EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HUMANITARIAN AID - ECHO

# HUMANITARIAN AID
# for
# Vulnerable population groups
# In
# THE DEMOCRATIC REPUBLIC OF CONGO (DRC)

# GLOBAL PLAN 2006

## Humanitarian Aid Committee
## December 2006

ECHO/COD/BUD/2006/01000

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## Explanatory Memorandum

## 1. EXECUTIVE SUMMARY

The transitional government of the Democratic Republic of Congo (DRC) has survived a number of crucial tests in 2005 but remains very fragile. Insecurity in the East has remained a prominent feature throughout the year with the situation in Ituri degenerating into open conflict between rebels and the Mission d'Observateurs des Nations Unies (MONUC) and the Armed forces of the Government (FARDC). Two humanitarian aid workers were briefly kidnapped in July. In the Kivus, former Hutus rebels of the FDLR have refused to disarm and even committed a number of massacres of civilians in rural villages.

The International community has continued to support the transition process by applying political pressure and providing funds to keep the various transitional initiatives on track. A positive consequence has been the progress in the registration of voters for the referendum on the constitution and the subsequent elections which must be held before June 2006. On the other hand the Disarmament, Demobilisation and Reintegration (DDR) process and the security sector reforms have tended to drag behind schedule, with thousands of armed men still operating outside of government control. Also, whereas the successful elections in Burundi are a very positive development for the region, the continued presence of rebel groups hostile to the DRC's neighbours remains a significant source of potential destabilization.

According to the IMF the economy has seen some growth and DRC has crept up half a dozen places on the GINA scale but despite this the country remains in a desperate situation. An estimated 1-2 million people remain displaced internally or as refugees abroad. Nonetheless a significant number of these are now returning home, many under their own steam but some 180,000 are set to be repatriated in 2006 under the auspices of UNHCR.

Globally food security seems to be improving with a reduction in malnutrition rates (only one recent survey has shown acute malnutrition rates above WHO danger levels) but there are still islands of hunger, mostly resulting from insecurity and inaccessibility. Unfortunately these meager gains are under threat from the spread of the Mosaic virus which is destroying the staple manioc crop.

Mortality rates remain unacceptably high, especially in the under fives and all the other public health indicators are still amongst the worst in the world. Indeed DRC has less than 80% polio vaccination coverage and has even suffered outbreaks of bubonic plague. Also, despite the considerable efforts made in the health sector, access to affordable healthcare is still not universal. Violent attacks on women have remained an appalling feature of the insecurity and in that women are such a crucial part of household survival their targeting is the cornerstone of much of the socio-economic disintegration of the DRC.

2005 has seen a marked return of the major institutional donors. The World Bank, the European Commission and other traditional development donors are now set to re-invest massively into the Social development and infrastructure sectors, complimenting their other commitments to the various transitional initiatives. However much of this still depends on successful elections.

Thus in 2006 DG ECHO will be aiming to rationalize its programme in line with the developing situation. DG ECHO will thus consolidate and even expand its position in the east of the country i.e. in Ituri, the Kivus and parts of Maniema and North Katanga where the persistent insecurity continues to create significant humanitarian needs, which require the flexible response that DG ECHO is best suited to provide.

Activities to be funded in 2006 will continue to center around the similar objectives developed over the last years, notably:

Health (40%): To provide access to a basic package of healthcare for some 8 million beneficiaries with a special emphasis on women and children.

Resettlement (55%): to support the returning internally displaced, refugees and their host communities, through the provision of a package of assistance designed to meet their immediate needs and re-establish their ability to achieve self-sufficiency.

The envelope proposed for the DG ECHO DRC Global Plan for 2006 is EUR 38 million.

## 2. CONTEXT AND SITUATION

### 2.1. General Context

Since 1998, regional armed conflict in the Democratic Republic of the Congo (DRC) has claimed an estimated 3.3 million lives as a direct result of fighting or because of disease and malnutrition. The conflict has also displaced 3-4 million residents. In August 1999, the governments of the DRC (GoDRC), Angola, Namibia, Rwanda, Uganda, and Zimbabwe and the main Congolese opposition groups signed the Lusaka Peace Accords. These accords laid the ground for a subsequent agreement the *Acte Global et Inclusif* signed in Pretoria in 2002. This provided for a 24-month transitional period, during which Joseph Kabila would remain President, with the assistance of four Vice-Presidents, drawn from the two main former rebel movements, the MLC and RCD-G, the Kinhsasa government and civil society. The Presidential, parliamentary, and local elections scheduled for 2006 will be the first pluralistic and open polls in the DRC in 40 years.

The MONUC, with approximately 16,193 troops, is the largest UN. peacekeeping operation in the world. Despite the strength of MONUC, armed opposition groups including Forces Démocratiques de Libération du Rwanda (FDLR)/Interahamwe (Rwandans implicated in the 1994 genocide who subsequently fled to eastern DRC), Mai-Mai factions (bands of local DRC citizens originally formed to resist Rwandan army occupation), and ethnic or clan-based organizations continue to threaten security in certain areas. In Ituri a separate ethnic conflict erupted in heavy fighting in 2003. The international community reacted strongly, with UN Security Resolution 1484 of 30 May authorising a Chapter VII intervention in Bunia, to which the EU responded by deploying Operation Artemis.

According to the UN Office for the Coordination of Humanitarian Affairs (OCHA), 24 million people in the DRC remain vulnerable due to the effects of conflict and continued insecurity. Poverty is widespread, and the healthcare system has eroded due to a lack of resources and continuous looting. Sporadic insecurity has restricted access to agricultural land and traditional markets and prevented displaced populations from returning to the DRC.

Foreign aid has been the substantial source of survival for many Congolese people over the last six to seven years. Well over 100 million dollars of humanitarian aid a year (excluding food aid) has kept vital health and other social services going, despite severe difficulties. A similar amount of food and agricultural assistance has also been committed. Nonetheless access to millions of people has been restricted not just due to insecurity but also due to the appalling transport infrastructure, resulting in thousands of avoidable deaths. The humanitarian aid community has also suffered a toll sustaining constant threats, robberies, kidnappings and even deaths (ICRC staff killed in Ituri, 2001). As a result DRC numbers few aid organizations and even these have found it difficult to attract and keep international staff, leaving them reliant on local staff whose number is also limited due to the lack of recent educational opportunities.

### 2.2. Current Situation

The last twelve months have been fraught with incidents and setbacks both humanitarian and political but despite these significant progress has been made.

Clashes in N.Kivu at the turn of the year did not augur well. Dissident "rwandophone" RCD-G troops attacked GoDRC positions. This put ethnic issues back at the top of the agenda and threatened to drag in neighbouring countries. Considerable international pressure brought the situation under control but not before tens of thousands of civilians had been displaced and put in need of assistance.

By February problems had flared up again in Ituri. Conflict between Hemas and Lendus not only led to civilian casualties and displacement but to open clashes with MONUC. Nine Bangaldeshi peace keepers were brutally murdered by rebels leading to a protracted conflict between MONUC and the rebels, which continue to this day, causing continuous civilian displacement and suffering and preventing NGOs gaining humanitarian access. New IDP camps were spontaneously established in Gina, Tche and Tchomia but have proven difficult to service due to the insecurity. In June two MSF staff were kidnapped resulting in the withdrawal of MSF from Ituri (soon followed by Solidarité).

In S.Kivu it has been the Hutu militia of the FDLR that have been the major problem. Initially negotiations under the auspices of San Egidio, the catholic church-based reconciliation body, seemed to have set the stage for the FDLR to disarm and demobilize but the hope was short lived. Hard-line factions rejected the agreement and have since committed a series of brutal massacres in villages surrounding Bukavu. MONUC has engaged them but has been unable to fully contain them. A final deadline to disarm came and went on the 30 September.

Squeezed by a more aggressive MONUC in the Kivus the various armed factions have taken to N.Katanga where clashes have recently increased, with reports of a deteriorating situation for civilians. MONUC has requested reinforcements to deploy in this area.

In a bid to tackle the various rebel threats, units made up from the various former factions and the old FAC army have been cobbled together in a process of 'brassage' to form a new force – the FARDC. Unfortunately the FARDC is poorly trained, poorly led and rarely paid, leaving it more often looting and raping civilians than fighting rebels. It is arguably one of the top causes of insecurity and humanitarian problems.

Having seen off a putative coup in February the transitional government was next faced with having to prolong its tenure for a further six months on the 30th June. This

threatened to cause a major uprising but eventually the extension was achieved with minimal violence. Nonetheless, tensions rose forcing a down-turn in activities, which delayed a number of programmes. The relative calm was put down to the successful initiation of the electoral registration process in mid-June. So far some 15 million people have registered in what is seen as major step forward. It is hoped that this will allow a referendum on the constitution before the end of the year and the elections before June 2006.

Building on the success of the electoral registration process, the second half of the year has seen the International community bring increasing weight and funds to bear on achieving success in DRC. It has encouraged vital electoral laws to be passed and increased its financial support for the electoral process; pushed on the DDR programme and committed itself to assisting the reform of the police and the armed forces. MONUC is taking a far more aggressive stance in the East against rebels and the US sponsored tri-partite (plus one) commission (Uganda, Rwanda, DRC and now Burundi) has kept the former belligerent neighbours concentrated on coordinated and legal solutions (e.g. extraditions) to the intricate lattice of rebel factions that threaten them in each other's countries. As such the successful outcome to the elections in Burundi has undoubtedly been a terrific boost to regional stability.

