, is $42.[11]
- **Water and sanitation**: Based on assessment reporting, RRM watsan teams can build showers, latrines, rubbish dumps, spring catchment points, and rehabilitate small water distribution networks. In densely populated areas, hand washing stations are installed to improve personal and community hygiene thus limiting the transmission of water-born disease. Such interventions are limited to sites that are also accessible by the local community. Community sensitization to promote effective use of the inputs is organized using volunteers from the local community. With the exception of Katanga, RRM teams also have the capacity to install water tanks, bladders and emergency distribution systems for clean water, which is either transported in trucks or drawn from existing or rehabilitated local sources. Like NFIs, watsan equipment is pre-positioned in the five key locations and teams are at the ready. In Katanga, the UNICEF water and sanitation section ensures emergency needs are covered through standing

[11] The December 2007 RRM meeting in Bukavu analyzed the findings from post-distribution monitoring activities, and has refined the standard NFI package accordingly. Changes include (1) increased soap amount to three 800-gram bars for a family of five (Sphere standards are 450 grams/person/month); (2) systematic inclusion of clothing and/or women's wrap (*pagne*); (3) replaced individual plates with larger communal bowls; (4) elimination of kitchen forks and knives, which are rarely used; (5) provision of two 10-liter collapsible jerry-cans instead of one. UNICEF expects these refinements to be fully phased into existing stocks and distributions by April 2007.

partnerships with other INGOs operating in strategic areas of the province and through the cluster coordination mechanism.

- **Education kits and material support:** Education was introduced in the second RRM phase and is now fully integrated into the emergency response package. Activities include the construction of temporary classrooms, school rehabilitation, construction of separate latrines for girls, boys and teachers (except in Katanga), distribution of teaching and learning materials to participating teachers and students. As with watsan interventions, educational assistance provides a direct benefit to the host community, particularly those who do not receive NFI distributions. Specifically, for every one IDP student receiving education at a host community school, four student kits are provided to non-IDP students from the community.
- **Medical kits** include essential drugs and medical supplies and are provided to existing health centers directly or through NGOs operating in the region serving the host population where a large IDP influx has arrived. Materials and supplies for the construction and set up of Cholera Treatment Centers (CTCs) are on hand for quick response to outbreaks, and transmission prevention activities (hygiene and sensitization) can also be implemented by RRM teams. The curative component of cholera response is organized by the health cluster and usually falls to a specialized medical INGO, such as MSF. In South Kivu, however, cholera endemicity is high, and IRC is quite involved in the medical side of cholera response, supplying ORS and Ringer Lactate, conducting trainings and orientations of local medical staff and making regular follow-up visits post-intervention.

4. The humanitarian context in the DRC

Areas of RRM operations in eastern and southern Congo continue to be characterized as a 'complex emergency' with a fluid mixture of acute and chronic needs. Security and physical access are extremely challenging, thus complicating the operating environment for all humanitarian actors. Characteristics of this ongoing emergency may be identified as follows:[12]

- **A ten year crisis:** The toll on civilians, particularly women and children, of Congo's two successive civil wars surpasses the statistics usually employed to describe the scale of the crisis. Four million dead, with an estimated 1,200 continuing to die daily—the highest mortality rate due to indirect causes of any global conflict since World War II. The resulting humanitarian crisis is one of multiple, inter-related causes: decades of dictatorship and inept governance, a proliferation of rival armed factions with competing ethnic identities and political adherences, predation of mineral resources and their unregulated export, non-existence of social services and massive flight of human capital.
- **Infrastructure and social fabric in ruins:** Roads, communications, railroads, shipping, ports and airports are barely or non-operational from years of neglect. Schools, health facilities, legal and other public administrative structures are non-existent. Commercial and industrial assets and capacity have been pillaged or destroyed. The formal economy is paralyzed; the vast majority of commercial activity is informal.

[12] Adapted from "Rapid Response in the DRC: Dealing with acute emergencies in a complex emergency setting," UNICEF, June 2006.

- **Persistent insecurity and high frequency of violence against civilians:** Belligerents have committed systematic exactions against civilians, encouraged by the climate of total impunity. Women are particularly targeted through rape and sexual violence. In the eastern provinces it is estimated that one out of three women has been raped. All combat and troop movement entails looting, killing, mutilation, forced labor and the forced recruitment of boys and girls by armed groups. Massacres of civilians have been regularly documented and continue to occur despite 17,000 UN Peacekeepers and a newly integrated national army (*Forces Armées de la République Démocratique du Congo*, or FARDC) present across the volatile eastern provinces.
- **Difficult access to affected populations:** Destroyed and abandoned infrastructure conspires with continued insecurity to limit access by humanitarian actors to vulnerable populations. Helicopter and small aircraft are the only viable solution to the obstacles posed by poor or non-existent roads and pockets of ongoing conflict—an exceedingly expensive solution to the problem of humanitarian access.
- **Limited funding and little local capacity as force multiplier:** The Congolese crisis has been chronically under-funded for the last ten years, particularly in proportion to the scale of the crisis, its complexity, and the number of beneficiaries. A recent comparison between funding for the Darfur crisis and that of Congo showed an enormous disparity in favor of Darfur. The same disparity holds for the 2005 Tsunami and for humanitarian activities in Iraq in 2003. The duration and intensity of Congo's crisis has also triggered a massive flight of human capital ("brain drain"), leaving a capacity vacuum in all professional sectors. Government bodies are ill-equipped to assume their duties toward the population, with diversion of aid monies a recurrent risk. Local NGOs and religious networks exist but lack technical skills, human capital, material and financial resources to act independently.

5. Rationale of the RRM response

In the years prior to the inception of RRM, the operating environment was characterized by a significant humanitarian presence in affected areas, with numerous actors but little emergency response capacity. Many of these agencies remained after their initial intervention during the Rwandan refugee crisis in eastern Congo from 1994 to 1996, and working throughout the duration of the Congolese conflict. 2003 brought a formal end to the second war and the beginning of a transitional, power-sharing government.

The mood was hopeful and post-conflict programming became the order of the day, while acute emergencies and forced displacement of populations continued. Humanitarian INGOs active in these areas worked to respond adequately, using additional resources provided by UN agencies, which were generally limited to in-kind support such as food from WFP; NFIs and other forms of assistance from UNICEF in health, nutrition, protection, and education. Yet those actors with their own core funding, such as MSF and ICRC, do not typically seek partnerships with UN agencies even though their coverage and impact is limited. Other INGOs, technically capable and dedicated, could partner with UNICEF for NFI distribution and other forms of emergency assistance but lacked significant start-up financing of their own to cover essential operational costs. The quality of the general relief activities was uneven, differed drastically between agencies and crises. In the end, many crises received no response

because of access problems and insecurity, but also for lack of capable partners with sufficient resources.

An additional constraint was UNICEF's laborious administrative and budgetary process: necessary but tedious conditions for partnership agreements with willing INGOs. These bureaucratic burdens resulted in slower reactivity and inefficient use of time and energy. As the number and intensity of small-scale but acute crises continued, the failings of this ad hoc approach became increasingly apparent to agencies and donors alike. Alternative, more flexible modes of partnership between humanitarian INGOs and UN agencies were needed.

Donors were initially reticent to pre-finance INGOs to purchase bulk relief supplies and maintain emergency response teams on stand-by, which did not appear cost efficient. Two acute, widely publicized crises in 2004—Buniakiri and Bukavu—served to force the issue, as critical needs in health, nutrition, NFIs, watsan and protection all converged to overwhelm the handful of INGO agencies working in these areas. For UNICEF and other bilateral donors to mobilize the requisite funds and secure agreements with additional INGOs was a bureaucratic and time-consuming process, as no rapid disbursement mechanism existed. Congo's political transition was evidently a fragile process, acute emergencies due to insecurity would continue, and the capacity of humanitarian agencies to provide a coordinated, multi-sector response to rapid onset crises had proven negligible.

Massive looting during the Bukavu violence emptied the stocks of relief materials and assets of UN agencies and INGOs, further diminishing their emergency preparedness and reactivity. The British Department for International Development (DFID) was concerned by the prospect of even graver humanitarian consequences given agencies' operational paralysis, offering to replace lost relief supplies and operational assets. DFID also welcomed a joint proposition from UNICEF and OCHA to fund their plan to both pre-position emergency stocks and to establish stand-by response teams capable of rapid assessment and intervention. The core components of what would become RRM were now in place.

Neither OCHA nor UNICEF can implement projects or intervene on their own. They require specialized INGO partners who, for their part, rarely have access to rapid funding or supplies with the speed and scale required. The synergies of such a partnership serve the interests of donors, humanitarian agencies, and above all beneficiaries.

6. How RRM meets beneficiary needs

Besides the two core components of pre-positioned relief supplies and prior financing of stand-by teams to conduct assessment missions and intervene where needed, RRM functions at multiple levels, all of which are essential to ensuring an appropriate and timely response to acute needs. RRM aims to move away from the traditional 'charity-based' approach towards one grounded in the fundamental rights of the person as displaced, whereby humanitarian assistance does not further dependency but rather builds local capacity and rights awareness. This objective is pursued among both afflicted populations as 'rights holders' and among their primary 'duty bearers', Congolese national authorities, in whose stead humanitarian agencies are working. Progress against

these goals is difficult to measure, however, and dependency on foreign aid providers remains prevalent.

With the newly elected democratic government now in place, the RRM program can invest more in holding military and civilian authorities responsible for the plight of their citizens, as efforts begin to include national authorities in the decisions and activities of the larger humanitarian community operating in DRC.

- **Assessments:** Missions are conducted by RRM teams within 72 hours, depending on security and logistics access. Assessment reports documenting various vulnerability indicators within seven different sectors, with recommendations for action, are presented to the wider humanitarian community and discussed at weekly coordination meetings (OCHA and the CPIA).[13] Real-time assessments as crises are unfolding offers an invaluable service to the wider humanitarian community, as needs can be prioritized and complimentary assistance strategies elaborated and executed. Difficulties arise in ensuring a multi-sector response by different cluster leads; these challenges are considered and recommendations proposed in the body of this report.
- **Response:** RRM has dramatically reduced response time and increased the number of crises reached by virtue of its stand-by teams and pre-positioned supplies. Individualized needs assessments also ensure a tailored response, one that avoids the risk of supply-driven or formulaic interventions.
- **Rights-based approach:** The underlying cause of the crisis to which RRM responds is the fundamental lack of protection for the population of displaced persons and war-affected civilians. This insecurity is as much physical as it is legal—the basic right of the displaced to protection and to humanitarian assistance. Where national authorities are derelict in their duty to uphold their legal obligations to protect and provide for IDPs—or are complicit in their suffering—international humanitarian agencies may serve as the surrogate duty-bearer, providing IDPs with protection (physical and legal) and life-saving humanitarian assistance. RRM exists in part to uphold the rights of IDPs to protection and assistance, as identified in international human rights law and in international humanitarian law. While training on IHL and human rights is the province of the protection cluster, RRM endeavors to operate in this spirit, investing in local capacity building wherever possible. Comments on RRM's ability to realize these commitments, given the obstacles of a difficult working environment, are found in Section V of this report.
- **Community involvement:** Local capacity building and community participation are two parallel RRM objectives. Because RRM interventions are time critical, however, adequate community participation is sometimes difficult to ensure. Local capacity of church networks and civil society is weak, and requires a long-term commitment that RRM is not ideally suited to provide. Community participation, on the other hand, occurs as a result of RRM teams trying to be as efficient as possible by maximizing the involvement of beneficiary communities in the actual intervention. Similarly, multi-sector interventions have proven essential as a palliative to hostility from the local population, who also benefit indirectly from watsan and education inputs. Community participation is easier to

[13] The weekly OCHA meeting is open to all concerned agencies, including local NGOs and officials. The CPIA or inter-agency provincial committee comprise UN agencies and select INGOs, with ICRC sometimes in attendance.

mobilize in these two sectors, as populations tend to see watsan and education benefits as longer lasting.

- **Monitoring:** Ongoing crises are monitored and interventions followed-up to ensure positive impact and meet emerging needs. Monitoring criteria and indicators are not yet standardized between partners, which is essential to creating a single database to record progress and impact. A set of possible indicators to be shared among RRM teams is proposed in the body of this report.
- **Advocacy:** Having RRM teams on the front lines of emerging crises allows OCHA and UNICEF to have updated information as a crisis evolves. This is effective for advocating for wider intervention and mobilization of resources, and for informing local and international media. RRM advocacy initiatives, undertaken by OCHA and UNICEF independently or together, tend to focus on the need for a wider intervention, lack of protection for civilians, access to crisis areas, and funding situations.
- **Funding and cost effectiveness:** RRM teams are rarely idle and the turnover of pre-positioned relief supplies is constant, contrary to donors' initial fears. In some areas, crises in particular sectors tend to dominate over others, as in South Kivu where cholera outbreaks in 2006 have surpassed instances of displacement and natural disasters many times over. RRM teams compensate for this concentration of activity by investing in mobile surveillance strategies and regular follow-up of prior interventions. Ongoing sensitization in watsan and education ensure that communities practice regular maintenance of RRM installations (schools, latrines, water catchment systems, etc.).

7. Program improvements since 2005

After an initial period of exposure to the challenges of field experience, RRM partners met in March 2005 to take stock of the mechanism, its strengths and weaknesses, with recommendations for improvement. How have these recommendations evolved since then—which were implemented, which were surpassed by events, which remain to be realized?

