

A review of the humanitarian response to the 2012-13 emergencies in North Kivu, Democratic Republic of Congo

Analysis of the emergency response capacity of the humanitarian system – Case study 2

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Executive Summary

In April 2012, units of the Armed Forces of the Democratic Republic of the Congo (FARDC) mutinied, named themselves the M23, and moved to take control over the eastern province of North Kivu, briefly seizing the capital Goma in November before turning to the negotiating table. This sparked realignments by other armed groups in the province, as some took advantage of the withdrawal of FARDC units to fight the mutiny to move into new territory. All of these actions by armed actors had significant impacts on civilian populations, including killings, sexual violence, looting of villages and enormous displacement. Between March 2012 and March 2013, it was estimated that the number of people displaced in North Kivu almost doubled from 554,949¹ to 920,784², or 16% of the total population of 5.7 million people. The beginning of the M23 crisis and the widespread displacement prompted a shift towards more emergency programming by the humanitarian community.

In assessing this emergency response, we found:

- What the people of North Kivu want above all is **security and protection** from armed violence – but there is no one capable of stopping pillages, robberies and attacks. For the those actors whose main responsibility it is to protect civilians, this remains the central failing.
- Assistance to **internally displaced persons** is overwhelmingly concentrated on the 14% living in “official” recognized camps. The 16% of displaced living in spontaneous sites receive significantly less protection and assistance, including in food, non-food items, water and sanitation and health services, while the remaining 70% have sought shelter with families and host communities and generally do not receive targeted assistance of any kind. Further, assistance is heavily concentrated on the camps close to Goma, while those in the worst-affected periphery receive significantly less help. Location and “status” are more important determinants of assistance and protection than need.
- Claims by humanitarian agencies to have “**covered**” **humanitarian needs** in certain zones or sectors are often poorly founded. In health, agencies have adopted an approach which stresses geographic coverage over the quality or resilience of the actual service; during the emergencies of 2012-13, most of these health services evaporated.
- The widespread **incidence of sexual violence** attracted much attention from the humanitarian community, but little in the way of medical services. Further, serious breaches of medical confidentiality, in ostensible pursuit of justice against perpetrators, went largely unchallenged.

¹ OCHA (2012), *Eastern Africa: Displaced Populations Report*. Issue 12, 31 March 2012 to 30 September 2012.

² OCHA (2013), *Eastern Africa: Displaced Populations Report*. Issue 14, 30 September 2012 to 31 March 2013.

- Humanitarian agencies have adopted a **stance on security which is risk-averse** and which led, in more than a few cases, to populations being without emergency assistance when they most needed it. Further, it seems that many agencies have allowed the practice of negotiating access with all armed actors to fall into disrepair, limiting their presence to those zones patrolled by MONUSCO.
- The humanitarian community's programming was generally **too cumbersome and inflexible** to allow for quick reaction to the emergencies that occurred during the 2012-13 crisis, even despite readily available funding. Rather, only a very few larger agencies (ICRC, MSF, Oxfam, WFP, etc.) possess serious emergency response capacity, although the UN's RRMP mechanism does add some relatively small-scale additional flexibility in the sectors of NFIs, watsan, education and (to a lesser extent) health.
- While capable in its emergency response, **MSF constrained itself to a withdrawn role** within the larger humanitarian community. While it did communicate about some of what its teams witnessed and advocated directly in a small number of instances, it did not respond publicly to the mass rape in Minova and generally did not seek to exercise a significant mobilizing role, even in areas of its technical competence such as health provision and medical response to sexual violence. Internal coordination issues and the lack of a wider DRC advocacy and positioning strategy appear to be key causes.

The humanitarian response to the needs generated during the 2012-13 crisis in North Kivu was successful in several respects, but was also limited. There is no evidence available on the levels of excessive mortality throughout the province (although one survey in Walikale did show emergency levels), and so it is difficult to determine what impact the humanitarian response had. The assistance was relevant and appropriate – but only for those “lucky” enough to be in a location which received it. Poor coverage of needs was the most significant limiting factor for the impact of humanitarian assistance. Timeliness and quality also receded further away from Goma.

The poor coverage of needs during the 2012-13 crisis is ironic given that many agencies have adopted a model which prioritises geographic “coverage”. But the agencies that chose such a model showed that they were not very capable of actually supporting such programmes during emergencies. In trying to cover everybody (within the camps) with patently insufficient resources, major gaps have appeared, including for the most vulnerable. What resulted was a thin veneer, which gave the appearance but without much of the substance of humanitarian assistance.