According to the IMF the economy of the DRC has at last been growing although this may be difficult for many Congolese to see. Certainly international development aid is beginning to pick up with several donors committing and programming new funds. The World Bank and the EC are in the process of launching social development programmes that will total over USD 1,400 million. The UN is about to launch an Action Plan covering humanitarian and transitional needs that will appeal for over USD 800 million.

## 3. IDENTIFICATION AND ASSESSMENT OF HUMANITARIAN NEEDS

The assessment of humanitarian needs is an on-going business in Congo in that the humanitarian community has been present in the country for several years and continuous assessment is an integral part of its mandate. DG ECHO also maintains a team of four experienced technical assistants in DRC who constantly make their own assessments and liaise with partners in the field to enhance our understanding of the needs in the country.

OCHA has taken on a specific role in determining the humanitarian needs in DRC. They lead an annual exercise to assess the needs, define the response strategies, establish the required capacities and finally calculate the costs. Formally known as the Consolidated Appeal Process it has now become a more dynamic and more inclusive Action Plan. A draft has yet to be published for 2006.

As OCHA discovered in its recent assessment mission for their Action Plan obtaining a snapshot of the humanitarian situation in such a vast country is not easy. Also much of the often quoted information is either old, or unsubstantiated. This is most problematical went it comes to the number of internally displaced people (IDP), where different figures vary by up to a million here or there. As such DG ECHO prefers to consider IDP figures at a level whereby they present themselves as concerning a population group in urgent humanitarian need and that has been specifically assessed. Often displaced people manage to survive on their own coping mechanisms and only require assistance when these are exhausted, or when they have just moved or returned. The latter two are clearly the most obvious and subsequently the easiest to assess. Keeping informed on the former

is more nuanced but can be achieved by nutritional, food security and market surveys, or often just by having a long-term presence and keeping in touch with communities, all of which are employed by DG ECHO and its partners.

Refugees under the care of UNHCR are normally registered individually and we believe that the published figures are a fair estimation of their number (see table 1). Also as one knows their area of origin one can prepare their return. However there are refugees that have not registered with UNHCR who could number in the hundreds of thousands (maybe up to 300,000 in Tanzania) and of whom little is known.

| **Country** | **Registered Refugees** | **DRC Main province of return** | **2005 Spontaneous return** | **2005 Organized Facilitated return** | **2006 Planning returnee figures** | **2007 Planning returnee figures** | **Total** |
|---|---|---|---|---|---|---|---|
| Angola | 14,000 | Katanga | 300 | | 1,600 | 1,600 | 3,500 |
| Burundi | 30,000 | N/S Kivu | 2,000 | | 10,000 | 10,000 | 22,000 |
| CAR | 4,800 | Equateur | | 1,700 | 2,000 | | 3,700 |
| RoC | 58,000 | Equateur | | 24,000 | 30,000 | 4,000 | 58,000 |
| Rwanda | 48,000 | N/Kivu | 3,000 | | 10,800 | 20,000 | 33,800 |
| Sudan | 1,500 | Orientale | | | 1,500 | | 1,500 |
| Tanzania | 154,000 | S/Kivu | 5,000 | 15,000 | 35,000 | 65,000 | 120,000 |
| Uganda | 19,000 | Orientale | | | 6,500 | 6,500 | 13,000 |
| Zambia | 60,000 | Katanga | 10,000 | | 20,000 | 16,000 | 46,000 |
| Southern Africa Countries | 37,700 | Katanga, Kivu, Kinshasa | 2500 | | 5,900 | 5,900 | 14,300 |
| | | | | | | | |
| Total | **433,000** | | **22,800** | **40,700** | **123,300** | **129,000** | **315,800** |

**Table 1. UNHCR REFUGEE FIGURES DRC 2005**

IDPs , refugees and the host communities generally have similar classic requirements: Physical security, access to clean water, an energy supply, food until they can grow, or buy their own; seeds and tools to grow their own food, shelter and a minimum healthcare package. Also and particularly in Congo there is often a need to repair the roads that lead to populations in distress, or to the villages of return, or even to vital markets.

Health needs come essentially in three categories. Firstly there are the recurrent epidemic emergencies such as, measles, plague, cholera and at times the more sinister hemorrhagic viruses (Ebola Marburg etc). Secondly there is the need to re-establish and sustain access to minimum health services providing basic curative and preventive care. Thirdly there are the specialized needs of women (and men) victims of sexual violence. Of note in 2005 was that DRC introduced (wisely) the new ACT treatment for malaria which costs USD 1.5 per treatment and therefore adds some 10% to curative health budgets.

The various macro-development surveys, such as the UNDP human development index, show that DRC, as a whole, is in desperate need in almost every conceivable sector. The OCHA action plan also highlights that there are desperate needs across the whole country. However as the IRC mortality survey and the more recent MSF survey show, the most life threatening situations are to be found in the areas of highest insecurity i.e in the East. Whereas development donors and the government itself can now begin to tackle the dire problems in the more secure areas it remains incumbent upon DG ECHO and its partners to tackle those in the insecure areas namely in: Ituri, the Kivus, Maniema and N.Katanga.

- Needs per region:

Ituri :

Despite its reputation large parts of Ituri have returned to normal and are able to re-accommodate those populations that had fled. More than one hundred thousand have returned this year and a further hundred thousand are set to return in 2006. Unfortunately some 50,000 have had to flee renewed fighting and require emergency assistance. Another approximately one hundred thousand remain displaced and in a semi-self-sustained situation that requires monitoring and potentially intermittent assistance. The whole district needs basic health support and road repairs.

N. Kivu :

Much of the province now enjoys a degree of stability but sporadic clashes still cause displacement of populations. N.Kivu is also host to several thousand IDPs from Ituri who live precariously with host families. Their condition is monitored and at times they require assistance. Finally there are large parts of North East N.Kivu that are under the control of the FDLR, or other renegade rebel groups. The populations in these areas live in difficult conditions but are impossible to access. At times due to changing military circumstances (MONUC operations) these areas become accessible and require urgent assistance. These areas are becoming fewer but they still concern tens of thousands of people. Paradoxically N.Kivu already enjoys a certain amount of development assistance with much of the province already covered for healthcare by development donors.

S.Kivu :

Much of the urgent need in DRC is concentrated in South Kivu. Not only does the province suffer from a significant presence of rebels and uncontrolled armed factions but it is also the area of origin of the greatest number of refugees on top of its due share of IDPs.

The area to the west of Bukavu, around Walungu, is still the scene of constant attacks, with the killing of villagers, rapes, kidnappings and the looting and destruction of property. This will require continuous classic emergency intervention.

To the south of Bukavu, from Uvira to Fizi, is the zone to which most of the refugees in Tanzania will return. This area has been particularly heavily damaged during the war and requires basic rehabilitation assistance. UNHCR expects to repatriate 30,000 refugees to S. Kivu in 2006. Also as S.Kivu is still ‘off the radar’ for most development agencies,

many essential services such as health and education will continue to need DG ECHO support.

N. Katanga :

This traditionally neglected area suffered considerable damage during the war but is now set to receive returning refugees from both Tanzania and Zambia. DG ECHO has established a basic health infrastructure, which it will hopefully hand over to DG DEV/AIDCO in June 2006 but there are still urgent basic infrastructure and food security needs that are required to accompany the refugee and IDP return. The total returnee number is estimated at 60,000.

- **Other specific needs.**

Refugees.

Refugee returns – UNHCR has estimated that it will repatriate some 123,000 refugees to RDC in 2006 and require a budget of USD 75 Million.

Manioc Mosaic Virus

Manioc (cassava) is the staple throughout the sub-region. In the last two years the mosaic virus that shrivels the plant and tuber has spread from Uganda through Rwanda, Burundi and DRC. It is a major threat to food security in the region and thus to life itself. Resistant strains exist and need rapid introduction.

Air Transport.

With 17 air crashes since the beginning of the year DRC represents almost 25% of the world's air disasters and unfortunately walking is not an option. In view of this safe air transport for humanitarian personnel is essential.

Coordination.

With a humanitarian crisis of such complexity covering such a large country coordination is vital. UNOCHA has provided real value added in this department and a need for their continued service is obvious.

## 4. PROPOSED DG ECHO STRATEGY

### 4.1. Coherence with DG ECHO´s overall strategic priorities

The Strategy for Congo is coherent with DG ECHO's overall strategy. In a country that is amongst the neediest in the world, be it measured by GINA score, or in avoidable mortality, DG ECHO's assistance is necessarily **needs based**. DG ECHO has focused its resources on the most **vulnerable groups** in the worst affected areas. Amongst the most vulnerable, DG ECHO has specifically targeted **children** less than five years of age with nutrition and MCH/EPI programmes. Assistance to **women** will be a particular concern of this programme, with continued support to specialised obstetric care and special programmes to assist victims of sexual violence in conflict areas.

A feature of the Commissions work over the last few years has been tackling the problem of **LRRD** (Linking Relief to Rehabilitation and Development). In Congo this has been a priority with particularly close co-operation between DG ECHO and the other Commission services. Health programmes that have been resuscitated by DG ECHO during the conflict period are being brought back into the mainstream MoH health service with long-term funding from the EDF or the World Bank. Four major programmes will be passed on at the end of 2005 as planned and another four will go in Mid-2006. Work will now concentrate on **LRRD** for those areas where populations have successfully returned but need further socio-economic re-integration to become fully self-sufficient.