The primary weakness recognized in the mechanism was its inability to respond holistically in other vital sectors, particularly in education and watsan but also in food, health and protection. Following the March 2005 workshop, RRM partners recommended:

- Incorporating watsan and emergency education into project activities and budget. [**UPDATE**: This objective was accomplished, except in Katanga, where the INGO partner there delivers NFIs and occasionally school and medical kits, but no watsan assistance. The number of other humanitarian agencies working alongside RRM means that assistance gaps are not severe, although watsan needs have been raised for action by UNICEF and its partners];
- Selecting and create a roster of stand-by implementing partners specialized in sectors outside those immediately available to existing RRM teams [**UPDATE**: although still useful, such a roster has not been formalized by province. Potential partners in all provinces are known to RRM in case of emergency. They are not always available, however, in view of their own program demands. Contingency funding and relief supplies are made available by RRM, and only human capacity is required. The proposed roster should still be formalized to facilitate institutional memory and ensure emergency readiness];

- Including transport costs directly in partners' budgets rather than requiring the submission of separate funding requests to cover transport [**UPDATE**: recommendation has been realized];
- Creating a contingency fund for response in provinces not formally targeted by RRM [**UPDATE**: recommendation realized; additionally, UNICEF disposes of surge capacity of materials when assistance demands surpass the wherewithal of RRM. The November 2006 RRM meeting in Bukavu revisited the issue of surge capacity and the speed of emergency funding vehicles, finding fault and room for improvement at two levels: insufficient pro-activity and slow administration between OCHA Kinshasa and OCHA Geneva, where the RRF is located. The shared view is that OCHA support to interventions through the Rapid Response Fund where RRM teams do not maintain full-time presence needs improvement]. Additional obstacles include:
    - The RRF cannot fund local NGOs, so even competent local/national NGOs like Caritas are not eligible.
    - Delays in receiving funding require the recipient to pre-finance operations themselves.
- Standardizing multi-sector assessment methods to ensure consistency of reporting on real-time crises, making it easier to mobilize rapid response in other sectors [**UPDATE**: recommendation not yet realized, although reaffirmed as a priority by the December 2006 workshop in Bukavu];
- Including a percentage of the most vulnerable members of the host community together with beneficiaries selected according to standard RRM criteria [**UPDATE**: INGO partners apply the principle differently according to province. One partner, IRC, automatically includes 5% of acutely vulnerable from host population per intervention. CRS and Solidarités emphasize sensitization of host communities about the goals and means of RRM interventions and, where appropriate, organize their watsan and education inputs to benefit the greater community].

Orientations for 2007: As the humanitarian reform agenda in DR Congo continues apace, the cluster system will develop emergency response capacity, in sectors where acute needs persist, according to the RRM model. In the medium to long-term, however, the exit strategy for RRM is not the cluster system itself, but the eventual handover of emergency response by the clusters back to their corresponding government bodies and institutions. For example, capacity and responsibility for rapid response to cholera will once again belong to the national health system. An action plan with timeline and targeted benchmarks in progress should be drafted by RRM, and shared with the relevant development actors in the new national government, with particular attention to differentiating needs that stem from rapid onset emergencies and those originating or exacerbated by structural problems: lack of transport, lack of medical system, predatory national army, etc.

Regarding the three emergency sectors presently covered by RRM, the need for NFIs, water and sanitation, shelter, and emergency education will decrease as and when security conditions in the country improve. RRM will be obsolete when forced displacement has ceased and populations can return to their home areas. In this way, RRM can have no active 'exit strategy' because the conditions determining RRM's continued necessity for 2007-08, and beyond, are contextual and beyond its control. When conditions improve and acute needs in its three sectors abate and disappear, so will RRM.

The recently launched UNICEF Program for Expanded Assistance to Returnees (PEAR) is therefore not meant to replace RRM but to compliment it, assuming security conditions improve in 2007 and large-scale returns become more realistic. By providing a broader and more studied assistance package to the high numbers of displaced and refugee populations expected to return to their communities of origin as the country stabilizes. Should security conditions improve and mass return movements transpire as predicted, RRM stand-by emergency capacity will nevertheless remain essential through 2007 as instances of displacement, epidemics and natural disasters will likely persist.

The December 2006 workshop in Bukavu raised the issue of RRM's limited mandate and its propensity for 'mission creep': RRM is increasingly expected to respond to all forms of crisis where no other viable emergency response option exists. This expectation frequently originates from other humanitarian actors not directly involved in RRM, and takes the form of assuming that RRM teams will respond to rapid onset emergencies in food, health, protection and other areas that are clearly beyond RRM's capacity. As part of its capacity building aims and its rights-based approach, RRM should accelerate efforts to hold national authorities accountable to their rightful role as the primary assistance provider to war-affected civilians. Continued substitution for the state's own duty to respond will ultimately contradict RRM's purported aim to oppose 'charity-based assistance', an orientation shared by RRM's managing agencies, UNICEF and OCHA.

Handover of humanitarian activities to government actors may not happen in the immediate future, but humanitarian actors prolong the logic of substitution by operating completely independently of them. To open this door to the people who will ultimately have to reclaim responsibility for Congolese well-being is the first step in moving away from charity-based assistance. It is also the highest form of capacity building and ultimately essential to the realization of a rights-based approach to humanitarian assistance—wherein humanitarian agencies are made redundant by a government's own capacity to respond to emergencies.

Reducing state dependency on RRM starts by reasserting the narrow parameters of the RRM mandate. Practically, this is immediately achievable in the following two ways: 1) Reduce or end RRM involvement in crises of structural origin—crises exacerbated by their physical remoteness and inaccessibility, as in central Katanga, where other humanitarian agencies are operating; 2) Limit RRM involvement in epidemic outbreaks in known endemic areas, as these are in principle foreseeable. Lack of advance preparation by state actors in concert with the health cluster is a structural problem, and not the responsibility of RRM.

IV. LESSONS LEARNED AND RECOMMENDATIONS

1. RRM process in the field

a) **Clear benefits to multi-sector interventions**. The evaluation found that multi-sector interventions programmed on the basis of assessment findings reduce tensions created by the 'under three month' criterion used to select beneficiaries for NFI distributions. In Katanga, where RRM teams intervene primarily with NFI/shelter, hostility resulting from the three month criterion is consistently high. RRM teams are generally able to manage such opposition, but in extreme cases have had to suspend interventions. In the East, where RRM has three-sector capacity, RRM teams note less hostility and wider participation from the host community, beneficiaries and local authorities when NFI distributions are accompanied by water and sanitation, and/or education inputs, than when NFIs alone are distributed. Absence of hostility and increased community participation are attributed to the fact that watsan and education inputs are open to a wider class of beneficiaries, including a proportion of local residents, than are the NFIs.[14]

b) **Of displacement caused by violence, "75% of these are due to FARDC exactions against civilians,"** according to RRM teams in North Kivu, South Kivu and Ituri District. The national integrated army (FARDC) operates in these areas both to pacify insurgents and to protect the civilian population. That they are also a recurrent cause of civilian displacement is gravely disconcerting to the humanitarian community. Persistent and high level advocacy by OCHA, MONUC and, in some instances, UNICEF, with FARDC commanders has yielded no improvement. Equally disturbing is the high number of RRM interventions on behalf of persons displaced by violence stemming from joint FARDC--MONUC operations against remaining insurgent groups. RRM managing agencies OCHA and UNICEF have attempted advocacy and sensitisation of MONUC commanders on the direct correlation between their joint FARDC actions and population displacement, apparently to little effect.[15]

Sources interviewed for this evaluation consistently maintained that neither of these causes of civilian displacement will abate without (a) a fundamental improvement in FARDC behavior and discipline, and (b) a change in MONUC military strategies to minimize 'collateral damage' by closely supervising their FARDC counterparts. Recent population displacement and return in Sake, North Kivu, following incursions by troops loyal to Laurent Nkunda—to cite one example—illustrates the degree to which RRM interventions are influenced by the presence of FARDC troops. Despite the need for NFI distributions to returning displaced, RRM could not act as long as FARDC troops remained present in town, so great is the security threat they pose to civilians.

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[14] Conversely, experience also shows that education or watsan interventions alone, where basic needs in food, nutrition and healthcare are not met, can result in opposition and hostility.

[15] Little has changed in this regard from the RRM 2005 Annual Report: "In this context, the conditions for beneficiaries have improved, but security remains the major concern in their places of origin and throughout the region in general. Failure to provide these communities with durable security solutions will result in serious food insecurity or worse over the months to come."

c) **Program monitoring and evaluation**. RRM generates a large quantity of documentation, particularly its assessment and intervention reports, and monitoring questionnaires. Monitoring surveys are conducted one to three months after the initial intervention or distribution. These serve to gauge the impact of the intervention, to learn of additional or unmet needs, or of recent new arrivals and their state of need. The bulk of this reporting serves real-time decision making by documenting remaining or additional needs and recommending immediate action in other sectors. A weakness noted by this evaluation is that none of this accumulated monitoring data is synthesized, quantified or fed back into a formal evaluation framework, with established performance indicators, in order to measure the impact of RRM interventions over time. The three core RRM INGO partners—Solidarités, Catholic Relief Services, and International Rescue Committee—plan to undertake such an evaluation in the course of 2007. A workshop is planned for the first quarter of 2007, convened by UNICEF, to help agencies take this initiative forward.

   On pp. 44-45, a methodology and set of basic indicators are proposed, to be shared by the three INGO partners in order to harmonize process and findings of their upcoming formal evaluation effort. Indicators may be divided between (1) intervention data that registers process and output, and (2) monitoring data, which is qualitative and geared toward measuring progress and performance. As this evaluation has indicated throughout this report the current RRM program is weak on both fronts. The indicators and the tools to record and quantify them, presented later in this report, will also be relevant in the future creation of a database for RRM and PEAR.

d) **Fraud-related problems exhaust RRM resources and time**. Efforts by local authorities to manipulate RRM interventions (with fraudulent, inflated beneficiary lists, for example) are common in all provinces. Inability to trust local information sources also compromises the degree of community participation in RRM interventions. As one RRM team explained, "The greater the community participation, the greater the fraud." Anti-fraud techniques have been developed, but the dilemma of how to eliminate fraud while encouraging community participation remains one of trust versus the need for control. Ideally, anti-fraud techniques should enable local counterparts and beneficiary populations to police themselves. After almost ten years of dependency on humanitarian aid, this ideal is very difficult to realize in the current Congolese context.

e) **Large capacity deficit among local counterparts and RRM interlocutors (state and non-state).** Distinct from fraud-related difficulties posed by local partners and Congolese authorities, there is a local capacity deficit in terms of emergency response know-how and readiness, human expertise, material resources and logistics. Capacity building of local partners and state cohorts is recognized by RRM management staff as an important objective, but given the time-critical nature of RRM interventions, substantial and sustained training of local counterparts becomes an often unattainable luxury. Present forms of local capacity building are discussed later in this report.

Recommendations for RRM in the field: OCHA, UNICEF and INGO implementing partners

a) **Introduce measures to ensure validity and utilization of RRM assessment findings by cluster leads in food, health and protection**. RRM teams voiced the recurrent frustration that multi-sector recommendations in RRM assessment reports are rarely accepted and acted upon by lead agencies in the relevant clusters. The solution is not for other sectors—food, health and protection specifically—to duplicate RRM assessments by conducting their own. Rather, RRM assessment tools can be vetted and approved by cluster lead agencies. Cluster leads can then agree to accept or reject RRM assessment findings and recommendations within 48 hours, or decide during the CPIA meetings that follow RRM meetings. Alternately, each cluster can allocate one specialist to the RRM assessment mission to ensure validity of findings, or cluster lead agencies could train RRM teams in each their approved assessment methodology. Either way, a binding commitment should be sought from cluster leads in food, health and protection that RRM findings will be accepted or rejected within 48 hours. If accepted, lead agencies commit to action within 72 hours. If findings are rejected or ignored, the issue is raised at weekly coordination meetings (CPIA and OCHA). If still no commitment to action is forthcoming, the issue is presented to the HAG in Kinshasa for further analysis. [For schema see Annex]. The Humanitarian Coordinator, who chairs the Humanitarian Advocacy Group, is ultimately accountable for the UN humanitarian response to emergencies in the DRC.

b) **Restore protection and medical components of RRM interventions to their rightful cluster.** In February 2006 RRM agencies elected to incorporate health and protection sectors into their assessment methodology and to augment their intervention with assistance in other sectors. During the December 2006 workshop in Bukavu, INGO partners expressed doubt about their added value in these additional sectors. While acute needs in protection (sexual violence and unaccompanied minors) and reproductive health (HIV/AIDS) should remain part of the multi-sector assessment tool, evaluation findings suggest that their value added as operational dimensions of the current RRM assistance package in the eastern provinces is minimal. RRM interventions can provide some critical assistance, but acute needs in health and protection would be better served by the specialized agencies comprising the protection and health clusters themselves.

c) **Advocacy undertaken by OCHA should be systematized for greater accountability**. RRM teams operate on the front lines of rapidly evolving humanitarian emergencies; their eyewitness accounts and real-time assessments of affected populations form a primary source of information for the wider humanitarian community, in particular its advocacy initiatives and media communications. While OCHA and UNICEF are responsive and engaged on this front, RRM teams in the field expressed disappointment with follow up and results of these initiatives, which require sustained attention and continued effort. Systematizing and tracking advocacy initiatives could improve their performance. OCHA's provincial information officers could

document and track such efforts, undertaken by the sub-office OCHA head, so that other RRM members could stay abreast of initiatives as they evolve and learn of their outcome. Each member of RRM should share a clear and equal degree of responsibility for the success of the mechanism itself, and by documenting and systematizing the advocacy initiatives that it undertakes on behalf of RRM, OCHA's role in this domain could be better measured and thus evaluated. Quantifying the success and failure of inter-cluster advocacy efforts would bring greater accountability to the cluster system as well.