The picture that emerges is of a humanitarian system which, despite its size and long presence in North Kivu, is surprisingly brittle and inflexible. Humanitarian agencies have themselves made choices which have undermined their own capacities to respond rapidly and effectively to emergencies. They have locked themselves into programmes which are hard to change and redirect; they have adopted models of service delivery which evaporate during emergencies; they have chosen an approach to security risk which is not well-suited to the setting; and they've oversold and under-delivered.

Introduction

In April 2012, units of the Armed Forces of the Democratic Republic of the Congo (FARDC) mutinied and moved to take control over the eastern province of North Kivu, briefly seizing the capital Goma in November before turning to the negotiating table. The uprising by the March 23 Movement, or M23, sparked violence and population displacement across the province, the worst seen for many years. More than 900,000 people sought protection from violence and humanitarian assistance in a series of displaced camps across the province, and the humanitarian community rallied to provide very significant quantities of food, non-food items, water, sanitation, medical assistance and other forms of aid.

This case study was undertaken to assess and analyse this humanitarian response, to understand better its strengths and weaknesses in order to inform MSF's own positioning as an emergency humanitarian responder in eastern Congo. This case study is part of a wider analysis of the emergency response capacity within the humanitarian aid system.

Methodology

This paper was based on a field visit by both authors to North Kivu conducted in April 2013, including to MSF projects in Minova, Kitchanga, Mweso and the Mugunga I and III, Buhimba and Bulengo camps around Goma, as well as a review of reports and documents from MSF and the wider humanitarian community. While Minova is located in South Kivu, inclusion was based on the emergency's significant effects on the town. A total of 57 key informant interviews were conducted with field and headquarters staff from MSF and other humanitarian agencies, with personnel from the Congolese government, and with representatives of local and displaced communities (a full list of interviewees is in Annex 1, and an itinerary is in Annex 2). The reference period under review was from the formation of the M23 in April 2012 until the field visit in April 2013. The case study used a qualitative methodology, aimed at drawing on the insights and judgments of a broad set of actors, rather than a detailed review of quantitative data. Further, the case study looks at the overall response, and does not attempt an in-depth review of MSF's medical operations.

Context

North Kivu, in the eastern Democratic Republic of Congo, has been at the centre of conflict, displacement and instability in that country for almost two decades. The driving events include the decomposition of the regime of Mobutu Sese Seko, the Rwandan genocide and its spillover effects, the armed contestation for state power and resource wealth between rival factions of the Congolese political class and most of the country's neighbours, and the subsequent proliferation of dozens of armed groups operating widely and freely. North Kivu was at the centre of all of these events, and remains the heartland of conflict.

Since the formal end of the Second Congo War in 2003, attempts have been made to buy peace with the armed groups by offering some of them integration into the Congolese armed forces, the FARDC, in a policy known first as *mixage* and later *brassage*. Also put in place was the world's largest UN peacekeeping force, first called MONUC and then called MONUSCO, with a mandate to both assist the FARDC and protect civilians; today it numbers some 17,000 troops. In November 2008, this broke down spectacularly when one group, the CNDP, aligned with Rwanda and led by Gen Laurent Nkunda, launched a direct attack on Sake and towards Goma. In 2009, a deal between Congolese President Joseph Kabila and Rwandan president Paul Kagame led to the end of the rebellion, the replacement of Laurent Nkunda as CNDP leader with Bosco "Terminator" Ntaganda, and the reintegration of CNDP forces into the FARDC.

The emergency

Under pressure following the ICC indictment of Thomas Lubanga, in April 2012, Bosco Ntaganda and his soldiers again mutinied, declaring themselves the March 23 Movement or M23. The name was taken from the date of the 2009 agreement by which the CNDP rejoined the Congolese military, an agreement which Ntaganda and his movement claimed had been breached by the government. The M23 initially established itself in Rutshuru territory, bordering Rwanda and Uganda, taking control of the border town of Bunagana on July 6 and then Rutshuru and Kiwanja two weeks later, before settling in to consolidate positions. In November 2012, the M23 again took the offensive, this time driving the FARDC out of the provincial capital of Goma and along Lake Kivu as far as the town of Minova. Fearing large-scale civilian casualties in the city, MONUSCO did not resist the advance but rather took a defensive posture. The militia held Goma for 11 days from November 20 to December 1, before the opening of political talks in Kampala led to their withdrawal from the city and back to positions in Rutshuru territory.