Finally, in certain quarters DRC is considered a **forgotten crisis**. This is not the case with DG ECHO where DRC has featured in the top three recipients of assistance for several years or with the Commissioner himself, who has taken particular and obvious interest in the Great Lakes region.

### 4.2. Impact of previous humanitarian response

The Commission adopted a Global Plan for 2005 of EUR 38 million. At the time of writing 95% of this has been contracted and 99.5% has been allocated.

The Budget needed minor adaptations including the commitment of the reserve. This reflected the need to provide additional logistic support.

The figures below are a reflection of the results of 2005 programmes at roughly the 2/3 point.

*Health:*
Catchment 8,076,000 Total

| | Target | Achieved | % |
|---|---|---|---|
| Zones de Santé covered | 87 | 87 | 100 |
| Direct beneficiaries curative (million) | 4.4 | 3.9 | 88 |
| Average cost-per-beneficiary (€) | 3.5 -5 | 5.5 | +14% |

*Food security, nutrition and resettlement*:

| | Target | Achieved | % |
|---|---|---|---|
| Therapeutic feeding | 8569 | 6,700 | 80 |
| Supplementary feeding | 25,000 | 28.511 | 116 |
| Food, seeds and tools | 1,00,000 | 750,000 | 75 |
| Road rehabilitation (km) | 400 | 320 | 80 |

- **Analysis of 2005 activities.**

In terms of 'quantitative' achievements the programme is proceeding very positively and appears on target but behind the figures we have seen undeniable problems. These are:

- A certain slowness in the completion of infrastructure programmes due to difficulties in procurement and logistics; administrative harassment and continued disruptions due to insecurity.

- A less than anticipated health service usage. On discussion with the partners it was realised that many were setting their target of 0.6 new cases per patient per year just on the catchment area of the health **structures** they supported and not on the potential catchment area of the whole health **district** (not all health districts have an ideal number of clinics so that some clinics are intended to cover larger than normal areas). When one adjusts figures to measure the effective coverage the new case rate is 0.49 well below the 0.6 targeted. This implies that people are not travelling more than a certain distance to get healthcare.

- Most disappointing have been recent surveys that show that the mortality figures across the country are still totally unacceptable (MSF survey 2005). In DG ECHO funded areas this reflects problems of physical access to health centres (not enough centres) and quality of care (lack of qualified personnel). Unfortunately this is less a question of a lack of immediate financial resources but more a problem of too few partners for such a large country, limitation of logistics and limitations in the number and quality of local personnel. In areas covered by development donors blame has been put on excessive cost recovery. There is also a direct relation between high mortality and insecurity.

- Although surveys are showing that malnutrition figures overall are dropping it is noticeable that children, or rather their mothers/carers, are not using the centres. This is due to insecurity and to the obligation to stay in the centre for one month (to the detriment of their other commitments). As such DG ECHO is piloting a new home based therapy regime.

On the other hand there have been real successes:

- The infrastructure and food security programmes have had a very positive impact both qualitatively and particularly in terms of local appreciation. They have introduced seeds and tools and demonstrated how to introduce new crops and small animals. This has not only been very popular but has brought down malnutrition figures and helped over 150,000 returning families to re-establish their livelihoods.

- Road rehabilitation has been one of the most successful activities. It has brought communities together and thus promoted reconciliation; it has opened areas to assistance and then subsequently to markets and it has put money salary, or food for the building work (whichever was more necessary) into peoples hands and re-given them purchasing power, pride and dignity.

## 4.3. Coordination with activities of other donors and institutions

- ***Commission: DG DEV/EuropeAid***

In December 2004 the mid term review process of the 9th European Development Fund resulted in an additional allocation of EUR 270 million. This brought the total allocation to EUR 489 Million.

The net result of these changes will be an increase of EUR 200 million in the A-envelope covering programmed assistance (including an EUR 80 million package earmarked for healthcare) and of EUR 70 million in the B-envelope for non-programmed assistance. DG ECHO has been closely associated with the identification process for the new funds during the first half of 2005

| | 9th FED plus unspent previous FEDs | After mid- term review | Difference |
|---|---|---|---|
| | EUR | EUR | EUR |
| Envelope A | 188.604 285 | 388.604.285 | + 200.000.000 |
| Envelope B | 30.900.000 | 100.900.000 | + 70.000.000 |

The additional EUR 80 million for health will become available in the new year and target North Kivu, Oriental and the Two Kasais.

EUR 65 million of the so-called B-envelope funds are being allocated to a programme that has been specifically entitled Linking Relief to Rehabilitation and Development in Easter DRC. It will cover roughly the same area as DG ECHO does now i.e Ituri , the Kivus, Maniema and N. Katanga. The programme will fund activities in the following sectors: Land Management, Capacity building; Infrastructure; Social development and Economic revival. The programme is in the process of being approved and is set to launch in the first half of 2006. Its health component is set to take over DG ECHO's programmes in N. Katanga.

Amongst its more traditional cooperation programme the Commission is also supporting the Election process, Security Sector Reform, the Disarmament and Demobilisation and Re-integration

- ***Other donors and institutions: Good Humanitarian Donorship (GHD) and the AP***

DG ECHO has fully supported the role of the UN Humanitarian Coordinator (Ross Mountain) as the main focus for humanitarian coordination in DRC. Together with OCHA, the HC has played an extremely positive role in pushing forward the humanitarian agenda and providing fora for donors and partners to meet and coordinate their activities. They have been responsive to donor concerns about the 'non-inclusiveness' of the CAP and developed a more inclusive exercise - the Action Plan (AP). DG ECHO and other donors fully participated in defining the broad principles and strategy of the Action Plan. Its details are being tackled in the field (where they should be) as DG ECHO has long now pushed for. The advantage of the AP is that it will/should

match the needs with the capacities and thus highlight gaps and as it will be continuously up-dated, it will be a dynamic document.

DRC has been a pilot project for Good Humanitarian Donorship (GHD) chaired by B and the US. Much has centered on the UK pooled funding initiative, whereby their funds for the UN are combined with those of SE, IE, CN and NL and channeled through the HC. DG ECHO and the US do see the advantage of the HC having a limited emergency fund at his disposal but feel that donors should target their assistance to best meet the needs *themselves* and in coordination with UNHC and UNOCHA.

Since the beginning of its intervention in DRC, DG ECHO has been very conscious that it could become involved there for ever such are the needs. DG ECHO has thus concentrated on walking a tightrope between applying a pointless 'band-aid' and getting involved in long term development. Crucial to keeping the balance was to build a relationship with the development donors so that an understanding could be reached whereby DG ECHO held on long enough and prepared the ground in such a way, that the development donors could take over as appropriately and as effectively as possible. Thus DG ECHO has built up such a good relationship with the World Bank and the other Commission services that it should eventually allow for the handing over of at least 8 programmes, covering the needs of some 5 million people,.

Unfortunately the Health Action in Crisis (HAC) initiative that was launched by WHO to improve health coordination and responses to health problems in crisis countries has not got off to a very dynamic start. Recruitment problems have meant that the programme has not developed as planned and thus provided little value added in DRC.

DG ECHO held a food security workshop for partners in Goma in September and a more general partner meeting to discuss the 2006 strategy in Brussels in October. Of particular concern to partners were the continued insecurity and administrative harassment and the fear that LRRD would not proceed smoothly resulting in funding gaps.

### 4.4. Risk assessment and assumptions

The main risks and assumptions associated with the proposed programme are primarily linked to the political process. If the considerable pressure already being exerted by the international community through the CIAT, MONUC and successive Security Council Resolutions fails to deliver the desired political outcomes (notably the organisation of elections and a successful democratic transition in 2006), it is unlikely that the large-scale transitional and development funding now being programmed will be deployed. Indeed, a serious breakdown of the internal political process, or a further escalation of instability generated by the still fragile situation in the Greater Kivu region, would result in most LRRD programming being revised substantially downwards, and plans for DG ECHO's phased withdrawal being reviewed.

Conversely, a rapid acceleration of the stabilisation process could see a greater, or more sudden than expected return movement, particularly with regard to the repatriation of DRC refugees from Tanzania and Zambia respectively to South Kivu and Katanga provinces. Abrupt, large-scale repatriation might well overwhelm the existing community-based capacity already supported by DG ECHO. Under these circumstances, further funding may be required on an ad hoc or emergency basis.

## 4.5. DG ECHO Strategy [1]

Principal objective : Mortality and morbidity rates among the targeted population groups are contained within emergency thresholds and the resettlement and stabilization process is supported where possible through appropriate integrated and coordinated activities.

Geographical focus:

DG ECHO will focus its attention almost exclusively on ***the east of the country in 2006*** (see annex 2 for map)

- Areas still affected by, or just emerging from conflict: Ituri and the Greater Kivu area (North Kivu, South Kivu and Maniema) and parts of North Katanga.

***DG ECHO will withdraw from the a***reas formerly affected by conflict, stabilising since 2002: former Lusaka front-line (part of Equateur, the Kasais and Katanga).

- There will be a specific hand over of health programmes in Equator and S.Maniema to the World Bank at the of end 2005 and in Kasai and N. Katanga to the EC FED in the first half of 2006

DG ECHO will continue to support an emergency health response programme covering the whole country and support through UNHCR a national refugee return programme.