d) **Program monitoring and evaluation.** Assessment, monitoring and evaluation tools are not yet standardized between RRM teams in all provinces. RRM, the established means of providing stand-by capacity to satisfy acute needs of vulnerable groups—potentially anywhere in the country—should possess a common set of assessment, monitoring and evaluation indicators across all provinces of activity. Doing so will facilitate comparison of activities between provinces, and facilitate overall performance and impact evaluation of RRM on a national scale. A proposed set of common M&E indicators is provided in this report.

e) **Need for closer study of reasons why beneficiaries sell NFIs.** The primary focus of post-distribution monitoring by INGO partners has thus far been to determine the percentage of households who sell NFIs. If less than 5-10% of families sell one or more items, this is considered positive. While such data offers some insight into the accuracy of RRM's initial assessment (by confirming that NFIs were among the population's acute needs), it is equally important to learn why the items are sold; i.e., how is the money then used? There is considerable debate over whether the sale of NFIs indicates the inappropriateness of certain items in the kit (some are deemed superfluous, thus sellable), or if sale is evidence of an assistance gap, meaning that other forms of emergency assistance are desperately needed or are late to arrive. Anecdotal evidence suggests that NFIs are sold to purchase food, medicines or money to access medical care, and seeds.

f) **Where RRM activities are less intensive, use teams to provide sustainable inputs.** As it is normal to have fluctuations in RRM activity, or to see a predominance of specific types of interventions over others within a given period, not all RRM sector teams are consistently in demand. For instance, in South Kivu from July to November 2006, RRM addressed eight cholera outbreaks compared with three forced displacement episodes. Such fluctuation is not a reason to reduce the number of active teams (or their funding), because RRM exists to provide stand-by capacity in the event of acute crisis, which by definition do not occur daily. Specifically, water and sanitation teams could monitor known areas of vulnerability for possible interventions in spring catchments, reparation of older systems, sanitation projects, and sensitization efforts. NFI sensitization teams could rotate in the field for follow-up visits to intervention sites. Education teams could study rehabilitation needs of schools in previously unsupported areas of each province.

g) **For 2007, limit interventions in crises that are predictable or of structural origin.** Reducing state dependency on RRM starts by reasserting

the parameters of the RRM mandate. Practically, this is achievable in the following two ways: 1) Reduce or end RRM involvement in crises of structural origin—crises exacerbated by their physical remoteness and inaccessibility to humanitarian actors, as in central Katanga; 2) Limit RRM involvement in epidemic outbreaks in known endemic areas, these being foreseeable in principle. Lack of advance preparation by state actors in concert with the health cluster is an institutional failure, and does not constitute an emergency for RRM.

Concretely, this means that in Katanga, CRS should prioritize its PEAR activities, limiting its RRM role to zones such as Bukama where no emergency agencies are operating. In 2006, CRS basically 'filled gaps' in ongoing assistance effort in emergencies where it was not the first responder. In 2007 it should limit its NFI/shelter assistance to zones lacking agency support (thus more vulnerable in event of crisis), and consider dropping the multi-sector assessment activity, except in zones like Bukama where it will intervene in the event of crisis.

For South Kivu, an inter-agency agreement should be sought stipulating that cholera response in an endemic zone is the duty of the health cluster, in conjunction with state authorities. RRM should not continue to substitute for lacking capacity in the health cluster. Adequate funding to the health cluster will be required, and RRM should push for this. If this is successful, intervention data for 2006 suggests that without cholera, RRM interventions in other sectors are minimal. If this pattern continues, AVSI, the new PEAR partner, may be capable of absorbing reduced RRM roles and activities. Having a single partner for both RRM and PEAR per province would streamline information management and project coordination, ideally to beneficiaries' benefit.

In North Kivu and Ituri, insecurity and pacification efforts are likely to continue through 2007, and RRM will continue to provide essential services in its three sectors on a regular basis. In Ituri, the health cluster is very operational and able to organize response to epidemic outbreaks that do not depend entirely on RRM materials and expertise. Solidarités will need to coordinate closely with NRC, the new PEAR partner, to ensure complimentarity. No reduction or integration of RRM activities by the PEAR partner is warranted or foreseeable, as is the case in Katanga and South Kivu.

2. Vital sectors outside RRM

a) **Epidemic response capacity is limited to prevention; curative solutions are ad hoc.** RRM teams offer effective preventive and containment solutions to malaria and cholera epidemics, both materially and through sensitization. Yet RRM lacks the crucial curative component in life-threatening epidemics. Curative solutions in the field are presently ad hoc, resulting as much from informal arrangements between RRM teams and medical INGOs, as from formal agreements between RRM (OCHA and UNICEF) and WHO working in concert with MSF, for example. In the short term, RRM assessment teams would benefit from a specialist delegated by the health

cluster. This would ensure an appropriate technical assessment and greater ownership of relevant findings and recommendations for action, and ultimately accelerated reactivity by the health cluster lead.

b) **The food cluster requires better rapid response capacity.** Like UNICEF, WFP contracts INGO partners for its assessments, distributions and monitoring. While these arrangements offer a standard level of reactivity in the field, they are not specifically designed to deliver rapid response (under 72 hours). One reason is that instances of sudden, acute food needs are not the predominant mode of vulnerability in Congo today; another is that WFP cannot stockpile perishable goods for long periods.

Recommendations for other vital sectors: cluster lead agencies

a) **RRM for the health cluster**. The sustainable solution to the lack of agency preparedness and stand-by capacity in the health cluster is to allocate adequate funding to WHO's 'Health Action in Crisis' wing in order to increase its own emergency standby capacity in vulnerable areas by (a) signing partnership agreements with medical INGOs and (b) pre-positioning emergency medical supplies in bulk for immediate use as epidemics unfold. WHO has declared its wish to follow the RRM model,[16] just as OCHA and UNICEF now do with their INGO partners in NFI, watsan and education. Should the necessary financing come forward in 2007 from the Pooled Fund (UNICEF/OCHA received 10% of Pooled Fund in 2006), CERF or other source, WHO can establish an RRM-like mechanism for the health sector.[17] Duplication of the current RRM multi-sector assessment tool should be avoided by the health cluster when it acquires its own emergency response capacity—the existing multi-sector assessment tool has proven its adequacy at the onset of epidemics in cholera, malaria, and measles.

b) **RRM for the food cluster**. Emergency food needs arise periodically, and RRM and WFP try to coordinate their distributions as much as possible. According to RRM teams, simultaneous distributions of NFIs and food are, however, regularly planned but rarely occur. This is due to differing speeds of emergency reactivity between WFP and RRM. The consequences of food delays are difficult to bear for affected populations, who resort to selling received NFIs to procure food locally. Food delays thus undermine the utility of rapidly delivered NFI kits, when these latter are traded or sold by the intended beneficiaries to procure vital goods promised by another supplier. Reported examples are not widespread but have occurred in Dubye and Mitwaba in central Katanga, and in Isale, North Kivu.

   Recommendations developed in this report include (a) the validation of RRM multi-sector assessments for food needs by WFP and (b) the creation of a rapid response fund (RRF, between WFP and OCHA) for the purpose of emergency local purchase of food and, if needed, transport costs, for rapid

[16] WHO interview, Kinshasa, December 12 2006.

[17] Although WHO finances increased approximately 600% between 2005 and 2006, it serves to recall that the 2005 baseline was a mere $110,000. CERF and Pooled Fund monies in 2006 for WHO totaled approximately $5 million: hence the "600% increase," which sounds significant but in real terms is not nearly enough to establish an RRM-like arrangement for the health sector.

distribution by existing (or new) INGO partners of WFP at the provincial level.

b) **Eastern Congo is first and foremost a civilian protection crisis, yet little emergency response capacity exists in the protection cluster.** Documentation and monitoring of exactions are ongoing by several agencies in the protection sector. In February 2006, RRM elected to incorporate protection concerns into its assessment methodology and interventions. These activities focus on the referral of unaccompanied minors and cases of SGBV to the competent agencies. As in the food and health clusters, crisis reactivity and emergency preparedness is directly related to available funding, and the protection cluster is under similar constraints.

3. Beneficiary selection and the three-month vulnerability criterion

a) **Three month selection criterion for NFI distributions a frequent source of hostility and fraud**. RRM teams in all provinces maintain that successful distributions depend on transparent and rigorous beneficiary identification and verification, a multi-tiered process. In practice, no RRM partner accepts at face value beneficiary lists provided by local authorities (or other local counterpart) without a thorough cross-check. Hostility from host populations and direct interference with the beneficiary registration process by local authorities are considered the norm for RRM interventions, and each agency has developed its own coping mechanisms. Training in practical strategies for conflict mediation and resolution would provide an additional resource for RRM teams facing such hostilities. As noted above, multi-sector interventions alleviate these tensions because watsan and education inputs are open to a wider class of beneficiaries, and include host populations.

b) **Temporal selection criteria: IDP discrimination or prioritization?** Non-discrimination is a fundamental principle of IDP assistance (Principle 18 of United Nations Guiding Principles on Internal Displacement), and RRM's three month criterion excludes those displaced for longer than three months from its interventions. Further, there is little empirical evidence to support RRM's working assumption that IDPs who have been displaced longer than three months are somehow less vulnerable or critical than the more recently displaced. All things being equal, the use of a temporal indicator as the primary criterion of acute vulnerability is ultimately arbitrary. The three month selection criterion is therefore not only controversial, but is in practice a frequent source of hostility from local populations and less recent IDPs who assert their equal right to assistance.

Despite these arguments against it, RRM teams defend the three month criterion as a useful means of prioritizing the most vulnerable in crisis situations. There is an institutional reason behind the three month criterion, as well. OCHA maintains that "traditional emergency donors such as ECHO, OFDA and to a certain extent DFID" require three months on average to finalize INGO partnerships and to commence relief operations. RRM's three month window was thus conceived to provide immediate funding in order to

fill this assistance gap.[18] Finally, it should be emphasized that the criterion is applied flexibly. All three INGO partners admit a proportion of the local population as beneficiaries. International Rescue Committee, for example, automatically includes 5% of acutely vulnerable local persons in its distributions.

Recommendations on beneficiary selection and the three month criterion: OCHA, UNICEF, INGO implementing partners and cluster lead agencies

a) **The three month criterion should be retained as a primary yet flexible indicator of vulnerability.** The RRM experience in DRC illustrates both the utility of this criterion as a prioritization tool in situations of chronic displacement, and its limits. In North Kivu, for example, where pre-emptive displacement is a common civilian self-defense strategy, the three month criterion is no longer reliable as an indicator of acute vulnerability. Instead, RRM teams assess vulnerability in purely material terms: prior possession of NFIs, shelter, access to water, health care and education. Incorporating SPHERE standards as baseline initial assessment indicators into the existing tool would facilitate the quantitative component of post-intervention follow-up, by providing a baseline against which progress and impact could be measured.

4. Relations with other agencies and UN reform initiatives

a) **RRM important to wider agenda of humanitarian reform, particularly the cluster approach.** RRM is essentially a management solution enabling field teams (INGO partners selected by UN agencies) to work with quick disbursements of up-front financing and bulk materials pre-positioned at key points in probable crisis areas. As such, RRM can be applied to capacity gaps in any given sector or sectors. It need not limit itself to OCHA, UNICEF and the current roster of INGO partners; it can include other sectors and their cluster leads, such as WFP and food, or WHO and health. Any cluster that lacks crisis reactivity and emergency preparedness in its sector is a candidate for RRM.

In its current configuration, RRM ensures accountability in NFI, education and watsan, all clusters for which UNICEF is the 'provider of last resort'. RRM need not be limited to these three clusters, however, and is readily adaptable to satisfy the need for emergency response capacity for other clusters where rapid onset emergencies are common, and which do not receive the same degree of funding as do NFI/shelter, watsan and education under the present RRM configuration.

Recommendations on interagency relations and UN reform initiatives: OCHA, UNICEF and cluster lead agencies

a) **Cluster accountability also depends on effective mapping of humanitarian needs against available resources to facilitate interagency advocacy and planning**. RRM multi-sector assessment reports

[18] Email correspondence with OCHA Kinshasa, 22 Jan. 2007.

currently provide a regular source of raw vulnerability data that OCHA can build into a mapping tool to document existing needs vs. resources for the wider humanitarian community. If data entry is sustained over time, the tool could serve to demonstrate the progress of needs, their corresponding response by agencies, or where such a response did not occur. If managed correctly, such a tool could assist in planning for future program funding needs according to sector, on a quarterly, semi-annual or annual basis.

b) **Today's IDP estimates and monthly mortality rates for eastern Congo require recalibration.** All actors, RRM or other, agree that current figures to describe IDPs and mortality per month, particularly in the eastern provinces, are no longer accurate. Instead of continuing to cite these figures, RRM should harness its energies to bring needed clarity and certainty to this problem.[19] OCHA is ultimately responsible for the accuracy and updating of these figures, but because it is field-based RRM represents an ideal monitoring tool of the current humanitarian situation. PEAR success in planning and execution will require confirmation of IDP figures, which RRM is well suited to compile and verify.

5. Performance and impact

a) **Simplicity makes for success.** A more complex response mechanism entails heavier coordination, resulting in slower reactivity. It is clear that the current RRM configuration in the eastern provinces (NFI/shelter, water and sanitation, education) owes much of its success to the relative simplicity of the mechanism, which is primarily due to successful pre-positioning of relief supplies and pre-financing of INGO partners. Nevertheless, RRM as it currently stands cannot make up for a comparative lack of emergency preparedness in health, food and protection. Adoption of an RRM-like structure for the food, health and protection clusters--with equivalent funding levels to the current RRM—is a key recommendation proposed by this evaluation. Specifically, this means the creation of a rapid response fund (RRF) for both WFP and WHO, using Pooled Funds, for 2007 to ensure sufficient emergency capacity and reactivity in areas of known acute vulnerability.