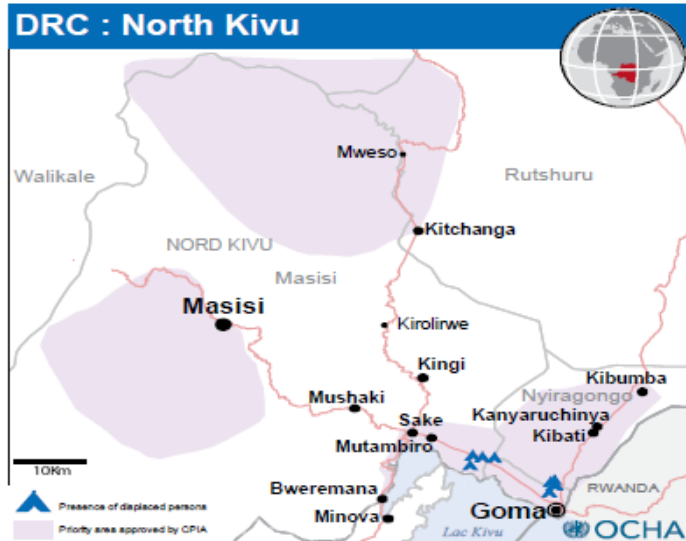
All of these military offensives were accompanied by displacements of populations, principally into camps around Goma. Firstly, people from along the Rutshuru-Goma axe fled to safety in the camp of Kinyaruchinya, just north of Goma. Then, when the M23 assaulted the town, those and many others fled to displaced sites west of the town, including Mugunga I and III, and to the towns beyond, such as Sake and Minova.

As significant as its actions were in Rutshuru and Goma, the M23 rebellion had far wider knock-on effects. In the western territory of Walikale, and across the border in South Kivu, a force re-emerged, the Mai-Mai Raia Mutomboki. Claiming to be defenders of the “autochthones” against Rwanda, the M23, and all Rwandaphones (both Tutsi and Hutu), the group launched attacks across a swathe of the two provinces. In June 2012, the militia attacked the town of Masisi and then, in July, attacked and briefly held Walikale, before being pushed back by the FARDC. Further, the advance of the M23 led to a repositioning of its forces by the FARDC and a withdrawal from several areas in the hinterland, in favour of positions around Goma. This encouraged some armed groups to step up confrontations with the FARDC, led to new alliances between previously opposed groups and contributed to a power vacuum into which other groups stepped. In Masisi territory, along the axe running from Kitchanga to Pinga, several armed groups took advantage – the Mai Mai Cheka took control of Pinga several times amid considerable bloodletting, while the FDLR (a group whose origins are in the Rwandan genocidaires) and the APCLS stepped into other towns including Kitchanga, sparking widespread violence in February 2013 when most of the town was burnt down.

All of these actions by armed actors have had significant impacts on civilian populations, including killings, sexual violence, looting of villages and enormous displacement. Between March 2012 and March 2013, it was estimated that the number of people displaced in North Kivu almost doubled from 554,949³ to 920,784⁴, or 16% of the total population of 5.7 million people. Most of these people displaced to camps close to Goma, but there were also significant concentrations around Masisi, Kitchanga and further afield. The three priority areas for humanitarian intervention coincided with the locations of the most severe fighting and the concentrations of displaced: in and around Goma, in and around Masisi, and along the “axe” between Kitchanga and Pinga.

³ OCHA (2012), *Eastern Africa: Displaced Populations Report*. Issue 12, 31 March 2012 to 30 September 2012.

⁴ OCHA (2013), *Eastern Africa: Displaced Populations Report*. Issue 14, 30 September 2012 to 31 March 2013.



The response

The humanitarian community has had a large and continuous presence in North Kivu since 1994, running large-scale programmes across all sectors. Since the CNDP crisis ended in 2009, a “stabilisation agenda” has been in place and humanitarian agencies have largely considered the situation to be transitioning into “post-conflict” and so have concentrated their resources on assisting processes of return of displaced people to their home regions.

The beginning of the M23 crisis and the widespread displacement prompted a shift towards more emergency programming by the humanitarian community. From July 2012, displaced persons from Rutshuru territory moving towards the perceived safety of Goma first found shelter at the Kinyaruchinya camp north of the town. Initially a spontaneous site of displacement, due to its proximity to the front-lines, the camp was later accorded official status by the UNHCR and the Congolese government, allowing for significant amounts of assistance to be provided to the 60,000⁵ population concentrated there. In November 2012, the M23 advanced on Goma and forced a withdrawal by the FARDC, the entire population of Kinyaruchinya fled the camp and moved along the road west towards Sake. During the 11 days that M23 held Goma (known locally as the “*Prise de Goma*”, the Taking of Goma), the city came to a standstill, with targeted killings, looting, the release of prisoners, and the closure of businesses, the airport and port, banks and civil amenities including electricity and water. Key government officials were evacuated by MONUSCO, as did many humanitarian agencies across the border into Rwanda, although skeleton services were still provided by hospitals and some agencies. Many of the displaced settled in old displaced sites at Mugunga, leading to the formation of one official (Mugunga III) and five unofficial (Mugunga I, Lac Vert, Bulimba, Bulenge and Nzulo), with a population 100,000 people⁶. Once the M23 withdrew from the town, these camps became a major focus of humanitarian assistance.