In line with the strategy developed and progressively refined over the last few years, the following main sectors of intervention are proposed for 2006:

***Specific objective 1: healthcare*** **(EUR 15.550 million*).*** The population of targeted health zones has **equitable access** to a minimum package of basic healthcare, with special emphasis on women and children.

Public health administration in DRC: DG ECHO support to the health sector in DRC is channelled through the existing public health network; no parallel structures will be funded, with the exception of temporary interventions in emergency situations. The DG ECHO health programme is articulated through the decentralised administrative entity of DRC's public health system, the health district or *Zone de Santé* (ZS), its facilities and personnel. The ZS is administered by a *Bureau Central de Zone* (BCZ), run by the *Médecin Chef de Zone* (MCZ). There are 515 ZS. However, DG ECHO funds will not be used for the construction of new hospitals or BCZ premises. Healthcare partners funded by DG ECHO in DRC must conclude a Memorandum of Understanding (MoU – *Protocole d'Accord*) with each ZS. The MoU must clearly set out the undertakings and entitlements of all parties, in particular specifying the facilities to be supported, the

[1] Grants for the implementation of humanitarian aid within the meaning of Council Regulation (EC) No.1257/96 of 20 June 1996 concerning humanitarian aid are awarded in accordance with the Financial Regulation, in particular Article110 thereof, and its Implementing Rules in particular Article168 thereof (Council Regulation (EC, Euratom) No 1605/2002 of 25 June 2002, OJ L248 of 16 September 2002 and No 2342/2002 of 23 December 2002, OJ L 357 of 31 December 2002). Rate of financing: In accordance with Article169 of the Financial Regulation, grants for the implementation of this Decision may finance 100% of the costs of an action.
Humanitarian aid operations funded by the Commission are implemented by NGOs and the Red Cross organisations on the basis of Framework Partnership Agreements (FPA) (in conformity with Article 163 of the Implementing Rules of the Financial Regulation) and by United Nations agencies based on the Financial and Administrative Framework Agreement (FAFA). The standards and criteria established in Echo's standard Framework Partnership Agreement to which NGO's and International organisations have to adhere and the procedures and criteria needed to become a partner may be found at http://europa.eu.int/comm/echo/partners/index_en.htm

services to be provided, the user fees (tariff) to be applied, the utilisation of income from fees, the frequency and type of supervision, and the level of performance-related incentives paid to healthcare staff.

Beneficiaries: partners are provided with detailed explanations of the concepts of coverage, catchment population, and direct beneficiaries, and clear instructions (with examples) of how to calculate them. The current 83 health zones targeted by DG ECHO will reduce to 42 in the first half of the year then go down to 25 for the second.

Curative primary healthcare: the vast majority of disease episodes in DRC can be addressed at health centre (*Centre de Santé* – CS) level, where nurses diagnose and treat common pathologies. The main focus of DG ECHO's healthcare programme is therefore on this, peripheral level; proximity and access are the programme's watchwords. However in view of health survey results for 2005 DG ECHO will encourage further training and consider an increase in the number of clinics per zone. User fees will also be re-appraised with the possibility of further reductions.

Preventive primary healthcare: this category includes all Mother and Child Healthcare (MCH) activities at CS level. Activities include: ante-natal clinics, or *Consultaitons Pré-Natales* (CPN) and assisted deliveries; pre-school clinics or *Consultations Pré-Scolaires* ("CPS"), incorporating the *Programme Elargi de Vaccination* ("PEV" – Extended Programme of Immunisation or EPI).

Referrals: According to the 2004 evaluation, "less than 10% of patients referred from HCs actually reached the hospital." Consequently, hospitals are "under-used, with a rate of below 0.01 hospitalisations per capita per year:" HGRs tend to be run as private enterprises serving the affluent urban elite – the people who least need DG ECHO's support.

Cross-cutting components: sexual and reproductive health and malaria prevention activities will be integrated vertically into all healthcare programmes supported by DG ECHO in DRC as follows:

- Free CPN (ante-natal) clinics available to all comers in all supported facilities
- Systematic preventive treatment in CPN: anaemia, tetanus, malaria prophylaxis
- Reproductive health awareness (contraception, STDs and AIDS prevention methods)
- Condoms distributed to beneficiaries of CPN clinics and – on request – to all comers
- Demonstrations of hygiene and malaria prevention procedures in CPN clinics
- Distribution of long-life impregnated bednets to all beneficiaries of CPN clinics
- Safe blood transfusions guaranteed in referral facilities of all supported ZS

In keeping with the new MoH policy and in coordination with WHO and other health partners DG ECHO has decided to introduce the new Arthemisin based combined therapy (ACT) for malaria treatment. The improved effectiveness of this drug over the old Fansidar is so dramatic and the mortality and morbidity rates for malaria in DRC are so high that the introduction of ACT is essential. All MoH protocols will be respected with respect to this introduction.

In ZS with a high incidence of sexual violence (notably the Greater Kivu area), DG ECHO will support partners with the necessary skills and capacities for the following additional activities:

- Screening and treatment (including ARVs and "morning-after" pills for patients seen in time) for victims of sexual violence in appropriately trained and equipped facilities
- Referral system (transport included) for corrective surgery of serious cases
- Community-based counselling services
- Half-way houses for patients in recovery

Unit costs: for programming and project appraisal purposes, DG ECHO uses two key unit costs, the overall (i) cost-per-beneficiary and the (ii) cost of drugs and consumables per new contact. Healthcare programmes funded by DG ECHO in DRC in the last five years have on average fallen within a bracket of 3-6 EUR/beneficiary. The cost of treating each disease episode in terms of drugs and consumables has been between 0.7 – 0.9 EUR per episode but will now rise an additional 5 – 10% due to the introduction of ACT which costs 1.5 Eur per treatment.

Drug procurement

In line with Article 1.2 of the General Conditions of the Framework Partnership Agreement (FPA) (enjoining partners to endeavour to use local human and material resources), it is the policy of the Commission and other donors in DRC to promote the development of the fledgling national network of regional drug procurement centres (*Centres de Distribution Régionaux*, CDRs). Partners are of course required to follow rigorously the rules and procedures applicable for the awarding of contracts and procurement of goods in the context of humanitarian aid operations as laid down in Annex V of the FPA, and in line with the Financial Regulation.

User fees: in the interests of promoting ownership and laying the basis for a sustainable handover of maturing humanitarian programmes to long-term development instruments, DG ECHO will concur with the practice of charging fees to the beneficiaries of its healthcare programme in DRC, on the following conditions:

- User fees will take the form of a lump-sum tariff levied for all curative primary healthcare "episodes".[2] Lower rates will be set for children up to 15 years of age.
- Tariffs will be determined not in relation to the real cost of providing the service concerned, but on the basis of the purchasing power of the beneficiary community.
- Individuals the community considers *indigents* will be treated free of charge.
- All MCH preventive healthcare (CPN, CPS, EPI) will be provided free of charge to all comers.

It is the responsibility of each partner to negotiate, set and monitor the user fees at levels which ensure the beneficiary community has economic access to the healthcare services

[2] Comprises: consultation, laboratory analysis and prescription. No differentiation between the component parts (e.g. between "consultation charges" and the cost of the drugs) will be permitted.

provided. Tariff levels will vary considerably from region to region and from time to time and can be waived entirely if need be.

Healthcare partners have also received a standard framework for DG ECHO programmes in DRC, identifying the minimum quantity and quality indicators to be addressed by proposals and reports. Amongst these will be the measurement of mortality as a performance indicator.

***Specific objective 2: resettlement (EUR 20.5 million).*** Displaced, resettling and host families receive an integrated package of community-based assistance designed to respond to immediate needs while paving the way for a rapid return to productive activity and thus contributing to the stabilization of conflict –affected areas.

With respect to refugees, DG ECHO will support UNHCR to accomplish the process of their physical repatriation to DRC and obviously to secure their protection. However, DG ECHO will support rehabilitation activities directly through traditional executing partners in order to promote a community-based approach to the re-installation.

The different activities under this objective may appear disparate but experience has shown that displaced populations have similar needs and require a 'back to self-sufficiency' package whose different elements are all inextricably linked:

(a) Essential relief items: family kits of non-food items (blankets, cooking sets, etc) providing emergency assistance to the displaced and support to resettling families who will have had these items looted.

(b) Food security and nutrition: targeted communities affected by or recovering from conflict and displacement are provided with appropriate agricultural inputs and – in the case of those awaiting their first harvest – temporary food rations, with additional targeted feeding programmes for acutely malnourished children. Partners will be expected to formulate programmes that take into consideration the realities of the local markets and give maximum choice to beneficiaries (e.g. seed fairs etc). Bulk food stuffs will be provided by WFP.

DG ECHO and its partners will continue to pilot the new community based therapeutic feeding technique in a bid to increase the coverage of its nutritional programmes. The results will be shared with UNICEF and the MoH in order to reconsider the current national policy.
DG ECHO will pay particular attention to the introduction of mosaic virus resistant strains of Cassava that have been approved by GoDRC and FAO.

(c) community-based rehabilitation:

- *local roads:* using labour-intensive methods to reopen roads and allow agricultural production to circulate again while providing an immediate fillip to the local economy through cash-for-work .
- *social infrastructure:* small-scale projects to reopen looted or destroyed schools, health centres and water distribution systems are "plugged into" the road as it advances in order to encourage resettlement. Labour and bulk raw materials are provided free by the community, technical supervision, equipment and specialist materials (from roof timbers to school books) by DG ECHO.