The arrangement would operate much as does the current RRF with OCHA/UNICEF: partners are identified and pre-financed (WFP already has partners); the necessary material stocks are pre-positioned at the provincial level. For WFP, again, immediate local purchase is preferable to standing, pre-positioned stocks of perishable goods. Where WFP does not have an INGO partner, UNICEF RRM partners may serve, given prior consent. For WHO, relevant supplies to respond to outbreaks of known endemic illnesses (cholera and malaria, particularly) must be purchased and pre-positioned by identified INGO partners in susceptible areas. The RRM formula is not complicated, and is readily applicable to any sector where acute emergency needs are foreseeable: adequate financial support provided up-front to

[19] Commonly cited figures include the monthly mortality rate of 1200, approx. 1.5 million IDPs ('old caseload') and more than 600,000 'new' IDPs for 2006. Projections for 2007 include 1.1 million IDP and 850,000 IDP returnees.

capable INGO partners, along with pre-positioned material supplies at the ready.

b) **Success entails substitution and dependency**. Particularly in the eastern provinces, RRM has become the 'reference actor' for any crisis requiring rapid assessment and emergency response. The dilemma is that while extending the life of RRM through 2007 is warranted from a humanitarian perspective, its success and efficiency appears to stifle any sense of ownership of emergency response by clusters beyond RRM, particularly in health, food and protection. In North Kivu, for instance, inter-agency assessment missions have decreased as the humanitarian community increasingly defers to RRM to provide authoritative findings on acute needs in emerging crises. RRM teams in Ituri and South Kivu report a similar path of development, whereby proven success sees a corresponding growth in RRM's substitution for providers of last resort in other sectors, particularly health. Success is therefore a mixed blessing, as it announces a dangerous dependency on RRM to respond to acute crises beyond its immediate expertise and, in some cases, outside its mandate.

   The consequences of this growing dependency are twofold. First, it demonstrates that state capacity for crisis response and preparedness is marginal, even nonexistent. Reinforcement of state capacity in this regard is thus a long-term undertaking and beyond the scope of the RRM mandate. Second, it underscores the need for an RRM-like solution for acute vulnerability and rapid response capacity in the health, protection and food sectors.

c) **RRM augments UN reactivity on the ground by outsourcing its operations to INGO partners.** The RRM approach of outsourcing program implementation to INGOs is beneficial both to the UN agencies involved and to INGO partners. UN agencies dispose of larger financial resources than INGOs, as well as greater procurement capacity. INGOs, on the other hand, offer greater mobility on the ground, as their security regulations are generally more adaptable in fluid, insecure contexts than those of the UN.

Recommendations on performance and impact: OCHA, UNICEF and INGO implementing agencies

a) **State ownership of humanitarian crises should figure among RRM objectives.** Capacity building and resources are needed if a solution to RRM dependency, particularly by state actors, is to be found. Key state actors such as the Inspection Provinciale de la Santé (IPS), lack resources and expertise, but also basic information about unfolding crises and emergency response. In part because of this disparity—in terms of resources, capacity, support and thus reactivity—RRM and other humanitarian actors tend to overlook or bypass their state counterparts. Ultimately, however, the state is the only truly sustainable exit strategy for RRM, and for the wider community of humanitarian/development actors. Including them as observers in planning meetings, assessment visits and even interventions would allow state cohorts to see, judge, learn and facilitate future autonomy. Ultimately, however, the time-critical nature of RRM interventions often assumes priority over the

program's parallel aim to build local capacity and to secure community involvement.

In the long-term, the negative consequences of prioritizing immediate needs include creation of dependency and substitution for the state. Handover of humanitarian activities to government actors may not happen in the immediate future, but we prolong the logic of substitution by operating completely independently of them. To open this door to the people who will ultimately have to reclaim responsibility for Congolese well-being is a form of local 'capacity building', just as it is 'community participation', only at a different level.

b) **Baseline study of sector needs at program outset facilitates final evaluation of program impact**; **this step should precede other RRM interventions elsewhere.** At the inception of its operations in 2004, RRM did not conduct a multi-sector needs assessment or baseline study, against which it justified program priorities (NFI, water and sanitation, education). Instead, RRM re-conceived vulnerability assessment and prioritization within a dynamic, living model that evaluates needs in real-time as each crisis unfolds. In this way, it establishes baseline vulnerability indicators that, while not quantified or formalized systematically as with a 'baseline survey', nevertheless serve the immediate operational objectives of informing, focusing and tailoring each intervention to best meet beneficiary needs. While such an innovative and dynamic model has its clear advantages, it is unable to measure and demonstrate its overall impact against classic baseline indicators (morbidity, mortality, access to potable water, school attendance, etc)—the standard measure of performance and impact typically required by international donors. Indicators of process are useful (number of beneficiaries reached, number of NFI kits distributed, etc.), but they do not measure RRM's impact on the quality of beneficiary lives.

RRM donors are satisfied with its performance in the DRC, and have not demanded qualitative or quantitative data to demonstrate overall impact on beneficiaries. RRM cannot expect this level of trust from donors in other contexts where it may seek to operate. This evaluation recommends that any future replication of the RRM model should begin with a baseline needs assessment in the areas of projected intervention. This will assist with program planning and coordination, and will establish baseline vulnerability against which RRM can subsequently measure its wider impact for donors.[20]

In the future, the work of establishing baseline indicators and gaps according to sector should be done by the lead agency of the relevant cluster. Doing so will contribute to greater accountability of the clusters, a key aim of the humanitarian reform agenda.

[20] It is important to note that OCHA and UNICEF do not accept this recommendation. While they acknowledge the need for baseline studies at the outset of "typical humanitarian programs," they have consistently maintained that "RRM has its particularity that has been accepted by donors." More concretely, because each individual RRM intervention is preceded by its own needs assessment, the performance and impact of that intervention can in theory be measured. This would make the need for a cumulative set of baseline indicators redundant, according to OCHA and UNICEF. Email correspondence with OCHA Kinshasa, 22 Jan. 2007.

V. EVALUATION FINDINGS

A more detailed discussion of the following five themes comprises the remainder of the report. The first section addresses 'RRM process in the field' and considers the process and impact of multi-sector assessments, its interventions in three sectors, community participation and capacity building, monitoring and evaluation, and advocacy. The second section considers 'Beneficiary selection and the three month vulnerability criterion'. The third section addresses 'Vital sectors outside RRM', in particular food, health and protection, while the fourth and fifth sections examine 'Relations between RRM and other interagency initiatives' and the 'Performance and impact of RRM', respectively.

1) RRM process in the field

a) Multi-sector assessment

RRM assessments strive to be rapid and comprehensive, multi-sector, suitable for immediate implementation, and to provide relevant data and to the larger humanitarian community. Multi-sector reporting in seven sectors (NFI/emergency shelter materials, water and sanitation, emergency education, food aid/food security, nutrition, health, and protection) allows RRM teams to tailor their response to specific needs in a variety of sectors, according to context. NFI kits are assembled such that certain items (plastic sheeting, bednets, high-energy biscuits) can be added or subtracted, thus increasing a team's ability to target distributions to meet specific local needs—these specific recommendations are elaborated by assessment teams. An additional value of the multi-sector assessment approach is that it minimizes the risk of an inappropriate or supply-driven response by widening the scope of possible assistance beyond RRM's core services in NFI, watsan and education.

Through RRM assessment reports emergency needs are documented and recommendations for action made. These reports are supposed to form the basis of a comprehensive diffusion system carried out by OCHA provincial offices. Follow-up advocacy and coordination is then pursued, in theory, by OCHA to ensure that actors operating in sectors outside RRM capacity are engaged and their involvement secured. The evaluator noted that cluster lead agencies are not regularly included on OCHA's diffusion list for RRM assessment and monitoring reports—rectifying this would reinforce information sharing between RRM and the cluster system.

Since the inception of the mechanism in October 2004, RRM teams have conducted 165 assessments, of which 120 or 72% have resulted in interventions. On average, 47% of all interventions involve multiple sectors: some combination of non-food items, water and sanitation, education, health kits, food or other. In Katanga the situation is different, as RRM teams deliver primarily NFIs and, more recently, education kits. RRM actively coordinates with other humanitarian actors to provide watsan and medical inputs where needed, and in this way RRM Katanga avoids the traps of a supply-driven response.

An important indicator of the relevance and utility of multi-sector assessments is the number of times that recommendations for action in other sectors were realized by non-RRM agencies. Examples of success would include food distributions by WFP or its partners where RRM noted acute food or medical interventions, or where immediate curative or emergency nutritional assistance was noted and agencies from these clusters

responded. Unfortunately this data is not available, as RRM teams in the field do not document or track the outcome of their recommendations for action in other sectors.

In the first five months of RRM III covered by this evaluation, in all three provinces the number of assessment missions exceeds the number of interventions undertaken.

RRM III	Katanga (CRS)	South Kivu (IRC)	North Kivu & Ituri (Solidarités)
Number of assessments vs. interventions	6 interventions of 7 assessments	16 interventions of 53 assessments	32 interventions of 54 assessments

While donors might see this as inefficient use of resources, the added value of ongoing monitoring, surveillance and follow-up activities by RRM teams is precisely what makes RRM the pre-eminent first responder in the eastern provinces. Because of its mobility, it is the first to access and register crisis events and their effect on civilian groups. Prior to RRM, the critical weakness of the humanitarian community in provinces of chronic insecurity and vulnerability was the absence of regular surveillance and monitoring activities.

While this mobile monitoring role and its benefits to the wider humanitarian community are well established in the eastern provinces, in Katanga RRM teams are based in Lubumbashi, which is several days' drive from crisis areas in the central and northern belts of the province. Consequently, monitoring, surveillance and follow-up activities are not routine, but extensive logistical undertakings, and costly. This has proven a serious limiting factor on RRM's operations and impact, yet it is a burden that affects all agencies equally. A possible solution would be to position field staff with vehicles and relief supplies at key hubs, and maintain them as stand-by capacity. Given the vast size of the province, the difficulty of transport and travel, and the inability to predict where the next crisis will arise, this option would be costly and inefficient. Until roads, bridges and barges are fully repaired, RRM efforts will have to rely on air transport into the interior from Lubumbashi. Cars and trucks are rare in the interior, further complicating intervention logistics.

Introduce measures to ensure validity and utilization of RRM assessment findings by cluster leads in food, health and protection. RRM teams voiced the recurrent frustration that multi-sector recommendations in RRM assessment reports are rarely accepted and acted upon by lead agencies in the relevant clusters. The solution is not for other sectors—food, health and protection specifically—to duplicate RRM assessments by conducting their own. Rather, RRM assessment tools can be vetted and approved by cluster lead agencies. Cluster leads can then agree to accept or reject RRM assessment findings and recommendations within 48 hours. Alternately, each cluster can allocate one specialist to the RRM assessment mission to ensure validity of findings, or cluster lead agencies could train RRM teams in each their approved assessment methodology. Either way, a binding commitment should be sought from cluster leads in food, health and protection that RRM findings will be accepted or rejected within 48 hours. If accepted, lead agencies commit to action within 72 hours. If findings are rejected or ignored, the issue is raised at weekly coordination meetings (CPIA and OCHA). If still no commitment to action is forthcoming, the issue is presented to the HAG in Kinshasa for final decision. [See Annex for schema]

b) Interventions

RRM interventions aim to be timely (under 72 hours), targeted to the specific needs of the most vulnerable, harmonized across all areas of intervention, compliant with current service standards (Sphere, UNICEF), include complimentary sectors (watsan, NFI and education) where needs warrant, and well coordinated with response capacities of other agencies—particularly in food, protection, health and development/recovery programming.

Benefits of multi-sector interventions. The evaluator was struck by degree of popular support for multi-sector interventions, evidenced by an increase in voluntary community participation over those where only NFIs were provided. When programmed on the basis of assessment findings, multi-sector interventions offer a very useful palliative to tensions over the NFI beneficiary selection process. Watsan and education assistance (even medical kits to local health centers) are open to a wider class of beneficiaries, and their impact arguably longer lasting than NFI items. While RRM does not deliver all these sectors together in every intervention simply in order to pacify a potentially hostile population (acute needs of the core beneficiary population dictate modalities of service delivery), the option to offer additional, more sustainable inputs (watsan particularly) is a useful point of leverage when gauging how to intervene in a situation where vulnerability and indigence are equally acute among host populations and the newly displaced.

The dilemma of rapid response vs. popular support. The 72 hour time limit for RRM assessments and interventions entails certain compromises. The dictates of rapid response also means less time to explain and justify beneficiary selection criteria to local authorities, host populations and the newly displaced themselves. A common result is a residual absence of popular support, based on a lack of understanding, for RRM beneficiary selection criteria for NFI distributions. Failure to understand and accept the terms of RRM's engagement can result in overt animosity RRM teams, sometimes resulting in the cancellation of a planned distribution due to overt hostility.

Were time a luxury and more explanation and exchange possible, not only would communities demonstrate more support for RRM operations, but popular hostility and even fraud by local actors to inflate beneficiary numbers would likely diminish. An additional effect of the hostility provoked in part by poor grasp of RRM terms of engagement is reduced community participation. Where there is time to explain, listen, and re-explain RRM's operational constraints and capacities, partners noted that community participation was more forthcoming.

c) Non-Food Items

In just over two years of activity, RRM has delivered NFI kits to 815,000 persons in its four provinces of operation. NFI items provide shelter, warmth, food, clean water, and basic household instruments to those who have lost everything. This represents far more than the value of the individual items themselves. The RRM relief package allows a family to make its first step towards self-sufficiency, and the dignity that entails. Equally important, it reduces the pressures of daily survival, so common in abrupt, violent displacement, thus enabling families to remain intact instead of breaking apart, each forced to go their own way in search of safety and sustenance. These are all essential aspects of human security and dignity of the person, ideals shared by all humanitarian actors with a clear rights-based, protection mandate.