Further afield, the violence disrupted the provision of humanitarian assistance in many areas, including to other displaced camps in and around the towns of Masisi, Walikale and Kitchanga. Distributions of food and non-food items to displaced populations became more difficult to conduct

⁵ UNHCR (2012), *60,000 Congolese in North Kivu spontaneous IDP site wait for better tomorrows*, 8 October. <http://www.unhcr.org/5072cd459.html>

⁶ Reuters (2012), *Rape occurring daily in and around Goma camps, says MSF*, 21 January. <http://www.trust.org/item/?map=rape-occurring-daily-in-and-around-goma-camps-msf/>

regularly or at scale, due to insecurity on the roads and also by the re-concentration of resources around Goma.

At the time at which the field work for this case study was conducted (April 2013), the situation had settled somewhat. The FARDC and MONUSCO were back in control of Goma and most of the other population centres, but the M23 still held most of Rutshuru territory and Pinga was still abandoned. Political talks were ongoing but not looking hopeful in Kampala, but there were also plans about an upscaling of MONUSCO's capacity to respond militarily, including via the introduction of a Rapid Intervention Force mandated by Security Council resolution 2098, an idea that had been put on the table already in 2012 in the framework of the *Conference Internationale des Etats des Grands Lacs*.

Findings

The principal needs, and failings, are protection

The conflict in North Kivu takes many forms. In some cases, such as Walikale in July or in Pinga in August and then around Kashuga and Kalembe in November and December 2012, it features somewhat-conventional fighting between the government and allies (FARDC, APCLS) and oppositional groups who seek political control and access to mining areas (such as various Mai Mai groups) over towns or territories. In many (perhaps even most) situations, armed clashes also feature deliberate and ethnically-targeted violence against civilians, with militiamen going door to door hunting for members of a certain ethnicity and burning their houses, resulting in the destruction of most of the town. In other cases, the targeting of civilians is the only motivation for the violence, such as the case in Minova in December 2012, when soldiers allegedly raped some 130 women. In yet other cases, the violence may simply be more criminal in character: such as the looting that occurred in the camps around Goma in November 2012.⁷ Violent conflict often also includes pillage, rape and other forms of exactions and violations against civilians, as well as the looting of public buildings including schools and health centres. Violence against humanitarian workers, medical facilities and staff was also a feature: in Minova, doctors were forced to operate at gunpoint, hospital facilities were taken over by armed men and patients expelled from their beds. In any case, it is generalized through most parts of North Kivu, and especially the territories of Walikale, Masisi, and Rutshuru. According to confidential figures seen by the reviewers, the last six months of 2012 showed very sharp increases in the incidents of violence involving regular armed groups, irregular armed groups and violent criminality.

The principal humanitarian needs in North Kivu are directly linked to conflict and consequent displacement – civilians suffer attack (or more commonly hear of a likely attack) by armed groups who predate upon them, they then flee to a place perceived to be safer, there they find themselves highly vulnerable due to lack of access to their own fields and livelihoods, and they then require some level of humanitarian assistance. Some 84% of displacement in North Kivu is considered “preventative”, while 9% is in response to a direct attack⁸. A retrospective survey carried out by MSF in Walikale, found that 6.4% of people had directly experienced violence since July 2012, in 82% of which the perpetrators had worn some kind of military uniform; 78.9% of households had suffered loss, theft or destruction of cattle or property⁹.

⁷ MSF (2012), Forced to flee by violence in North Kivu. MSF web update, November.

<http://www.msf.org.uk/article/drc-forced-flee-violence-north-kivu>

⁸ Commission des Mouvements de Population (2013), “Analyse de Mouvements de Populations en Province de Nord-Kivu”, January.

⁹ Carrión AI (2013), *Retrospective mortality survey in the MSF catchment area of Walikale, North Kivu, DRC*. [Powerpoint presentation.]