(d) Mine clearance: ad hoc professional humanitarian mine clearing will be provided to accompany emergency humanitarian interventions and to resettlement activities (e.g. along roads or in the vicinity of social infrastructure to be rehabilitated).

(e) Air support: DG ECHO will fund a new dedicated humanitarian air service in DRC. It will respond to the highest international safety standards and will operate a priority based booking system. It will only have limited cargo capacity leaving a need that may require supplemental capacity on an ad hoc basis. However road improvements will hopefully reduce the need for some cargo to be flown.

***Specific objective 3: technical assistance (EUR 0.45 million).*** In order to maximise the impact of the humanitarian aid for the victims, the Commission decides to maintain a DG ECHO support office located in Kinshasa, Goma and Bukavu. These offices will appraise project proposals, co-ordinate and monitor the implementation of humanitarian operations financed by the Commission. An office provides technical assistance capacity and necessary logistics for the successful accomplishment of its tasks.

***Reserve (EUR 1.5 million):*** a 5*%* margin to provide for unforeseen contingencies and the flexibility to respond rapidly to increased access or implementation capacity in one or other sector or area.

### 4.6. Duration

The 2004 evaluation noted that, with many of the operations funded by this type of decision that comprises sophisticated healthcare projects, it is appropriate to plan individual projects over a 12-month timeframe. In line with this recommendation, and to avoid administrative bottlenecks, a staggered approach is proposed, with contracts being issued gradually throughout the first half of the year and beyond if necessary. Also the uncertainty of the political climate and the daunting task of overcoming the logistical hurdles presented by the lack of infrastructure have and are likely to cause significant delays in programme execution and completion. Consequently the implementation timeframe for this decision will be 18 months starting from 1 January 2006. Expenditure under this decision shall be eligible from 1 January 2006.
If implementation is suspended due to *force majeure* or any comparable circumstance, the period of suspension will not be taken into account in calculating the duration of the decision. However, should implementation remain suspended for more than one third of the planned duration of a given operation, the Commission reserves the right to cancel and liquidate the contract concerned. In this respect, the procedures established in the general conditions of the specific agreement will be applied.

### 4.7. Amount of Decision and strategic programming matrix

**4.7.1 Total amount of the Decision:** EUR 38,000,000

## 4.7.2. Strategic Programming Matrix

| **Principal objective** | *Mortality and morbidity rates among the targeted population groups are contained within emergency thresholds and the resettlement and stabilization process is supported where possible through appropriate integrated and coordinated activities.* | | | | |
|---|---|---|---|---|---|
| **Specific objectives** | **Allocated amount (EUR)** | **Geographical area of operation** | **Activities proposed** | **Expected outputs / indicators** | **Potential partners** |
| **Specific objective 1**:<br><br>The population of targeted Health Zones has equitable access to a minimum package of basic healthcare, with special emphasis on women and children. | **15,550,000** | Ituri ,<br>North Kivu<br>South Kivu<br>Maniema.<br>N. Katanga<br><br>Epidemics and Emergency response: Whole country | Curative primary healthcare<br>Full range of curative PHC activities carried out by Congolese healthcare staff in all supported ZS. DG ECHO partner provides drugs and consumables, and logistical and technical support (supervision and training). User fees are set at levels commensurate with the beneficiary community's revenues (nominal or zero if necessary), with no fees for *indigents*.<br><br>Preventive primary healthcare<br>All MCH activities at CS level, including CPN (with systematic malaria prophylaxis and bednets) and assisted deliveries, and CPS, incorporating EPI (PEV). Accelerated EPI campaigns in selected ZS. All preventive services provided free of charge.<br>Obstetric referrals. At risk pregnancies offered have access to hospital care<br><br>Safe Blood transfusion<br>Grouping and HIVTesting<br><br>Sexual violence<br>• Screening and treatment of victims of sexual violence in selected facilities<br>• Corrective surgery for serious cases Counselling and recovery services<br><br>Epidemic Response.<br>Epidemiological monitoring<br>Contingency planning<br>WHO HAC | General: access<br>• *Zones de Santé (ZS)* supported: 42 – 25 (after 6 months)°<br>• target utilisation rate (curative PHC) = 0.5 new contact/person/ year<br>• economic access: % of structures supported displaying and respecting tariffs = 100%<br>• Mortality Rates<br>adult< 1.5 /10,000/day<br>*<5 yrs < 25/10,0000/day*<br><br>Curative primary healthcare<br>• stockouts for sentinel drugs (antimalarials, mebendazole, paracetomol, amoxycilline) (average no. days/structure/month) = < 5<br>• % of joint training supervisions/no. of supervisions planned (1/CS/month) = 100%<br>• Protocols respected = 80%<br><br>Preventive primary healthcare<br>• % of health facilities with adequate latrines and clean water = 100%<br>• CPN utilisation (first session) = > 80%<br>• % attended deliveries/ expected no. of attended deliveries = 60%<br>• CPS utilisation = > 80%<br><br>Obstetric Referral<br>• theoretical referral rate: 0.02/PHC nc/yr.<br>• no. of caesarians performed/no. expected (catchment pop. x 4% x 7%): 80%.<br>Safe Blood Transfusion<br>% transfused blood tested for HIV and respecting indications = 100<br>Sexual Violence<br>• Number of cases treated.<br>Epidemic Response.<br>• case fatality cholera after week 1 of intervention = < 4 | - AMI - FRA<br>- CARE - FR<br>- CARITAS - BEL<br>- CHRISTIAN AID - UK<br>- COOPI<br>- CROIX-ROUGE - CICR- ICRC - CH<br>- CROIX-ROUGE - FRA<br>- GOAL<br>- IRC - UK<br>- MALTESER HILFSDIENST<br>- MDM - FRA<br>- MEDAIR UK<br>- MEMISA<br>- MERLIN<br>- MSF - BEL<br>- MSF - CHE<br>- MSF - ESP<br>- MSF - FRA<br>- MSF - NLD<br>- NOVIB<br>- PMU INTERLIFE<br>- PSF - FRA/CLERMONT-FERRAND<br>- SOLIDARITES<br>- TEARFUND - UK<br>- UN - UNICEF - BEL<br>- UNFPA<br>- WORLD VISION DEU |

| | | | | | |
|---|---|---|---|---|---|
| **Specific objective 2**:<br>Displaced, resettling and host families receive an integrated package of community-based assistance designed to respond to immediate needs while paving the way for a rapid return to productive activity and thus contributing to the stabilization of conflict-affected areas | **20,500,000** | **Whole country but concentrating in :**<br>Ituri ,<br>North Kivu<br>South Kivu<br>Maniema.<br>N. Katanga | • Nutrition: Implementation of therapeutic (TFC) and supplementary (SFC) feeding programmes in line with anthropometric evidence of global acute malnutrition (GAM) rates (normally > 10% among children < 5 yrs)<br>• Food security: Targeted distribution of food, seeds and tools to families with malnourished children, displaced families and their hosts, and other vulnerable groups<br>• Rehabilitation of local and agricultural feeder roads and social infrastructure (including water systems, health centres and schools) in areas of resettlement, using labour-intensive, community-based methods<br>• Distribution of non-food items and school kits to displaced and resettling communities<br>• Humanitarian demining<br>• Decentralised air transport support<br>• Support to protection<br>• Support to Coordination activities | Nutrition:<br>Supplementary feeding: 25,000 beneficiaries<br>Cure rate: > 80%<br>Duration of stay: =/< 90 days<br>Default rate: < 15%<br>Therapeutic feeding: 8000 beneficiaries<br>Cure rate: > 80%<br>Duration of stay: < 30 days<br>Mean weight gain (g/kg/d): > 10<br>Default rate: < 15%<br>Mortality rate < 5%<br><br>Food security and rehabilitation:<br>• Food, seeds and tools: 200,000 families (1.2 million individuals)<br>% families assisted planting: < 90%<br>av. surface area planted/family: > 900 m2<br>% families assisted harvesting: > 80%<br>av. yield /family assisted: 45 kg<br>GAM among children < 5 yrs in targeted areas contained at < 10%<br>Food basket monitoring: targeted families receive > 1100 KCal/p/d<br>• NFI kits: 57,000 families (285,000 individuals)<br>• Schools rehabilitated: 70<br>• Road rehabilitation: 450 km<br>• Water rehabilitation: 110,000 people have easy access to clean water<br><br>Air support<br>No of Pax/mile<br>Kg/ mile<br>NGO requests satisfied 80%<br><br>demining,<br>No of UXO destroyed.<br>No sites /Roads made safe.<br><br>Protection<br><br>coordination | - ACF - FRA<br>- ACTED<br>- ASF<br>- ASF-BELGIUM<br>- ATLAS<br>- AVSI<br>- CHRISTIAN AID - UK<br>- COOPI<br>- CROIX-ROUGE - CICR- ICRC - CH<br>- CROIX-ROUGE - DEU<br>- CROIX-ROUGE - FRA<br>- GERMAN AGRO ACTION<br>- GOAL<br>- IOM<br>- IRC - UK<br>- MAG - UK<br>- MALTESER HILFSDIENST<br>- NORWEGIAN REFUGEE COUNCIL<br>- OXFAM - BEL<br>- OXFAM - UK<br>- PREMIERE URGENCE<br>- SOLIDARITES<br>- TEARFUND - UK<br>- UN - FAO-I<br>- UN - UNHCR - BEL<br>- UN - UNICEF - BEL<br>- UN - UNOCHA<br>- UN - WFP-PAM<br>- WORLD VISION DEU |

| | | | | | |
|---|---|---|---|---|---|
| **Specific objective 3**: DG ECHO maintains an appropriate field capacity to assess evolving humanitarian needs and devise coordinated responses, and monitor and evaluate the operations financed by the Commission. | **450,000** | Kinshasa<br>Goma<br>Bukavu<br><br>Covering whole country with emergency capacity for neighbouring countries | **Assessment**<br>**Monitoring**<br>**Evaluation**<br>**Coordination** | • Improved responses.<br>• Improved co-ordination.<br>• Regular Project Monitoring (at least one field visit per contractual period)<br>• Timely reporting and administrative dealing of contracts. | 4 persons. |
| **Risk assessment** | *Insecure environment in the East. Potential for security deterioration.* | | | | |
| **Assumptions** | *Development funds will be deployed in the course of 1st half 2006 that will take over.*<br>*Refugees will return as expected by UNHCR*<br>*Global security environment.will remain better or improve.* | | | | |
| **Reserve** | 1,500,000 | | | | |
| **Total cost** | 38,000,000 | | | | |