RRM is not the sole agency to distribute NFI kits to the displaced and other vulnerable groups in its provinces of activity. It is however the sole agency to apply the 'under three month' selection criterion, however, although generally RRM coordinates with other NFI agency to conduct shared distributions to affected areas. Kit contents are not identical between agencies, a difference explained by varying resources per agency. Further, NFI kits are partly flexible, enabling teams to tailor their response to circumstances. RRM teams can add or subtract BP5s, plastic sheeting and, where they exist, bednets. In most provinces, bednets have only recently become an option for RRM distributions.

Perceived value of kit contents. RRM teams conduct post-distribution surveys to determine, among other things, which items are most appreciated and useful to beneficiaries. Sale of NFI items are also investigated. Although survey data has not been formally centralized and compiled, a general overview of the questionnaires suggests that the most widely appreciated item is the plastic sheeting; the second is the blankets (2) and third the cooking pot (1). The item most commonly requested and not included in the kits is clothing; the second is a second cooking pot and/or a washbasin. The soft jerrycans (10 litre, compressible plastic) are the most widely criticized component of the kits, given their lack of durability and short lifespan.

An interesting extract from one such survey (CRS, Manono, Katanga) is presented below. It shows the top six choices when beneficiaries were asked **what they would have purchased had they received cash instead of a kit.**

Article	Nº Responses	% Responses
Clothing	71	29.6%
Mosquito Net	35	14.6%
Food/Salt	23	9.6%
Add'l Cooking Pot(s)	20	8.3%
Tools	15	6.3%
Kitchen Utensils	14	5.8%

It is worth noting that mosquito nets (bednets) are the second most desired item. RRM has only recently begun to systematically include bednets in its NFI kits, as budgetary constraints had previously prohibited their procurement. This is a serious shortcoming in a country with exorbitant rates of malaria morbidity and mortality. Participants at the December 2006 workshop in Bukavu agreed that bednets should be prioritized as standard for all kits.

Bednets not used despite sensitization. The evaluator visited a village in North Kivu (Lisasa) where bednets had been distributed, along with sensitization messages as to their purpose and benefits. Yet in houses visited the bednets were still in their plastic packaging, seemingly unused, with recipients claiming that they 'didn't want to get them dirty'. Although beneficiaries acknowledged that the area was malaria endemic, and still despite sensitization people were not using the bednets. They may have been preserving them for subsequent sale, although they denied this was their intention.

Sensitization accompanying NFI distributions. To maximize their beneficent effects, particularly on health and hygiene (limiting oral-fecal transmission, for example), NFI distributions are accompanied by sensitization campaigns. UNICEF has funded the creation of visual flipcharts to assist sensitization efforts, although only CRS in Katanga appear to possess and use the flipcharts in its sensitization efforts. On the basis of focus

group discussions with beneficiaries in North Kivu and Ituri, it was apparent that sensitization is effective and that messages were retained by beneficiaries.

An additional focus of NFI-related sensitization is to explain the beneficiary selection criteria to host populations and beneficiaries.[21] In this sense, it serves as a conflict-reduction measure, as RRM selection criteria are perceived to discriminate, thus creating hostility towards RRM teams.

Although rare, NFI sales serve to meet unmet vital needs. A related indicator of appropriate assistance is the rate of post-distribution sale of NFIs by beneficiaries. However, RRM monitoring visits found that on average under 10% of families sell NFI contents post-distribution. Additional beneficiary data collected by RRM teams suggest not that NFI sales were due to the inappropriateness of the items. NFI sale indicates rather that other forms of emergency assistance were late arriving or were desperately needed, and that money was required to purchase them. These tend to be food, seeds, and medicines or money to access medical care.

Utility of high energy biscuits (BP5) as nutritional buffer. BP5s are a detachable component of the RRM NFI kit; their inclusion is thus discretionary. Where acute food needs are recognized, BP5s are incorporated into the NFI kit, and the appropriate sensitization regarding their preparation (dilution, bouillon) and use accompanies their distribution. Mothers interviewed at RRM sites in South Kivu, North Kivu and Ituri all answered correctly when asked about BP5 use and preparation, and recognized their value for children. RRM teams emphasized their value as a minimal if effective nutritional buffer in the early days immediately following displacement, pending WFP distributions or until local procurement solutions were found.

d) Water and Sanitation

Since the RRM program began in October 2004, close to 693,500 persons have benefited from its 49 interventions in emergency water and sanitation. This figure represents 46% of the total number of RRM beneficiaries, and serves to emphasize how integral water and sanitation interventions are to RRM and its beneficiaries. At the provincial level, in the first five months of RRM III in South Kivu, IRC completed 16 interventions, of which 13 were in watsan. In Ituri and North Kivu during the same period, Solidarités completed 32 interventions, of which 15 were in watsan.

These interventions have included water treatment, water trucking, water catchment construction, rehabilitation of small water distribution networks, bladder installations, jerry can distributions, temporary latrine construction and hygiene education. Watsan interventions are not restricted to RRM; the watsan cluster is equally active. Its interventions typically include spring protections, well protections, borehole drilling, latrine construction, and hygiene education.

Watsan gaps in Katanga. RRM's integrated three-sector approach works well in the eastern provinces, particularly with Solidarités now handling all three sectors in North Kivu and Ituri (previously sector responsibilities were divided with CESVI during RRM I and II). But water and sanitation as a core RRM component is limited to the eastern

[21] The trainings and sensitization campaigns do not specifically address issues of sexual exploitation by humanitarian workers, peacekeepers or community leaders, though RRM teams inquire about all forms of rights violations, including instances of SGBV.

provinces. RRM in Katanga operated through ad hoc partners until June 2006 (RRM III) when CRS came on board. CRS do not have expertise in the watsan sector, which other specialized agencies provide in areas of need. According to the watsan cluster lead agency, UNICEF, gaps in watsan coverage in Katanga reportedly merit improved coverage. An RRM-like structure between UNICEF WASH and specialized watsan agencies in Katanga, such as ACF and MSF, is one possible strategy to ensure more consistent watsan coverage across the province.

Where cholera dominates watsan activities. In the eastern provinces, RRM teams possess watsan capacity but their activities tend to be dominated by cholera interventions, leaving them less time and resources to focus on classic watsan interventions. At the cluster level, this has created some tensions, as RRM watsan teams are expected to intervene and resolve crises that would typically fall under the responsibility of the health cluster: providing Ringer Lactate, oral rehydration salts (ORS), in particular. Known endemic areas, such as South Kivu, require long-term emergency preparedness and response from the health cluster and state authorities, not RRM. Lack of advance preparation by state actors in concert with the health cluster is a structural problem, and not the responsibility of RRM.

Given a continued lack of emergency preparedness and reactivity in the health cluster to respond to cholera outbreaks, RRM is obligated to respond. One solution to this drain on RRM watsan is underway: UNICEF WASH and the watsan cluster are seeking funding options for other watsan actors (Oxfam GB and MSF-H) to expand their operations to include cholera endemic areas. RRM teams will continue to have the comparative advantage with its pre-positioned stock and prior financing, and will act as first responders to cholera outbreaks. Having other watsan actors available will ensure rapid hand-over, thus liberating RRM teams to continue to focus on crisis response elsewhere.

e) Education

Emergency education was added as a pilot for RRM II in September 2005. Of the 120 RRM interventions conducted since then, 18 (15%) of these were in education ,according to statistics received by the evaluator. 13,500 children received emergency education kits; teacher kits exist and are distributed although records of this are uneven.[22] [RRM literature cites an average of 50,245 school children benefiting from RRM interventions, and 1,054 teachers having received pedagogical kits, although these figures were not independently confirmed.] The number of schools rehabilitated and emergency education structures created was not available to the evaluator.

The education sector of RRM coordinates with the education cluster, led by UNICEF and co-chaired by an INGO according to province. Emergency needs assessments are carried out in coordination with the cluster and local CPIA.

In their distribution of education kits, RRM teams work with a ratio of four kits to community children for every one given to an IDP child. Local schools selected for rehabilitation and kit distributions are generally chosen according to concentration of

[22] For instance, the figures for education beneficiaries presented in the 2005 Annual Report are not accurate. In that report, table summaries of RRM interventions for all of 2005 (thus RRM I and II) are presented to corroborate the overall beneficiary numbers presented in the report. In the tables shown in the report that document education interventions during 2005, the total comes to 3374 students, yet the report itself states the overall beneficiary figure in education as 36,700.

IDP children. Both these approaches are clearly more flexible on the 'three month' selection criterion than with NFI distributions, and for this reason are able to benefit a wider group.

As a result, community participation in the education sector is high. For a rehabilitated school in Lisasa, North Kivu, local families provided wood, lime, dug holes, and painted the mud walls. Sensitization messages concern the importance of female enrollment and the long term care of latrines and classrooms. A committee is designated to conduct this maintenance.

f) Community participation and capacity building

Local capacity building and community participation are two parallel RRM objectives, equally critical to ensuring the move from charity-based assistance to rights-based programming. Because RRM interventions are time-critical, however, adequate community participation is sometimes difficult to ensure. Local capacity of church networks and civil society is generally weak, because dependent on outside resources and expertise to contribute effectively to emergency relief operations at an international standard of quality. Further, capacity building requires a long-term commitment that RRM is not ideally suited to provide.

Regarding community participation, RRM's interventions in watsan and education have garnered significant voluntary contributions from local populations, who commit both labor and materials. Community participation is easier to mobilize in these two sectors, as populations tend to see watsan and education benefits as directly benefiting local residents as well as the displaced groups in their midst. RRM partners also note that community participation requires time to explain RRM's operational constraints and capacities, which in turn builds trust. When time is available to discuss and exchange views with populations and authorities, partners report that community participation is more forthcoming.

However, an independent evaluation of the suite of rapid financing instruments managed by OCHA (Nov. 2006) found fault with the OCHA-managed Rapid Response Fund on the degree of community participation in its interventions. Specifically,

> "Congolese NGOs were frustrated by the lack of direct funding and expressed a desire for more comprehensive training by, and effective collaboration with, international NGOs. Implementing organizations and OCHA tend to communicate project plans with beneficiaries, local communities and government authorities so that interviewees were well-informed about projects. However, in the consultant's view, international NGOs did not use participatory approaches to the extent they could have."[23]

While the current evaluation also defends the importance of community participation and capacity building, the acute needs of the most vulnerable are the primary preoccupation and core mandate of RRM. The emergencies to which RRM responds are extremely time-critical. Victims of violence, displacement, epidemic outbreak and natural disaster who comprise RRM's caseload cannot afford to wait while others are trained in how to mount an emergency response, or to assess vulnerability according to precise indicators and international standards. The time required to do such training is a luxury

[23] "Summary of Findings from Review of ERF/EHI/RRF Mechanism, DRC," 14 November 2006.

that neither RRM nor its beneficiaries typically possess. Ultimately, the time-critical nature of RRM must be juggled with the corresponding demand for local capacity building, community involvement and, more broadly, a greater inclusion of Congolese authorities into RRM's decision-making processes if an effective handover to relevant national ministries is to occur.

Accessibility of RRM reporting to national partners. RRM teams (IRC and CRS) reported the frustration expressed by local NGOs, potential collaborators with RRM, over assessment reporting written in English, a language not readily understood and rarely used by Congolese. RRM reporting in a language not spoken or understood by Congolese partners is interpreted as a deliberate effort to exclude them from the circuit of information and, by extension, the process of decision-making regarding a given crisis. A motion to write all assessment reporting in French was proposed and accepted at the recent December RRM workshop in Bukavu.

g) Monitoring and evaluation

Post-intervention monitoring is generally conducted between one week and one month after the initial phase of project activities, and serves to evaluate the adequacy of the intervention against any remaining or emergent gaps in emergency assistance. Common anomalies that warrant regular surveillance may include new IDP arrivals or sudden departures due to insecurity, indications of epidemic outbreak, looting or pillaging as a result of NFI distributions, etc.

RRM has standardized its reporting format for assessments and follow-up monitoring visits. Basic data from these reports are compiled into a Summary Table of activities per province, and the practice should be continued. While this data serves to record key process indicators (cause of crisis, number and type of interventions, number of beneficiaries and dates), it does not serve to measure RRM impact or performance.

Post-intervention evaluations are insufficiently developed to capture program performance. Given the speed of events, follow-up visits to beneficiaries are not regular or common, except when problems are reported. All parties recognize this as a shortcoming in current activities. Where post-intervention monitoring does occur, agencies use surveys to determine beneficiary satisfaction and remaining gaps in assistance. Households interviewed are randomly selected and a representative cluster (10%) of beneficiaries is surveyed. A table with proposed impact indicators is presented below, many of which are drawn the variety of existing reporting formats used by the three INGO partners.

Exploiting locally-available indicators. No systematic analysis of RRM performance exists, although all INGO partners recognize this as an important need. While positive measurements of RRM impact may be elusive due to the temporary nature of the intervention (and lack of reliable baseline data), this does not preclude the use of locally-available indicators to track acute vulnerability following an RRM intervention. Doing so would allow RRM teams to measure impact in preventive terms by tracking the rise or fall of different forms of illness among the beneficiary population. To be sure, this approach is not a guaranteed indicator of RRM impact on acute vulnerability, as not all illnesses are reported to local health centers. Consultations being payable, indigents often prefer traditional medicine, which is far more difficult to track.

'Sustainability' an inappropriate impact indicator. Forced displacement due to violence is the predominant reason for the acute vulnerability to which RRM responds. RRM experience with victims of forced displacement indicates that such security-seeking behavior is largely temporary. Indeed, the low number of IDP camps created supports the case that displacement is a commonly used, temporary coping strategy.