Violence has had several different types of impact on ill health during this emergency. This can be direct: in Kitchanga in February 2013, the MSF team saw a total of 285 deaths, at least 47% were civilians (134); 6% children (17) and 5% women (14). Violence-related deaths in Masisi zone showed a massive increase during November and December of 2012, with the number of violent deaths and gunshot wounds seen in Masisi Hospital's OT increasing by 35% and 120% respectively¹⁰. By causing displacement, violence can also augment vulnerability to disease – in February, after returning home after being displaced, several children in Mpety near Pinga died of malaria; one likely contributing factor was increased exposure to mosquito bites in the bush while another was that all their mosquito nets had been pillaged by armed groups during their absence. In December, fighting in and around Pinga led to many health centre staff fleeing, and the looting and closure of health centres in the area, with consequent impacts on availability of medical treatment. And, further in the background, there are many mortality events caused by the very weak state of health services in North Kivu, such as the many cases of patients with otherwise treatable conditions who die because of “late presentation”, that is, the absence of a functional health centre close enough to them. Conflict and state fragility could be seen as contributing to this state of affairs also.

But, above any material assistance, displaced people told us that they most desire security and safety, so as to be able to go back to their own villages and live in some kind of peace. If the principal needs are for protection, that is also where the principal failings lie also. Armed groups of all stripes routinely ignore their obligations to populations under the laws of armed conflict, and instead predate on civilian populations for their livelihoods. A survey by Oxfam of 1300 people in North Kivu in 2012 found that extortion of civilians had “reached appalling levels with people facing violent forced recruitment, forced labour and continuous illegal taxation”.¹¹ These exactions are committed by all the numerous armed groups operating within North Kivu. For example, the village of Kashuga, in Masisi territory, was plundered 12 times between April and July 2012, by militias¹².

The UN peacekeeping force, MONUSCO, present in DRC since 1999, has an explicit mandate to protect civilians. And it does seem to have some protective impact. Its bases can offer populations safety from attack: during the Kitchanga events of February 2013, 10,000 local people sought shelter in the peacekeepers' base. Further, there is a relationship between MONUSCO road patrols and the absence of opposition armed groups in some areas, although which is cause and which is effect is not clear. And yet even covering 60,000 square kilometres of area with only 17,000 troops, MONUSCO in North Kivu has an impossible task; it cannot possibly protect the civilian population from attack, a fact demonstrated by the sheer number of violations committed by armed groups. Nevertheless at times it has failed even at passive protection, for example during fighting in Pinga in September 2012 when MONUSCO closed its gates to the fleeing population. Further, as was shown during the M23's taking of Goma, MONUSCO's mandate does not make clear how active it should be in defending the government from attacks by armed opposition groups; indeed, it claims to be “neutral”. This led to attacks by the population on MONUSCO, UN, ICRC and other agency bases in Walikale in North Kivu and in a number of cities around the country, in seeming protest at the mission's lack of action against M23. The likely deployment of a new Rapid Intervention Brigade will likely confuse this situation, making MONUSCO a clearer belligerent, but at the possible expense of some of MONUSCO's protective impact, as conflict with armed groups will likely rise.

MSF does not consider itself a “protection actor”; however, by virtue of its presence in conflict zones, many IDP leaders felt that they had not been abandoned as outsiders could witness their

¹⁰ Ponthieu A (2013), *Visit report – Democratic Republic of Congo – North Kivu: A L'Est, rien de nouveau*. AAU-HIT, March.

¹¹ Van Damme S (2012), *Commodities of War: Communities speak out on the true cost of conflict in eastern DRC*. Oxfam: Oxford. Available at: <http://www.oxfam.org.uk/blogs/2012/11/congo-protection-assement>

¹² Ibid.

suffering. In several instances, as in Rutshuru, villagers have sought protection (more accurately: shelter) within hospitals where MSF has been working; however, this protection is limited in duration and in number. In Pinga, site of many clashes over the last 12 months, the hospital “safe room” is not large enough even for all the staff, let alone local people. And when IDPs run, so does MSF, as the recent events in Kitchanga showed: *“When the recent events happened [the burning of the town on February 27/28], MSF ran with us. I went to the MONUSCO base. MSF stayed in its own base, and when it became clear that the fighting was serious, they also evacuated to MONUSCO. The teams helped a lot in the transit post at MONUSCO, they treated all the injured. Your presence protected us; do you think we could have treated all these wounded ourselves? You were the only ones who stayed.”*¹³