## 5. EVALUATION

Under article 18 of Council Regulation (EC) No.1257/96 of 20 June 1996 concerning humanitarian aid the Commission is required to "regularly assess humanitarian aid operations financed by the Community in order to establish whether they have achieved their objectives and to produce guidelines for improving the effectiveness of subsequent operations." These evaluations are structured and organised in overarching and cross cutting issues forming part of DG ECHO's Annual Strategy such as child-related issues, the security of relief workers, respect for human rights, gender. Each year, an indicative Evaluation Programme is established after a consultative process. This programme is flexible and can be adapted to include evaluations not foreseen in the initial programme, in response to particular events or changing circumstances. More information can be obtained at:

http://europa.eu.int/comm/echo/evaluation/index_en.htm.

## 6. BUDGET IMPACT ARTICLE 23 02 01

| - | CE (EUR) |
|---|---|
| Initial Available Appropriations for 2006 | 478,000,000 |
| Supplementary Budgets | - |
| Transfers | - |
| **Total Available Credits** | - |
| Total executed to date (by ..) | - |
| Available remaining | - |
| **Total amount of the Decision** | 38,000,000 |

## 7. ANNEXES

**Annex 1: Statistics on the humanitarian situation**
**Annex 2: Map of DRC and location of DG ECHO operations**
**Annex 3: List of previous DG ECHO operations**
**Annex 4: Other donors´assistance**
**Annex 5: List of abbreviations**

### Annex 1: Statistics on the humanitarian situation

Although HIV prevalence is relatively low in DRC ( The National HIV Prevalence Survey completed in 2004 found a 4.5 percent HIV prevalence rate in the DRC population of roughly 60 million.), the Congo's general health indicators are among the worst in the world. :

- DRC has the highest maternal mortality rate in the world: 1,289 deaths per 100,000 live births (World Bank, draft Health Rehabilitation Project, 2004)
- The fertility rate is 7.1, one of the highest in Africa (World Bank, ibid)
- The contraceptive utilization rate of 4%, among the world's lowest (World Bank, ibid)
- DRC has the fifth highest number of child deaths of any country in the world : 585,000 per year (World Bank, ibid))
- DRC has the ninth highest under-five mortality rate. The national average is 213 per 1,000 live births (World Bank, ibid), rising to 390/1,000 in eastern DRC (Merlin survey Maniema, 2003). The sub-Saharan average is 157 per 1,000 live births (Unicef, State of the World's Children, 2003).
- 30% of U5 mortality is attributable to malaria, meaning that around 300,000 children a year die from this treatable disease (World Bank)
- Measles vaccination coverage is 34% in the eastern provinces (Ministry of Health, 2003)

In terms of food security and nutrition indicators:

- The national global acute malnutrition rate is 16% (Ministry of Health, Plan d'Action 2004)
- Average calorific intake against minimum requirement of 2,300 Kcal/day is less than 70%. Average protein intake is only 50% of the required minimum. (OCHA/FAO, draft CAP 2005)

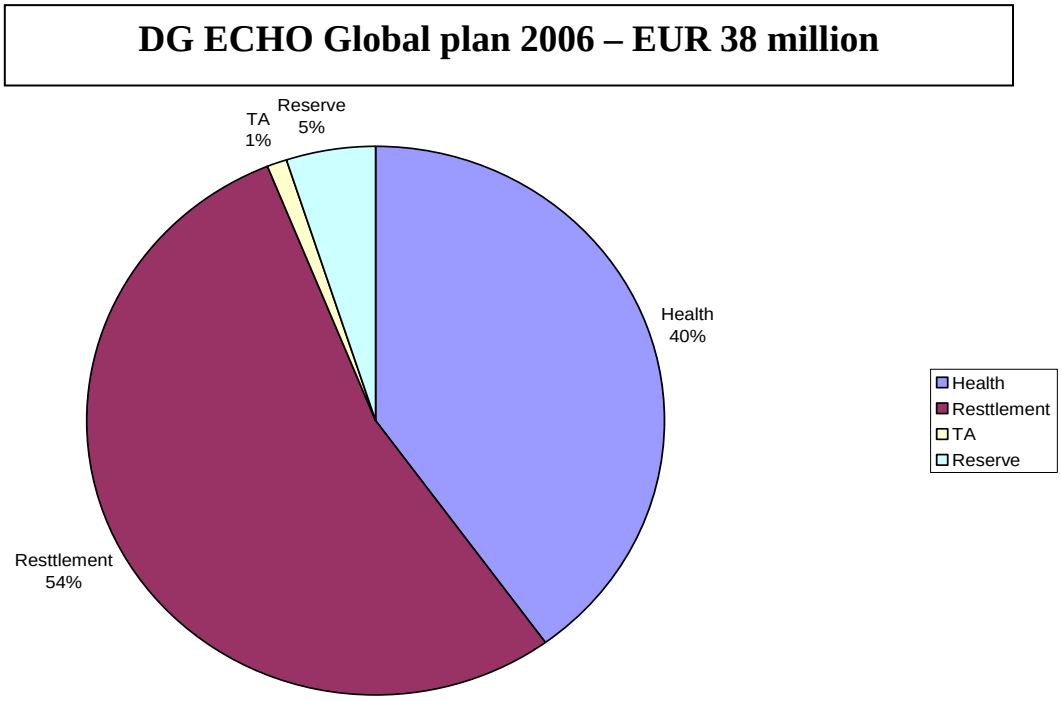
In terms of general and economic indicators:

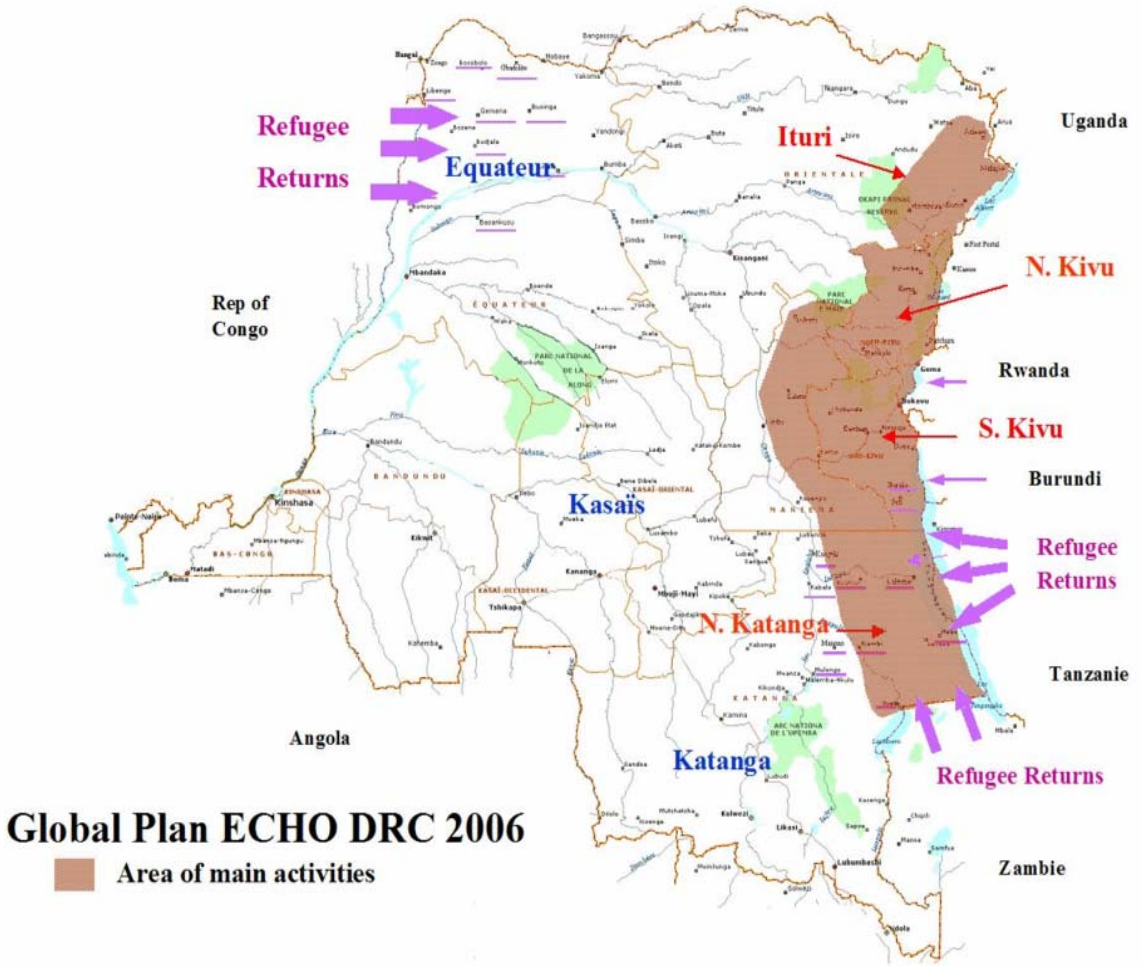
- There are still some 2 million internally displaced persons, plus around 390,000 refugees outside DRC (OCHA, draft AP 2006),
- GDP per capita (national average) was USD 96 in 2002, down from USD 167 in 1992 (World Bank, 2004). This is the equivalent of USD 0.26 a day, USD 1.85 a week, or USD 7.8 a month.
- 80% of the population lives on less than USD 0.5 a day (OCHA/FAO, draft CAP 2005)