For beneficiaries whose circumstances are temporary, 'sustainable impact' as an indicator of RRM success therefore seems inappropriate. A more accurate indicator of RRM impact in the instance of recurrent, temporary displacement would be the degree to which RRM interventions succeeded in preventing an aggravation of acute vulnerability among the recently displaced. More specifically, did local health facilities register an increase of water-borne disease, respiratory infection, or malnutrition among RRM beneficiaries subsequent to the intervention? Was the beneficiary population attacked or looted post-distribution, with the clear intent to target RRM beneficiaries, thereby exacerbating their vulnerability?

A workshop is planned for February 2007 that aims to identify core performance indicators to be measured and tracked by RRM teams. Once centralized, they will be incorporated into a shared database, available to agencies involved in the PEAR program. Suggestions for a set of common performance indicators are presented below: the emphasis is on simplicity but with adequate representation of impact in key aspects of RRM interventions.

TO BE MEASURED	INDICATORS	TARGET
PROGRAM OUTPUT (PROCESS)		
Assessment output	Number of assessment missions completed within 48 hours, security permitting , with reporting in French	10 per month[24]
Intervention output	Number of emergencies receiving a response within 72 hours of the assessment (security permitting)	5 per month[25]
Multi-sector	Percentage of interventions benefiting from a multi-sector response (RRM specific: any combination of NFI, watsan, education)	75%
Other sector	Percentage of interventions benefiting from inputs outside RRM (but informed by RRM assessment reporting), and their frequency by sector: food, health, protection, etc.	50%
Emergency preparedness	Number of days RRM warehouse in each province has insufficient emergency materials to deliver immediate response to 5,000 households	0
MONTHLY MONITORING (PERFORMANCE)		
Monitoring frequency	Percentage of emergency responses followed up by participatory evaluations one month after intervention	75%
RRM footprint	Percentage of interventions handed over to other agencies three months after initiation[26]	90%
	Number of interventions terminated within three months of initiation	

[24] Average by province per INGO partner, according to RRM III output.
[25] RRM III output indicates on average half of all assessments are followed by interventions.
[26] Interventions concluding on their own, and not requiring continuation or hand-over, would not be calculated here.

NFI impact	Percentage of beneficiaries whose NFI kits are still in use one month after distribution	90%
	Rate of NFI sale one month after distribution	Less than 10%
	Top three items sold (according to frequency), and reason for their sale, one month after distribution	(descriptive)
	Top three items most requested (according to frequency) that were not included in distribution	(descriptive)
	Percentage of NFI distributions for which women were direct recipients	90%
Community participation	Percentage of interventions involving tangible community participation (list top three kinds of participation, according to frequency)	75%
	Percentage of interventions where local humanitarian committees are trained in beneficiary identification and registration, and in other RRM assessment and monitoring tools	75%
Beneficiary movements	Percentage of departed beneficiaries, one month after distribution [27]	(descriptive)
Water and Sanitation	Number of rehabilitated water sources created and in use by targeted beneficiaries (both IDPs and host communities)	(to be determined acc. to size of province)
	Number of latrines in use and maintained by targeted beneficiaries	
	Number of hygiene committees created and maintaining RRM inputs	
Education	Number of schools assisted	(same as above)
	Number of students reached	
	Number of teachers reached	
Health	Number of health kits distributed	
	Increase/decrease of core morbidity indicators: malaria, respiratory infections, epidemic outbreaks, water-borne diseases	(descriptive: available from local health facilities)
Protection	Number of GBV cases and unaccompanied minors referred/directly assisted	(to be determined acc. to size of province)
Advocacy	Percentage of assessments and missions that are followed by the dissemination of reporting to all humanitarian actors	100%
	Percentage of requests for engagement by other actors/sectors/clusters that are realized with assistance (humanitarian advocacy)	75%
	Percentage of political advocacy initiatives that achieve desired objectives	50%
Security	Have security conditions changed post-intervention? Were beneficiaries directly affected or targeted by these changes?	(descriptive)
	Number of times displacement is triggered by MONUC-FARDC operations, FARDC alone, or non-state armed actor	(descriptive)
Sensitization	Percentage of direct beneficiaries who, one month after intervention, confirm contact with RRM sensitization teams (note which sectors are active)	90%
	Top three messages retained, according to frequency, one month after	(descriptive)

[27] Local IDP Committee can be charged to record names of departed, their reasons for departure, and destination. Informational link to PEAR here is essential to avoid duplication of effort.

	intervention	

The table below summarizes the four forms of reporting required by RRM teams in the field. The first three are already practiced and are intended for internal use only. The fourth may serve as a summary document, for possible external diffusion, of RRM process and impact indicators per mission.

Common RRM Reporting
1. Assessment reports
2. Intervention reports
3. Monthly monitoring reports (conducted once a month for up to three months, but longer if RRM is obligated to remain active)
4. Mission impact reports: summary of core data compiled from three above reports plus a synthesis of impact survey indicators from preceding table. Will serve as 'definitive document' for each intervention. Its process indicators and impact survey results will be entered into RRM database, enabling production of quarterly analysis by province, or combined for national snapshot.

h) Advocacy

Having RRM teams on the front lines of emerging crises allows OCHA and UNICEF to receive updated information as a crisis evolves. This is effective for advocating for wider intervention and mobilization of resources, and for informing local and international media. RRM advocacy initiatives, undertaken by OCHA and UNICEF independently or together, tend to focus on the need for a wider intervention, lack of protection for civilians, access to crisis areas, and funding situations. For the purposes of this evaluation, RRM advocacy can be grouped into initiatives that concern the mobilization of resources and engagement from within the humanitarian community ('humanitarian advocacy'), and that which seeks improved conditions for beneficiaries in the wider security context ('political advocacy').

Concerning interagency advocacy on behalf of additional sector needs identified by RRM assessment reports, so-called 'humanitarian advocacy', several avenues exist. Primary is the diffusion of RRM assessment reports to concerned actors. This information sharing is then reinforced with weekly coordination meetings, including the more limited CPIA gatherings, where precise needs are discussed with the actors from whom a response is solicited. Further discussions may ensue when these actors are the lead agency of a relevant cluster, such as nutrition or health. Cluster meetings provide another occasion to weigh available resources against needs as identified by RRM.[28]

The need for advocacy efforts outside the humanitarian community is common, so-called 'political advocacy', and OCHA is best placed to do this. Its access to MONUC, civil and military divisions, its access to FARDC hierarchies and civil administrative structures, make it the logical vehicle for political advocacy. It serves to recall that many such initiatives are undertaken by OCHA in reaction to a lack of protection for beneficiaries. Examples include requesting MONUC to increased patrols in areas of

[28] Although useful, it is not possible to calculate the number of times that OCHA advocacy on behalf of sector needs identified by RRM has secured engagement by actors in sectors outside RRM, as such efforts are not documented systematically.

RRM intervention to secure an area during and after a distribution, or meetings with FARDC generals to demand better troop discipline regarding in their treatment of IDPs, where instances of looting and rape are recorded. Although much source material for RRM's political advocacy comes from direct field experience of beneficiary conditions and the security context, the protection section of the RRM assessment report also provides relevant information specific to individual crises. In this way, RRM assessment reporting establishes an important link between the protection component of RRM and its advocacy.

Informality of humanitarian advocacy. Coordination and collaboration between RRM and other actors (via clusters, CPIA and OCHA meetings) appears regular and effective, allowing RRM to respect its mandate for high-impact, short duration interventions. As elsewhere, shortened reporting formats mean that partners can fulfill this obligation, yet INGO partners were skeptical of the wider impact of their assessment reports. Systematic diffusion of RRM reporting to the broader humanitarian community does not appear to be regular practice. From all accounts, assessment findings and recommendations, particularly concerning sector needs outside RRM, are pursued informally between actors, and ad hoc solutions negotiated. OCHA itself does not play any formal intermediary role here, as INGO partners are often better informed and positioned to explain precise watsan needs, for example, to a potential partner, such as Oxfam Quebec. Regarding gaps in assistance, too, these are generally resolved informally through direct discussion between Solidarités and the relevant actor.

Advocacy undertaken by OCHA should be systematized for greater accountability. INGO partners expressed disappointment with follow up and results of advocacy initiatives undertaken by RRM managing agencies. Systematizing and tracking advocacy initiatives could improve their performance. OCHA's provincial information officers could document and track such efforts, undertaken by the sub-office OCHA head, so that other RRM members could stay abreast of initiatives as they evolve and learn of their outcome. By documenting and systematizing the advocacy initiatives that it undertakes on behalf of RRM, OCHA's role in this domain could be better measured and thus evaluated. Quantifying the success and failure of inter-cluster advocacy efforts would bring greater accountability to the cluster system as well.

Advocacy on root causes—how engaged is RRM? 77% of crises to which RRM responds are caused by forced displacement due to conflict. No figure is available on how frequently these emergencies are 'collateral damage' from MONUC-FARDC operations, but RRM teams in the field assert they are the most common cause. Given its privileged position both as UN entity and as front-line operator, RRM is ideally placed to speak out about the root causes of man-made suffering currently affecting the DRC. The evaluator was provided with several briefing notes and email exchanges drafted by RRM managing agencies that depict the humanitarian consequences of joint MONUC/FARDC military operations and, specifically, how these directly influenced forced displacement, asset stripping and atrocities committed against civilians by FARDC. Clear causal links were documented between MONUC-FARDC operations, the number of IDPs generated, and the financial cost to RRM in terms of emergency assistance.[29] The impact of this particular initiative, however, was negligible. Joint military

[29] From one briefing report: "To date, 135,000 Congolese civilians have been displaced as a direct result of the joint MONUC/FARDC operations against the ADF-NALU, a Ugandan separatist movement operating in eastern DRC. Over $1.2 million has been spent providing these displaced populations with non-food items, emergency shelter and water and sanitation materials." OCHA briefing to DPKO/Jean-

operations continue to cause more forced displacement than any other known cause, according to RRM teams in North and South Kivu.

Such lobbying efforts attest to the fact that RRM advocacy does engage root causes that, in this case, stem largely from the same military-humanitarian complex to which RRM is ultimately beholden—the UN Mission in the DRC. The dire human consequences of this apparent inability to coordinate the peacekeeping mandate with ongoing humanitarian activities, given that both aim to protect and serve the same civilian population, cannot be justified as 'collateral damage' or the 'necessary costs of peacekeeping'. From any perspective—humanitarian, military, or other—peacekeeping should never be the primary driver of humanitarian crisis. That this is so in eastern Congo is inexcusable, and suggests a far-reaching failure in the management and coordination of the two 'halves' of the UN family's mandate in the Congo.

2) Beneficiary selection and the three month criterion

Among the displaced of eastern and southern Congo, RRM assesses the degree of vulnerability and selects its beneficiaries according to how recently they were displaced. A temporal criterion is applied: those displaced within the last three months are eligible for assistance. In theory, the most recently displaced (i.e., those within the last three months) are more acutely vulnerable than those who have suffered through initial displacement and established the necessary coping mechanisms in order to survive.

RRM teams in all provinces maintain that successful distributions depend on transparent and rigorous beneficiary identification and verification, a multi-tiered process. The three month criterion also serves to delimit the form of RRM assistance to emergency and 'life-saving', allowing other humanitarian actors to take over with programs aimed at reducing vulnerability in the short and medium term, or at supporting return and reintegration for IDPs in their community of origin.

In practice, no INGO partner accepts at face value beneficiary lists provided by local authorities (or other local counterpart) without a thorough cross-check. Despite patient efforts to explain RRM beneficiary selection criteria, RRM teams acknowledge that NFI distributions create a 'pull factor' effect. Solidarités, for example, distribute only to first arrivals and refuse to assist 'late arrivals' until careful verification using the three month criterion has taken place. Experience has shown that news of NFI distributions travels quickly, resulting in widespread demand for NFIs by the local population. Some late arrivals are legitimate, however. Repeat interventions in the same location are not recorded systematically, but RRM teams in Ituri and North Kivu report they are common (approximately 25% of interventions are in repeat locations).

Why the controversy? First, non-discrimination is a fundamental principle of IDP assistance (Principle 18 of OCHA's "Guiding Principles on Internal Displacement"), and the three month selection criterion discriminates. Second, in the absence of any baseline morbidity/mortality data taken before and after RRM interventions, the use of a temporal indicator as primary criterion of vulnerability is, ultimately, arbitrary. There is little empirical evidence to support RRM's working assumption that IDPs who have been

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Marie Guéhenno, "Humanitarian Impact of Joint FARDC/MONUC Military Operations against ADF/NALU," 2006 [exact date unavailable].

displaced longer than three months are no longer vulnerable or are better off than the more recently displaced.

Prioritizing female recipients during distributions. Some RRM partners referred to the practice of distributing NFI kits directly to women. Female recipients of NFI kits may or may not be heads of household, but either way they are the adult family member most likely to use and care for kit contents, as the activities associated with the individual items are executed by women (cooking, cleaning, domestic hygiene, water collection, etc.). Directly distributing to women is also a public acknowledgment of their importance to family cohesion and their central role in Congolese society.

3) Vital sectors outside RRM

An important finding of this evaluation is the obvious added value of multi-sector interventions over those involving a single sector, such as watsan or NFIs alone. Their primary advantage is the wider section of beneficiaries that multi-sector interventions are able to assist. The more diverse the beneficiary group, the more durable the impact, as fewer acutely vulnerable people will continue to drain already limited local resources.