MONUSCO’s mandate to protect civilians has prompted very different responses from humanitarian agencies, and in some cases a blurring of roles between MONUSCO and the humanitarian community. MONUSCO itself considers itself a “neutral” actor and that its protection of civilians mandate does provide overlap with humanitarian functions; it sees that one of its roles is to protect NGOs and so offers armed convoy assistance, ‘back up’ in case of problems in a distribution activity, and sanctuary for NGOs during armed conflict. Many agencies would appear to agree with MONUSCO’s self-definition. Some NGOs refer cases to MONUSCO for investigation and lobby for increased patrols. Some INGOs have taken on a ‘watchdog’ role, reviewing performance of MONUSCO and of the security sector in general, and providing advice and guidance on future deployments. This goes significantly beyond coordination and dialogue, and into cooperation and combined response: for example, there are Joint Protection Teams, based out of Goma, in which MONUSCO and humanitarian agencies (including INGOs) jointly investigate alleged violations and prepare recommendations. MSF and ICRC, in contrast, consider that MONUSCO is one armed group amongst many, and so have developed a bilateral relationship where cases can be discussed directly, but seek to maintain a distinction between what is MONUSCO and what is the humanitarian community. Differing concepts of what constitutes “protection” are not confined to the humanitarian community; it seems that authorities, armed groups and communities all have somewhat different views of what the concept means, or should mean.

MONUSCO has a Civil Affairs team which includes human rights investigators and sexual violence response teams. These teams play a monitoring role, and investigate allegations of abuse. Whilst this may seem laudable, in fact this further creates confusion in roles (as a UN body and as an armed actor) and allows MONUSCO to rise above any allegations of its own inaction. An example of this is the report published by the Joint Human Rights Office (a joint MONUSCO and OHCHR venture) which reads like a Human Rights Watch report, with recommendations to the Congolese authorities and ‘the international community,’ but without any comment on MONUSCO’s own role during the events in question.¹⁴ A similar point could be made about another UNJHRO investigation into several massacres around Masisi in November 2012¹⁵. This exemplifies the dangers of the integrated mission, where MONUSCO, which is an armed actor, can also position itself as a human rights monitor.

¹³ Interview with local civil society leader, Kitchanga, April 20, 2013.

¹⁴ United Nations Joint Human Rights Office (2013). *Report on Human Rights Violations Perpetrated by Soldiers of the Congolese Armed Forces and Combatants of the M23 in Goma and Sake, North Kivu and in and around Minova, South Kivu Province from 15 November to 2 December 2012*. May 2013. <http://reliefweb.int/report/democratic-republic-congo/un-denounces-sexual-violence-other-serious-violations-eastern-drc>

¹⁵ United Nations Joint Human Rights Office (2012). *Report of the Joint Human Rights Office on Human Rights Violations Perpetrated by Armed Groups During Attacks on Villages at Umufandu I and II, Nyamanboko I and II and Kibabi Groupements, Masisi Territory, North Kivu Province, Between April and September 2012*. November 2012. http://www.ohchr.org/Documents/Countries/ZR/UNJHRO_HRVMasisi_en.pdf

Assistance is based on camp status and location, rather than need

Continuous violence has caused huge displacements in rural areas and also around Goma. Humanitarian assistance in North Kivu is overwhelmingly concentrated on internally displaced persons. By the end of March 2013, some 900,000 persons in North Kivu were considered displaced in North Kivu, out of a total population of 5.7 million. The overwhelming majority of these people, 70%¹⁶, moved to the safety of family, friends and relatives (*familles d'accueil* or host families). Often, people would flee to the homes of other members of the same ethnic group: it is rare, for example, to find Hunde who would prefer to stay in a camp rather than with other Hunde, except if an area became saturated with displaced as is the present case in Kashuga, where many Hunde are in camps¹⁷. Displaced people in *familles d'accueil* are very hard for humanitarians to assist – both in terms of capacity to find and target, and in resourcing, especially if assistance to the host communities themselves is also required – and so they often go uncounted and unsupported. Representatives of the Hunde community in Kitchanga reported that the first food and NFI assistance they were aware of to such displaced was an ICRC distribution in March 2013, which only occurred because the whole centre of the town was burnt down. Further, much displacement is short-term and temporary, it lasts until the threat of attack subsides and so until the displaced can return to their homes and fields, so-called “pendular” displacement. This was the case with many of those who fled July 2012 fighting in Rutshuru: once the M23 took Goma in November, many of those in the Kanyaruchinya camp moved to other camps.