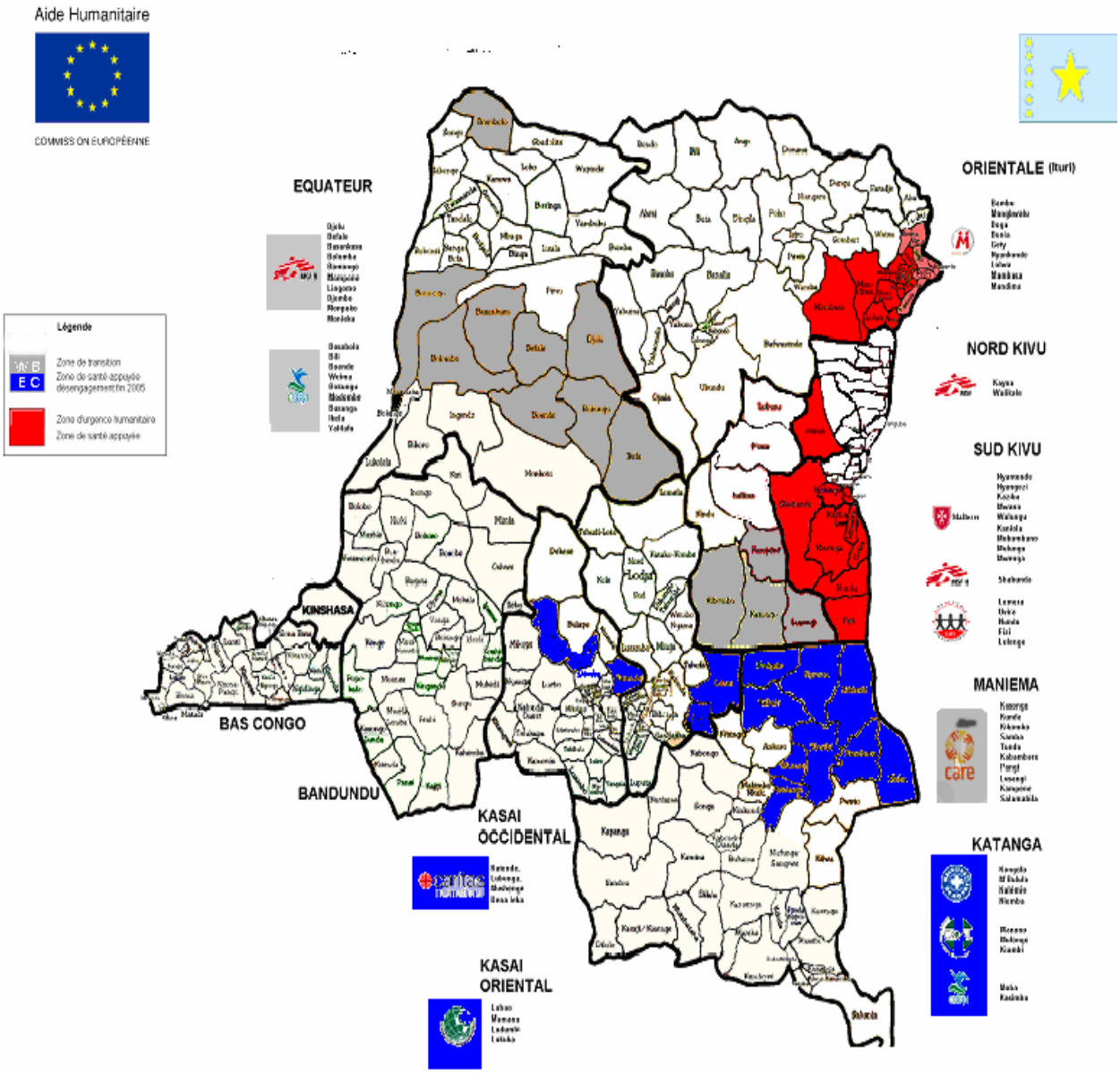
However according to the IMF ;

- Overall, real GDP grew by 6.8 percent in 2004; 12-month inflation fell to less than 5 percent by mid-2004 before rising to over 9 percent by December 2004 and further to 26 percent by end-May 2005.

## Annex 2: Map of DRC and location of DG ECHO operations






# ECHO Health Programmes DRC 2006

## Annex 3: List of previous DG ECHO operations

| List of previous DG ECHO operations in CONGO, DEMOCRATIC REPUBLIC OF | | | | |
|---|---|---|---|---|
| | | 2004 | 2005 | 2006 |
| Decision Number | Decision Type | EUR | EUR | EUR |
| ECHO/COD/BUD/2004/01000 | Global Plan | 40,000,000 | | |
| ECHO/COD/BUD/2005/01000 | Global Plan | | 38,000,000 | |
| | | | | |
| | | | | |
| | Subtotal | 40,000,000 | 38,000,000 | 0 |
| | Grand Total | 78,000,000 | | |

Dated : 14/10/2005
Source : HOPE

## Annex 4: Other donors'assistance

| Donors in CONGO, DEMOCRATIC REPUBLIC OF the last 12 months | | | | | |
|---|---|---|---|---|---|
| 1. EU Members States (*) | | 2. European Commission | | 3. Others | |
| | EUR | | EUR | | EUR |
| Austria | | ECHO | 38,000,000 | | |
| Belgium | 7,128,547 | Other services | | | |
| Cyprus | | | | | |
| Czech republic | | | | | |
| Denmark | 2,563,039 | | | | |
| Estonia | | | | | |
| Finland | 2,050,000 | | | | |
| France | 1,650,000 | | | | |
| Germany | 11,960,058 | | | | |
| Greece | | | | | |
| Hungary | | | | | |
| Ireland | 1,000,000 | | | | |
| Italy | | | | | |
| Latvia | | | | | |
| Lithuania | | | | | |
| Luxemburg | 219,080 | | | | |
| Malta | | | | | |
| Netherlands | 9,447,765 | | | | |
| Poland | | | | | |
| Portugal | | | | | |
| Slovakia | | | | | |
| Slovenie | | | | | |
| Spain | | | | | |
| Sweden | 7,234,570 | | | | |
| United kingdom | 18,417,080 | | | | |
| Subtotal | 61,670,140 | Subtotal | 38,000,000 | Subtotal | 0 |
| | | Grand total | 99,670,140 | | |

Dated : 14/10/2005
(*) Source : ECHO 14 Points reporting for Members States. https://hac.cec.eu.int
Empty cells means either no information is available or no contribution.

## Annex 5: List of Abbreviations

| | |
|---|---|
| **AAA** | Agro Action Allemande - a.k.a. Deutsche Welthungerhilfe and German Agro Action |
| **ACF** | Action Contre La Faim |
| **AIDCO** | EuropeAid – Co-ordination Office |
| **ALC** | Armée de Libération du Congo – armed wing of MLC |
| **ALIR** | Armée de Libération du Rwanda – alliance of ex-FAR, *interahamwe* and other Hutu groups |
| **AMI** | Aide Médicale Internationale |
| **ANC** | Armée Nationale Congolaise - armed wing of RCD-Goma |
| **APC** | Armée Patriotique Congolaise - armed wing of RCD-K/ML |
| **APR** | Armée Patriotique du Rwanda – see RPA |
| **ASF** | Aviation Sans Frontières |
| **ASII** | Assemblée Spéciale Intérimaire pour l'Ituri – temporary authority in Ituri |
| **AVSI** | Associazione Volutari per il Servizio Internazionale |
| **BCZ** | Bureau Central de Zone (de Santé) |
| **CAP** | Consolidated Appeal Process - UN fundraising instrument |
| **CDR** | Centre de Distribution Régional - provincial drug distribution centre |
| **CESVI** | Cooperazione e Sviluppo |
| **CHAP** | Common Humanitarian Action Plan - strategy/precursor of the CAP |
| **CIAT** | Comité International d'Accompagnement de la Transition |
| **CMR** | Crude Mortality Rate |
| **COSA** | Comité de Santé |
| **CPN** | Consultation Pré-Natale |
| **CPS** | Consultation Pré-Scolaire |
| **CS (-R-)** | Centre de Santé (- de Référence - ) |
| **DCA** | DanChurchAid |
| **DDR** | Disarmament, Demobilisation and Reintegration |
| **DG DEV** | Directorate General for Development |
| **DPKO** | UN Department of Peacekeeping Operations, responsible for MONUC operations in DRC |
| **DRC** | Democratic Republic of Congo |
| **DRC (ii)** | Désarmement et Réintégration Communautaire (Ituri precursor of DDR process) |
| **DWHH** | See AAA |
| **ECHO** | DG European Commission Humanitarian Aid. |
| **EDF** | European Development Fund |
| **EPI** | Extended Programme of Immunisation |
| **EU** | European Union |
| **FAO** | Food and Agriculture Organisation |
| **FAR** | Forces Armées Rwandaises – former Rwandan national army |
| **FARDC** | Forces Armées de la République Démocratique du Congo – transition government army |
| **FAPC** | Forces Armées du Peuple Congolais – mitilia controlling Aru and Mahagi, northern Ituri |
| **FCA** | FinnChurchAid |
| **FDD** | Forces pour la Défense de la Démocratie - Burundian rebel group |
| **FDLR** | Forces Démocratiques pour la Libération du Rwanda – Rwandan rebel group (see ALIR) |
| **FHI** | Food for the Hungry International |
| **FNI** | Front des Nationalistes et Intégrationnistes – Lendu militia in Ituri (Réthy) |
| **FPDC** | Forces Populaires pour la Démocratie au Congo – mainly Alur movement in Ituri |
| **FRPI** | Force de Résistance Patriotique en Ituri - Ngiti militia in Ituri |
| **GAA** | See AAA |
| **GINA** | Global Index for humanitarian Needs Assessment |
| **GP** | Global Plan |
| **HGR** | Hôpital Général de Référence |
| **ICC** | International Criminal Court |
| **ICD** | Inter-Congolese Dialogue |
| **ICRC** | International Committee of the Red Cross |
| **IDP** | Internally Displaced Person |
| **IOM** | International Organisation for Migration |