With only three core sectors at its disposition, however, even RRM's multi-sector interventions are not able to meet all critical needs of the acutely vulnerable. This is especially true for health, food and protection. In line with the larger aim of greater accountability, all clusters require stand-by emergency capacity in order to respond to acute immediate needs as and when they arise. RRM thus enables UNICEF, the lead agency for NFI/shelter, education and water and sanitation clusters to satisfy this requirement effectively. Other clusters prone to sudden onset, emergency needs—food, health and protection—may also wish to consider adopting an RRM-like solution to ensure emergency preparedness and rapid reactivity. As and when the humanitarian situation stabilizes in the DRC, RRM can continue to provide stand-by emergency capacity in all sectors where acute needs persist, beyond the current configuration of NFI/shelter, water and sanitation and education.

In addition to considering the degree of emergency preparedness and crisis reactivity possessed by these other vital sectors, this section proposes that relevant cluster leads adopt an RRM-like structure to improve crisis response in their sector.

a) Food

According to data made available to the evaluator, only eleven of RRM's 120 documented interventions since late 2004 were accompanied or followed by food deliveries. It is possible that the number of food distributions that accompany or follow RRM interventions be much higher (e.g., Solidarités claimed that between 60 and 70% of its interventions in the Grand Nord region of North Kivu were followed by food distributions, albeit with significant delays, and using half-rations), but documentation of the practice is not consistent.

RRM assessment teams register the need for food rations where necessary, but do not apply the same needs assessment methodology used by WFP (VAM). Food needs are therefore assessed rapidly through household visits to determine assets (food stocks, seeds/tools) and interviews conducted with the recently displaced, local population and authorities, civil society leaders (church, NGOs), etc. Primary indicators of food

insecurity are the presence or absence of food stocks among the recently displaced, the ability of new IDPs to access their fields from their new place of refuge, and the possibility of barter arrangements with local populations (food for work).

RRM recommendations on food needs pass through the usual RRM diffusion system, and WFP is invited to conduct its own needs assessment. In interviews for this evaluation, WFP stated its appreciation of RRM reporting of food needs among the recently displaced, given that WFP and its partners do not possess the same mobility and surveillance capacity as does RRM. WFP also acknowledges that it cannot always conduct its own needs assessments, or deliver food to needy areas because of logistics or lack of available stock.

Measurable consequences of food delays. Where simultaneous NFI and food distributions were planned but failed, the consequences of delayed food delivery are primarily limited to the post-distribution sale of NFI items by beneficiaries to procure food. By providing one type of good that is immediately exchanged for another type that "should have been delivered at the same time," RRM is effectively delivering food in the place of WFP. Food delays thus undermine the value of rapidly delivered NFI kits, when these latter are traded or sold by the intended beneficiaries to procure vital goods promised by another supplier. Reported examples of this specific scenario are not widespread but have occurred in Dubye and Mitwaba in central Katanga, and in Isale, North Kivu.

Local solutions to emergency food needs created by sudden displacement include working in the fields of the local population in exchange for a daily wage (approx. 300FC per day, or $0.60) or the equivalent in cassava, plantains or other local foodstuff. Other recently displaced were able to visit their fields once or twice a week, walking as far as 30km per day, security permitting. In every site visited for this evaluation, displaced populations reported that they were able to feed their families using one of these coping strategies, although one cannot generalize from these few impressions. During field visits in North and South Kivu and Ituri, RRM beneficiaries and partners alike spoke of situations where populations are cut off from all means of food procurement. Such scenarios are less frequent but are created by reigning insecurity, or when IDPs are actively blocked from visiting their fields by FARDC. No data was available on RRM recommendations for emergency food assistance in these situations, and how they were responded to by WFP. Another reason to track and monitor inter-cluster recommendations closely, as well as advocacy initiatives between UN agencies to secure emergency assistance.

Different reactivity speeds between RRM and WFP. In cases of extreme food insecurity affecting large numbers of recent IDPs, as occurred in Kanyabayonga (Jan. 05 and Feb. 06) in North Kivu (15,000 beneficiaries), WFP assessment and delivery was reportedly quick and responsive. According to RRM and WFP, however, this is not always the case. WFP does not have its own rapid response mechanism: there are no stand-by stocks ready for rapid distribution, no teams waiting to do emergency VAMs, no fleet of vehicles ready to commence immediate loading and departure to the distribution site. The timeframe at which RRM strives to operate (assessment and intervention within 72 hours), is not shared by WFP, who must evaluate, deliver and distribute using its own teams, available stock—never guaranteed—and logistics.

Should WFP develop its own RRM? In areas where RRM is also operational, WFP contracts local agencies to assess needs and distribute food. While this augments WFP's field presence and surveillance capacity, it has not accelerated its reactivity to acute needs in abrupt crisis situations. RRM and WFP thus operate at different speeds and different acute vulnerability indicators.

Investments to improve transport infrastructure (roads, barges and bridges) in central and southern Katanga is a current WFP strategy with short and long-term objectives. In the short term, it aims to increase agency reactivity to emergent, critical food needs across the province. In the medium and long term, it aims to stimulate commercial recovery by facilitating the circulation and sale of agricultural produce from isolated rural areas. Because commercial recovery in the agricultural sector implies a return to self-sufficiency for the individual farmer, the approach doubles as an effective exit strategy for WFP.

The immediate results of this strategy for the recently displaced in the lakes district of central Katanga, Mitwaba, Dubye, etc., are not yet palpable. Nor will emergency food needs in the eastern provinces abate without an improvement in rural security and protection for civilians. Addressing these root causes requires a combination of political and military solutions for the numerous militia, dissident and foreign armed groups operating across the eastern and southern provinces—solutions that have been elusive throughout the political transition and which are not likely in the immediate future. Further, RRM partners cite abuses and exactions against civilians by their would-be protector, the FARDC, as an additional and pervasive source of insecurity and displacement in North & South Kivu, and Ituri. Prospects for immediate change here, too, are slim.

Projecting into 2007, the likelihood of continued insecurity and civilian targeting in the eastern provinces means continued displacement and ruptured livelihoods. With sudden displacement comes acute vulnerability, including instances of food insecurity and the need for short-term emergency food aid. UN humanitarian reform efforts will continue apace; increased accountability and improved performance of the cluster system is expected. While RRM enjoys the support of and collaboration with all clusters and their lead agencies, its success has seen a certain displacement of responsibility for emergency response by cluster leads onto RRM. Problems arise between RRM and cluster leads over sectors not covered by RRM, particularly in health and food. For the realization of cluster ownership of emergency response, as envisioned by the cluster initiative as part of the UN reform agenda, RRM cannot continue to substitute for clusters that lack emergency preparedness and crisis reactivity.

RRM allows UNICEF to ensure effective crisis response and emergency preparedness in the three clusters under its responsibility: NFI, education, water and sanitation. The food security cluster should consider adopting the RRM model as a way to improve its own emergency preparedness and rapid response. As noted elsewhere in this report, should such a model be adopted and applied by WFP, the multi-sector assessment tool currently applied by RRM should not be duplicated by another one for food, implemented by WFP and its partners. Continued displacement, even in fertile areas like eastern Congo, means food insecurity. Planned return movements to villages of origin are contingent on improved security. If this occurs, returning groups will also require food assistance that is flexible and fast. This evaluation therefore recommends (a) the validation of RRM multi-sector assessments for food needs by WFP and (b) the creation of a rapid response fund

(RRF, between WFP and OCHA) for the purpose of emergency local purchase of food and, if needed, transport costs, for rapid distribution by existing (or new) INGO partners of WFP at the provincial level.

b) Health

Due to continued insecurity and lack of government resources in the DRC, INGOs continue to provide basic health services and emergency medical response throughout the country. In North Kivu alone, the 73 NGOs and 11 UN agencies are providing health services, which also constitute a major coordination challenge.

In its capacity to respond to epidemic outbreaks, RRM is not alone as a front-line responder, as several emergency medical agencies are operating in vulnerable areas of eastern and southern Congo. MSF maintains its 'Pool d'urgence' in Kinshasa which responds to epidemic outbreaks and medical emergencies across the country, working in collaboration with WHO where necessary. In addition to its response capacity and stand-by supplies for cholera and malaria, RRM teams provide medical kits to health centers to reinforce the curative capacity for beneficiaries and host populations during an RRM intervention.

While RRM possesses preventive capacity for cholera and malaria (through bednets and sensitization), it lacks any curative power. Preventive capacity consists in materials to contain cholera transmission, hygiene materials and disinfection structures, and in sensitization for personal hygiene as a vector-control strategy. For malaria, bednets and sensitization comprise the extent of RRM's prevention capacity. In view of the limits of prevention in areas where cholera and malaria are endemic, the importance of close collaboration with effective medical INGOs is key.

Nevertheless, RRM has demonstrated crucial reactivity to cholera both in towns and in less accessible rural areas. Materials for the construction of Cholera Treatment Centers (CTCs) are on hand for quick response to outbreaks, and transmission prevention activities (hygiene and sensitization) can also be implemented by RRM teams. The curative component of cholera response is organized by the health cluster and usually falls to a specialized medical INGO with emergency capacity, such as MSF. Such INGOs are uncommon in RRM zones of operation, which complicates matters.

WHO repeatedly expressed its indebtedness to RRM for mounting initial assessments and for mobilizing other actors to take up the curative component of cholera response. As noted elsewhere in this report, the problem of RRM substitution for rapid response by other clusters may be inevitable in the face of emergency, but it is not conducive to realizing the larger goal of cluster ownership of emergency preparedness and response.

Rapid response solutions for the health sector. As provider of last resort for emergency health care, WHO is seeking to accelerate the development of stand-by capacity and emergency response with an RRM-like arrangement with medical INGOs in areas of greatest vulnerability and endemicity. This it cannot do without sufficient funding, with which procurement of human expertise (INGO partners) and bulk supplies can begin at the scale required. WHO representatives in Kinshasa and Bukavu met during this evaluation maintained that their primary operational obstacle is lack of resources, and point to UNICEF and RRM as a clear example of how adequate resources enables partnerships with specialized INGOs who then carry out rapid assessments and interventions at the field level. Although WHO finances increased approximately 600%

between 2005 and 2006, it serves to recall that the 2005 amount was a mere $110,000. CERF and Pooled Fund monies in 2006 for WHO totaled approximately $5 million: hence the "600% increase," which sounds significant but in real terms is not nearly enough to establish stand-by capacity and pre-positioned supplies to meet the country's emergency health needs.

Role of RRM medical kits. RRM distribution of UNICEF medical kits is linked to an agreement with local authorities to ensure free medical care for IDPs for a limited time. Respect for and application of this agreement is difficult to enforce, and several cases of charging IDPs for basic consultation services were heard during field visits. Kits include essential drugs and medical supplies and are provided to existing health centers serving the host population where a large IDP influx has arrived.

Discussions with various interlocutors suggest that the medical kits are lacking anti-malarial drugs and antibiotics. The probable reason for their exclusion is to avoid erroneous or gratuitous prescriptions (the result of 'drug dumping') and the medical complications that would doubtless ensue. Paracetamol and vermifuge are the sole medicinal agents in the kits, which are otherwise comprised primarily of first aid materials: bandages, sterilization kits, etc. There is however debate among RRM teams as to whether they possess the necessary medical expertise and oversight to assume responsibility for a reinforced medicinal aspect to the kits, even anti-malarials.[30]

An area to be reinforced and for which RRM teams are well-suited is in public sensitization on specific health messages: malaria prevention with bednets, HIV/AIDS transmission and reproductive health, personal hygiene and water-borne diseases.

c) Protection

Protection continues to be a major priority for the humanitarian community in the DRC. The rights of Congolese civilians, including IDPs and returnees, are constantly threatened by armed militias, government forces, and even elements in their own communities. The high prevalence of sexual and gender based violence (SGBV), amidst a general climate of impunity, has called for efforts to address this problem. UNFPA administers a joint program, in which UNICEF is involved, providing a multi-sector approach to fight SGBV through the provision of medical, psycho-social, legal and economic services including reinsertion of victims into their communities. The approach recognizes that protection of Congo's mot vulnerable groups (victims of SGBV, IDPs, children and minority groups), is key to security sector reform. Specialized agencies have begun to intensify training of integrated FARDC brigades on the Guiding Principles for IDPs, humanitarian principles and SGBV.

The protection cluster was established in January 2006 and is led by UNHCR (MONUC co-chairs the working groups). Participants include UN agencies, MONUC, INGOs, and ICRC as observer. Due to the sensitive nature of most protection issues local NGOs and government officials have not been invited to take part in the meetings but are met

[30]IRC in South Kivu, by contrast, has a medical component to its programming so would in principle be less opposed to handling anti-malarials. Recall that Solidarités refused to distribute bednets in a malaria epidemic in North Kivu based on the correct reasoning that it warranted both a preventative and curative component that it was not equipped to provide. Negotiations between OCHA/UNICEF and WHO in North Kivu never materialized into agreement, and the epidemic transpired without intervention from the responsible cluster.

separately at the provincial level. Targeted actions by the cluster have included improving coordination between the humanitarian community and the MONUC military, the identification of FARDC officers accused of human rights violations, and civilian protection training for FARDC battalions.

In February 2006 RRM agencies elected to incorporate protection components into their assessment methodology and to augment their interventions with protection-related activities. Specifically, RRM teams seek out victims of sexual violence and unaccompanied minors in their areas of intervention, and refer or transfer these cases to specialized agencies in the region. RRM teams also coordinate its rapid assessment findings with a UNICEF-supported initiative to provide emergency medical and psychosocial response to SGBV victims in Ituri and the Kivus.

At the December 2006 workshop in Bukavu, however, INGO partners expressed doubt about their added value in the protection sector, seeing little tangible impact of their actions. Solidarités, for instance, has requested further training from UNHCR on protection monitoring. This evaluation recommends that RRM teams seek support and training from UNHCR throughout the eastern provinces. RRM should continue in its current support role of identification, referral and transfer of emergency cases in SGBV and child protection to specialized actors. This is an essential front line service and RRM teams are uniquely positioned to reach the most vulnerable given their role as first responder. However, RRM should not develop stronger programming priorities in protection, including case documentation, but leave this to appropriate agencies under the direction of the protection cluster.