The remaining 30% of displaced people are divided between 127,695 persons living in 27 “spontaneous sites” (16%) and 133,386 persons living in the 31 “official camps” (14%) connected to the humanitarians’ Camp Coordination Camp Management (CCCM) structures¹⁸. The latter are the “lucky ones” – they’re officially registered, their camps are generally better established (since 2008-09), better sited and better protected, and they are the ones targeted for food and NFI distributions and who receive greater assistance in water, sanitation, health and hygiene. Even in the better performing camps, the standards do not always meet the minimum. A December 2012 UNHCR study found serious problems across all the camps in many sectors including: poor security in half the camps, insufficient coverage of plastic sheeting for shelter in half the camps, non-systematic distributions of NFIs and especially after major displacements, education for children “practically non-existent”, poor WASH coverage in some camps, and so forth¹⁹. In particular, the frequency and adequacy of food delivery by WFP is not good: distributions should be monthly, but a review found that CCCM camps received an average of 2.7 distributions over a 10-month period from November 2011 (before the crisis) and August 2012²⁰. And there are certainly worse-performing camps too: the official camp in Mpati is very hard to get to and is reportedly controlled by an armed group who (according to the displaced) “hold them hostage”, with consequent poor humanitarian access and assistance.

The spontaneous sites, on the other hand, vary widely. Of the 40 such sites, they range in population from 10 families in a primary school in a village outside Masisi to 12,000 families in each of the large camps of Mugunga I and Lac Vert outside Goma²¹. In levels of assistance, some, such as the Mugunga I site near Goma, receive a very similar level of assistance to the nearby “official” Mugunga III site, although less organized and planned out, while others receive little or no assistance at all

¹⁶ OCHA (2013), *Nord-Kivu: Situation de personnes déplacées internes (PDI) au 25 janvier 2013*. [Factsheet.]

¹⁷ Interview with leaders of the local Hunde community, Kitchanga, April 20 2013.

¹⁸ OCHA (2013), *op. cit.*

¹⁹ UNHCR (2012), *The response to protection and assistance needs in the CCCM camps of displaced people in North Kivu – A review of the current situation and strategy of intervention in 2013*. [Report.] December.

²⁰ UNHCR (2012), *The response to protection and assistance needs in the CCCM camps of displaced people in North Kivu – A review of the current situation and strategy of intervention in 2013*. [Report.] December.

²¹ IOM (2013), *Statistiques: Sites de Déplacement au 25 Juin 2013*. [Datasheet.]

(such as Snel, close to Goma, largely unassisted because it has no suitable water sources). Only 50% of sites are assisted by the humanitarian community, according to estimates provided to us by an agency representative working in these sites. The spontaneous sites are considerably more unsafe than the official camps, usually lacking any police presence. Further, those living in spontaneous sites are often of a different ethnic background as the surrounding population, or are not welcome for some other reason, making the sites prone to violence. The main difference is in food delivery: as infrequent the distributions are in the CCCM camps, in the spontaneous sites, food distribution is almost non-existent. Results of a nutritional survey in the Goma camps, released in January, showed severe acute malnutrition rates at 2.5% and global acute malnutrition rates at 8.9%²²; those are not emergency levels but still concerning given the relative ease of food distributions in those camps. Water and sanitation can also be more problematic in the spontaneous sites, as WASH and other providers can be wary of building larger and longer-term systems for fear of this becoming a “pull” factor. UN agencies can also often prefer assistance to zones of return, to “pull” them in that direction, at the possible expense of those in informal camps.

The reasons for the differing standards are several, and some are reasonable. The government does not wish for there to be large, permanent concentrations of populations in camps, especially near Goma, and fears that official status would encourage permanency; it also does not wish for camps which could assist armed groups’ strategies, for example, easing infiltration of Goma. The UNHCR generally concurs with government policies and wishes, but also sees the designation of a site as an official camp as a kind of guarantee of certain minimum standards and does not want that status accorded to sites which it considers impossible to assist or protect (for example, due to proximity to armed groups and front lines). There is also a matter of resources and the need to prioritise somewhere: WFP’s position on food distribution to camps and not sites seems directly connected to resource questions, rather than any point of principle, and it would surely distribute more widely if it had the finances and logistics to do so.

Agencies provide better assistance and protection towards those persons, whether in official camps or spontaneous sites, who live close to Goma, as access is much easier²³. Camps in rural areas are often very difficult to access making transport more expensive and precarious. The conditions in Mugunga I, a spontaneous site, are preferable to that in Mpati or even Kashuga, all official camps but on the other side of the front line, because it’s half an hour away from Goma in a relatively safe zone. Walikale, despite being the site of considerable violence and displacement, was not even identified as a priority zone for assistance by the humanitarian community.