| | |
|---|---|
| **IRC** | International Rescue Committee |
| **LRRD** | Linking Relief, Rehabilitation and Development |
| **MAG** | Mine Action Group |
| **MCH** | Mother and Child Healthcare |
| **MDM** | Médecins du Monde |
| **MICS** | Multi-Indicator Cluster Survey |
| **MoU** | Memorandum of Understanding |
| **MLC** | Mouvement pour la Libération du Congo |
| **MONUC** | Mission d'Observateurs des Nations Unies au Congo |
| **MSF** | Médecins Sans Frontières |
| **MUAC** | Middle Upper Arm Circumference |
| **NFI** | Non Food Items |
| **NGO** | Non-Governmental Organisation |
| **NIP** | National Indicative Programme |
| **OCHA** | Office for Co-ordination of Humanitarian Assistance |
| **OFDA** | United States Office of Foreign Disaster Assistance |
| **PAR** | Programme d'Appui à la Réhabilitation |
| **PATS** | Programme d'Appui Transitoire à la Santé |
| **PHC** | Primary HealthCare |
| **PMA** | Paquet Minimum d'Activités |
| **PMI** | Protection Materno-Infantile |
| **PMU** | Pingstmissionens Utvecklingssamarbete-Interlife |
| **PPRD** | Parti du Peuple pour la Reconstruction et la Democratie – Joseph Kabila's party |
| **PU** | Première Urgence |
| **PUC** | Pool d'Urgence Congo |
| **PUSIC** | Parti pour l'Unité et la Sauvegarde de l'Intégrité du Congo – Hema militia in Ituri |
| **PSF** | Pharmaciens Sans Frontières |
| **RCD-G** | Rassemblement Congolais pour la Démocratie (Goma) |
| **RCD-ML** | Rassemblement Congolais pour la Démocratie-Mouvement de Libération |
| **RCD-N** | Rassemblement Congolais pour la Démocratie-National |
| **RDF** | Rwanda Defence Force (new name of FPA) |
| **RPA** | Rwandan Patriotic Army |
| **RPF** | Rwandan Patriotic Front |
| **SCF** | Save the Children Fund |
| **SFC/P** | Supplementary Feeding Centre/Programme |
| **SMI** | Santé Materno-Infantile (see MCH) |
| **SNIS** | Système National d'Information Sanitaire |
| **STD** | Sexually Transmitted Diseases |
| **TFC/P** | Therapeutic Feeding Centre/Programme |
| **UN** | United Nations |
| **UNDP** | United Nations Development Programme |
| **UNHCR** | United Nations High Commission for Refugees |
| **UNICEF** | United Nations Children's Fund |
| **UPC** | Union des Patriotes Congolais – Gegere (Hema) militia in Ituri |
| **UPDF** | Uganda People's Defence Force |
| **USAID** | United States Agency for International Development |
| **WFP** | World Food Programme |
| **WHO** | World Health Organisation |
| **WVI** | World Vision International |
| **ZdS** | Zone de Santé |

**COMMISSION DECISION**
**of**
**on the financing of humanitarian operations from the budget of the European Union in**
THE DEMOCRATIC REPUBLIC OF CONGO

## THE COMMISSION OF THE EUROPEAN COMMUNITIES,

Having regard to the Treaty establishing the European Community,
Having regard to Council Regulation (EC) No.1257/96 of 20 June 1996 concerning humanitarian aid[1] , and in particular Article 15(2) thereof,

Whereas:

(1) The Democratic Republic of Congo (DRC) is emerging from a period of conflict that has lasted since 1996, and parts of the country remain prey to different armed groups
(2) The years of fighting and its aftermath have prompted large-scale population displacement (3-4 million) and high mortality rates (> 2.5/1000/month) among the general population.
(3) The Commission's assessment of the situation leads to the conclusion that humanitarian aid operations should be financed by the Community for a period of 18 months,
(4) In order to maximise the impact of humanitarian aid operations financed by the Commission, it is necessary to maintain a technical assistance capacity in the field,
(5) It is estimated that an amount of EUR 38 000 000 from budget line 23.02.01 of the general budget of the European Union is necessary to provide humanitarian assistance to vulnerable population groups in DRC, taking into account the budget available, other donors' interventions and other factors,
(6) The present Decision constitutes a financing Decision within the meaning of Article 75 of the Financial Regulation (EC, Euratom) No 1605/2002[2], Article 90 of the detailed rules for the implementation of the Financial Regulation determined by Regulation (EC, Euratom) No 2342/2002[3] and amended by Regulation (EC, Euratom) No 1261/205[4], and Article 15 of the general budget of the EC [5].
(7) In accordance with Article 17 (3) of Council Regulation (EC) No 1257/96 of 20 June 1996, the Humanitarian Aid Committee gave a favourable opinion on 15/12/2005

HAS DECIDED AS FOLLOWS:

*Article 1*

1. In accordance with the objectives and general principles of humanitarian aid, the Commission hereby approves an amount of EUR 38,000,000 for humanitarian aid operations for vulnerable population groups in the DRC (Global Plan) from article 23 02 01 of the 2006 general budget of the European Union,

[1] OJ L 163, 2.7.1996, p. 1-6

[2] OJ L 248, 16.9.2002, p. 1

[3] OJ L 357, 31.12.2002, p. 1

[4] OJ L 201, 2.8.2005, p.3

[5] Commission Decision of 15.3.2005, SEC(2005)310

2. In accordance with Articles 2 and 4 of Council Regulation No.1257/96, the humanitarian operations shall be implemented in the pursuance of the following specific objectives:

- The population of targeted Health Zones has equitable access to a minimum package of basic healthcare, with special emphasis on women and children.
- Displaced, resettling and host families receive an integrated package of community-based assistance designed to respond to immediate needs while paving the way for a rapid return to productive activity and thus contributing to the stabilization of conflict-affected areas
- DG ECHO maintains an appropriate field capacity to assess evolving humanitarian needs and devise coordinated responses, and monitor and evaluate the operations financed by the Commission

The amounts allocated to each of these specific objectives are listed in the annex to this decision

*Article 2*

Without prejudice to the use of the reserve, the Commission may, where this is justified by the humanitarian situation, re-allocate the funding levels established for one of the specific objectives set out in Article 1(2) to another objective mentioned therein, provided that the re-allocated amount represents less than 20% of the global amount covered by this Decision and does not exceed EUR 2,000,000.

*Article 3*

1. The duration of the implementation of this decision shall be for a period of 18 months starting on 01 January 2006.

2. Expenditure under this decision shall be eligible from 01 January 2006.

3. If the actions envisaged in this decision are suspended due to *force majeure* or comparable circumstances, the period of suspension will not be taken into account for the calculation of the duration of the implementation of this decision.

*Article 4*

1. The amount of EUR 38,000,000 shall be conditional upon the necessary funds being available under the 2006 general budget of the European Union.
2. This Decision shall take effect on the date of its adoption

Done at Brussels,

For the Commission

Member of the Commission

## Annex: Breakdown of allocations by specific objectives

| Specific objectives | Amount per specific objective (EUR) |
|---|---|
| The population of targeted Health Zones has equitable access to a minimum package of basic healthcare, with special emphasis on women and children. | 15,550,000 |
| Displaced, resettling and host families receive an integrated package of community-based assistance designed to respond to immediate needs while paving the way for a rapid return to productive activity and thus contributing to the stabilization of conflict affected areas | 20,500,000 |
| DG ECHO maintains an appropriate field capacity to assess evolving humanitarian needs and devise coordinated responses, and monitor and evaluate the operations financed by the Commission. | 450,000 |
| Reserve | 1,500,000 |
| TOTAL | 38,000,000 |