4) Relationship of RRM to humanitarian reform agenda, cluster approach, PEAR and Pooled Funds

RRM is in principle limitless as a management solution to institutional requirements for rapid response capacity. The mechanism has proven effective in ensuring emergency preparedness and rapid response capacity in three key sectors affecting acutely vulnerable populations in the DRC: NFI/shelter, water and sanitation, and education. The primary shortcoming of the mechanism identified by this evaluation—and highlighted in the 2005 RRM Annual Report—is its difficulty to ensure a holistic response to immediate and acute needs in other sectors, particularly food, health and protection. Yet the mechanism is flexible and can be readily adapted to satisfy the need for emergency response capacity in the food, health and protection sectors.

Stand-by emergency response capacity will remain essential in all six sectors throughout 2007, provided effective pacification of non-state armed groups continues and violations against the civilian population by the newly integrated national army abate. However desirable and necessary these trends may be for the progress of the country, neither is guaranteed; cycles of insecurity and displacement could continue to disrupt civilian livelihoods beyond 2007.

RRM, the cluster system and the humanitarian reform agenda. RRM contributes to the UN reform process by realizing cluster commitment, as 'providers of last resort', to developing and ensuring emergency preparedness and response capacity in three sectors: NFI/shelter, water and sanitation, and education. In the first instance, it does this by outsourcing program implementation to specialized INGOs, a relationship that is

beneficial both to the UN agencies involved and to INGO partners. UN agencies dispose of larger financial resources than INGOs, as well as greater procurement capacity. INGOs, on the other hand, offer greater mobility on the ground, as their security regulations are generally more adaptable in fluid, insecure contexts than those of the UN. Continued progress in cluster accountability and performance can be facilitated by applying the RRM approach to meet acute, immediate needs in the food, health and protection sectors.

In a second way, RRM advances the cluster system by providing critical information in real-time on acute needs in evolving emergencies. Through its assessment reports and in inter-agency meetings chaired by OCHA, this information is made available to cluster lead agencies, thus enabling them to mobilize a response complimentary to that of RRM, if needed. While RRM covers emergency needs for three clusters and its interventions assist when needed in two others (health and protection), it remains the responsibility of these latter clusters to ensure their own emergency response capacity.

This evaluation has emphasized two weaknesses in the working relationship between RRM and the wider cluster system. First, cluster leads in food, health and protection do not consistently accept the findings and recommendations of RRM's multi-sector assessment reports. Second, differences over the validity of needs identified by RRM reporting can lead to a frustrating inability to secure commitment from agencies in other sectors. There are numerous examples of this conflict, hence the two recommendations of this evaluation to 1) ensure acceptance of RRM findings by other sectors, and 2) fund and develop emergency response capacity in the food, health and protection clusters.

In 2006, about $124 million USD has been allocated through the Pooled Fund to UN and NGO partners, including funding received from CERF (Central Emergency Response Fund) "chronically under-funded emergencies grant." RRM allocations received to date from the Pooled Fund have ensured that OCHA, UNICEF and partners in the field (Solidarités, CRS, IRC) can provide access to potable water and sanitation, emergency food aid and basic health care to the acutely vulnerable. In addition for 2006, OFDA has provided $1,000,000 USD to the initiative.

Links between PEAR and RRM

The UNICEF Program for Expanded Assistance to Returnees (PEAR) was launched in October 2006 with ECHO, OFDA and Irish Government funding and is not meant to replace RRM but to compliment it by providing a broader and more studied assistance package to the high numbers of displaced populations expected to return to their communities of origin as the country stabilizes. Should security conditions improve and mass return movements transpire as predicted, RRM stand-by emergency capacity will nevertheless remain essential through 2007 as instances of forced displacement, epidemics and natural disasters will likely persist.

The PEAR assists with the return of IDP families in eastern and southern DRC back to their homes, and support their reintegration and recovery via the cluster approach. One INGO partner in each project zone has been resourced with sufficient financial and material resources to monitor, assess and respond to the material needs of vulnerable families in return zones in the sectors of NFI and education, and assist other actors to prioritize programming in other sectors in clearly identified return zones. UNICEF

intends for the PEAR to grow into a major response tool to assist IDP returns in the DRC, as has been its experience with the RRM in response to acute emergencies. PEAR contributes to sectoral coordination and advocacy (via the cluster approach) through regular interaction with the Early Recovery Cluster, as well as education, health, water and sanitation, nutrition, food security, NFI/emergency shelter and protection clusters.

UNICEF is currently investing significant effort to ensure that assessment and monitoring tools are standardized and shared between RRM and PEAR for maximum synergy and impact. Shared assessment and monitoring tools will also be required to ensure that indicators and data are harmonized for the database, whose relevance depends on maximum utility to both RRM and PEAR, and to the wider humanitarian community.

5) Conclusions: exit strategy and possible replication

To reiterate the core findings of this evaluation: RRM has demonstrated its impact and pertinence through process indicators—beneficiary numbers, frequency of assessments and interventions, and the provision of emergency assistance in three vital sectors within 72 hours. Among RRM's 1.5 million beneficiaries since October 2004, 815,000 persons received NFI packages and/or emergency shelter, 693,500 benefited from emergency water and sanitation projects, and 13,500 children received emergency education kits. For all three phases since late 2004, RRM teams conducted 165 assessments, of which 120 or 72% resulted in interventions.

Need for standard indicators, systematic data compilation, and commitment from other sectors. Both process and impact indicators could be improved by being made more systematic and shared between INGO partners. This evaluation has provided recommendations on impact indicators to be shared by RRM teams in the field, and compiled on a quarterly basis at the provincial and national level. Another identified weakness is RRM's ability to respond holistically to acute needs in sectors outside its immediate capacity. Despite the recognized utility of its multi-sector assessments by actors in other sectors, these findings and recommendations are rarely realized, according to RRM teams in the field.

The solution is not for other sectors—food, health and protection specifically—to duplicate RRM assessments by conducting their own. Rather, RRM assessment methodology can be vetted and approved by cluster lead agencies in relevant sectors, followed by a formal agreement to accept or reject RRM findings within 48 hours. If accepted, lead agencies commit to action within 72 hours. If still no commitment to action is forthcoming, the issue should be raised at the HAG in Kinshasa for final decision. Alternately, each cluster can allocate one specialist to the RRM assessment mission to ensure validity of findings, or cluster lead agencies could train RRM teams in each their approved assessment methodology. Either way, a binding commitment should be sought from cluster leads in food, health and protection that RRM findings will be accepted or rejected within 48 hours. RRM managing agencies, OCHA and UNICEF, agreed in the recent Bukavu workshop to propose this accountability framework to cluster lead agencies in food, health and protection for approval. See Annex 1 for a diagram of how this *échéancier* would work in practice.

Bulk procurement, pro-positioning of stock and pre-financing are keys to success. A large part of RRM's success lies in the twofold ability of UNICEF to 1) procure essential relief materials in bulk and to ensure their delivery to strategy sites at the provincial level; and 2) secure prior financing to INGO partners enabling them to respond immediately with assessments and interventions as crises arise. This evaluation found that INGO partners agree with the above assessment but their performance has been hampered by the slowness of in-kind contributions, particularly vehicles and some kinds of office equipment, such as computers.

OCHA provides "access and voice we wouldn't have otherwise." INGO partners emphasize two primary benefits of their links with OCHA. First, OCHA's role as designated coordination agency conveys both access and a degree of neutrality to messages and concerns coming from RRM teams in the field. These teams are the INGO partners who, were they working independently of RRM, claim that they would not have access to WFP, WHO, UNICEF or other key UN agencies in the humanitarian sector, which OCHA affords. Related is the comparative impartiality that OCHA brings to any recommendation, advocacy initiative, or other demand made on behalf of RRM—a professional distance that the INGO partner would lack were it operating independently of RRM. Second, INGOs cited numerous examples where OCHA's access to MONUC has enabled RRM interventions to benefit from better security for assessment teams and beneficiary populations themselves. At OCHA's request, for instance, MONUC has provided patrols to consenting INGO partners[31] in sensitive areas of intervention, armed escorts for teams during assessment missions. In some cases, MONUC provided RRM with direct technical and material assistance (e.g., water trucking in South Kivu).

Advocacy undertaken by OCHA could be systematized for greater accountability. RRM teams operate on the front lines of rapidly evolving humanitarian emergencies; their eyewitness accounts and real-time assessments of affected populations form a primary source of information for the wider humanitarian community, in particular its advocacy initiatives and media communications. While OCHA and UNICEF are responsive and engaged on this front, RRM teams in the field expressed disappointment with follow up and results of these initiatives, which require sustained attention and continued effort. Systematizing and tracking advocacy initiatives could improve their performance. OCHA's provincial information officers could document and track such efforts, undertaken by the sub-office OCHA head, so that other RRM members could stay abreast of initiatives as they evolve and learn of their outcome. Each member of RRM should share a clear and equal degree of responsibility for the success of the mechanism itself, and by documenting and systematizing the advocacy initiatives that it undertakes on behalf of RRM, OCHA's role in this domain could be better measured and thus evaluated. Quantifying the success and failure of inter-cluster advocacy efforts would bring greater accountability to the cluster system as well.

a) Exit strategy – specific interventions and for RRM generally

As the humanitarian reform agenda in DR Congo continues apace, the cluster system will increase its emergency response capacity in sectors where acute needs persist. To do so, as this evaluation has argued, clusters requiring improved and reinforced emergency response capacity may adopt the RRM model, which has demonstrated positive impact

[31] IRC has accepted armed escorts but Solidarités refuses, as do other emergency actors in the region, such as MSF and ICRC. The issue of 'perceived independence' is important in Eastern Congo, where humanitarian agencies have experienced negative repercussions from popular amalgamation with armed actors, be they UN peacekeepers or national military.

and efficiency in three key sectors with critical emergency needs. In the medium to long-term, however, the exit strategy for RRM is the eventual handover of emergency response by the clusters back to their corresponding government bodies and institutions. Capacity and responsibility for rapid response to cholera, for example, will once again belong to the national health system.

Regarding the three emergency sectors presently covered by RRM, the need for NFIs and shelter, water, sanitation, and emergency education will decrease as and when security conditions in the country improve. RRM will be obsolete when forced displacement has ceased and populations can return to their home areas. Understood this way, RRM can have no active exit strategy because the conditions determining RRM's continued necessity for 2007-08, and beyond, are contextual and beyond its control. When conditions improve and acute needs in its three sectors abate and disappear, so will RRM.

The UNICEF Program for Expanded Assistance to Returnees (PEAR) is therefore not meant to replace RRM but to compliment it, assuming security conditions to improve in 2007 and large-scale returns become more realistic. By providing a broader and more studied assistance package to the high numbers of displaced and refugee populations expected to return to their communities of origin as the country stabilizes. Should security conditions improve and mass return movements transpire as predicted, RRM stand-by emergency capacity will nevertheless remain essential through 2007 as instances of forced displacement, epidemics and natural disasters will likely persist.

Reducing dependency on RRM. Handover of humanitarian activities to government actors may not happen in the next ten years, but we prolong the logic of substitution by operating completely independently of them. Reducing state dependency on RRM starts by reasserting the narrow parameters of the RRM mandate. Practically, this is immediately achievable in the following two ways: 1) Reduce or end RRM involvement in crises of structural origin—crises exacerbated by their physical remoteness and inaccessibility to humanitarian actors, as in central Katanga; 2) Limit RRM involvement in epidemic outbreaks in known endemic areas, as these are in principle foreseeable. Lack of advance preparation by state actors in concert with the health cluster is a structural problem, and not the responsibility of RRM.

Strong local emergency capacity enables RRM handovers. The prevalence of emergency-focused agencies in Ituri is a vestige of the district's high visibility in recent years, and a corresponding spike in emergency programs and funding. While some emergency agencies have withdrawn or reduced activities, several effective medical and watsan agencies remain. Handover to these groups comprises the bulk of RRM's exit strategy. However, state capacity is non-existent in Ituri; in the Kivus and Katanga the state exists but with little reactive capacity. Future RRM planning and possible scale down should take into account MONUC's timeframe for gradual withdrawal.

Exit strategy also depends on ending causes of displacement, primary responsibility for which lies with joint MONUC—FARDC operations against FDLR, and whose numbers have not decreased in two years. Primary advocacy point on root causes in SK consists in the message to MONUC that these joint operations need restructuring to be successful, and to stop the creation of humanitarian crises to which the aid community must always respond (e.g., "We are constantly cleaning up after their failures," said one RRM representative in North Kivu).

b) Considerations for future RRM exportation

RRM could serve to streamline and accelerate emergency monitoring response in similarly fluid, complex emergency environments where humanitarian actors exist but compete for funding from a limited number of donors. Easter Chad, Darfur and Somalia are potential candidates for RRM application where forced displacement is recurrent and access to vital resources (water, food, NFIs, shelter and medicine) is limited by poor security.

As demonstrated by its work in DRC, RRM offers strong value added where coordination alone was of little benefit to emergency actors lacking resources and materials (i.e., the situation pre-2004), and where logistics and infrastructure is poor or nonexistent. The degree of insecurity is a decisive factor for RRM viability in a given context, however. Where actors and resources are numerous but extreme violence impedes action, it is unlikely that RRM can operate successfully. Darfur, southern Somalia and Afghanistan all illustrate this type of operational paralysis. In such contexts, it is doubtful that RRM could improve humanitarian performance without a corresponding improvement in security conditions and access to affected populations.