Finally, the protection and assistance received by displaced is often subject to the vagaries of humanitarian agencies’ administrative systems. Agencies involved in camp management are very concerned about fraud, which is widespread: the median number of people per household in the camps was measured as 1.7. There is the (alleged) phenomenon of “*huttes fantômes*” (phantom huts) established by “professional displaced” trying to scam assistance packages, and scams involving re-selling of food vouchers are commonplace. As a result, agencies have constructed an elaborate machinery to register and verify displaced, including “fixings”, midnight operations by dozens of workers which seek to simultaneously verify the actual population figures of various camps: in this way, the population in Buhimba camp shrunk overnight from 50,000 to 30,000. Fraud has led to widespread mistrust by agencies delivering goods who, in a vicious circle, try to restrict and control distributions. This in turn has led many IDPs to seek to supplement their meagre rations by spreading their families around in different camps. Corruption is also reported within aid agencies themselves, including theft of food destined for displaced people.

²² MSF-OCA mission sitrep, Jan-Feb 2013.

²³ Old Kivu hands report that this over-concentration on Goma has long been the case in the province.

This system has become prone to delays: in two official camps in Kitchanga and a further two in Kashuga we heard of extensive delays, of up to 4-5 months, to get newly displaced people registered and receiving NFIs and food assistance. At the point at which they are most vulnerable, when they first arrived, it seems the displaced can sometimes not be helped.

What is left, then, is a system of assistance and protection which clearly favours the easiest to reach. Considerations of the actual vulnerability of a given displaced family are trumped by arbitrary designations by aid agencies or by the imperatives of logistics and security management. Rather than concentrating on meeting needs, agencies are prioritizing their own ease of intervention.

“It’s covered” – but is it really?

The 3Ws – Who, What, Where, a document showing humanitarian agency presence²⁴ – counts 87 “operational organisations”, comprising 48 international NGOs, 35 national NGOs, and 4 UN agencies, working in North Kivu. Within this seemingly large number, however, are considerable differences in geographic and cluster/sector coverage: the Grand Nord districts of Lubero and Beni are better covered (49 and 46 organisations present) than the more conflict-affected zones of Masisi, Kitchanga and Walikale (31, 22, 22). When sectors and clusters are added, the holes are clear (there are no nutrition actors in Masisi, no NFI actors in Kitchanga, only one WASH actor in Walikale, despite clear needs in all those areas), as are the areas which are “covered” (there are 12 food security actors in Beni and Lubero, 14 protection actors in Rutshuru and 6 health actors in Kitchanga and Masisi). This is one of the essential purposes of this OCHA-led exercise and indeed the cluster system: to prevent duplication of effort and ensure a better coverage of need.

But the concept of what is “covered” and what isn’t also needs much closer examination. Health is an example: in the Mweso health zone, part of Masisi district, there are at least four humanitarian actors in health, including MSF, which together cover all but four of the zone’s 23 aires de santés (localities). While MSF provides care at both the secondary (Mweso General Hospital) and primary (at six health centres) level, the three latter agencies concentrate on the primary level: one organisation supports three centres plus SGBV services elsewhere, another supports two reference centres in Kitchanga and five health centres, and the third supports eight health centres. This concentration on primary level is a perfectly reasonable programming choice made on solid public health grounds, as very many lives can indeed be saved at the primary level if services can attain a basic minimum service level.

And yet the capacities to ensure such base-level services vary widely. We spoke to many health staff, displaced persons and civil society representatives who complained bitterly of poor health services in many clinics in the Mweso health zone: medicine supplies frequently ruptured, poorly-motivated and under-supervised staff who were not paid on time sometimes for months, very sick patients (including malnourished children) who presented to hospital after initially failing to access quality treatment at their local clinic, reference centres which lacked beds and mattresses for patients to rest on. In large part, this seems to be due to agencies’ supporting a larger number of centres, in the hope of improving “coverage”. This is plainly more than they have the medical expertise, finances or management capacity to supervise in a good-quality manner. Indeed, the largest part of the support provided to most health centres in the zone by humanitarians is not medical at all, but logistical (delivery of medicines) and financial (payment of incentives to staff). It simply cannot be said that health centres in such condition “cover” the health needs of the local population.

This in turn has significant impact on health actors’ ability to cover needs during emergencies, which is far weaker than it would appear on paper. It cannot be expected that agencies which struggle to appropriately supply, supervise and resource primary level facilities during “peace” time can cope

²⁴ OCHA (2013), *Qui Fait Quoi, Où?* Factsheet, 31 January.

with the added emergency needs during times of war and displacement. Indeed, in at least two occasions during the period under review, MSF stepped into health provision in displaced camps at the request of Congolese health authorities who were unhappy at the capacity and service levels of other health actors. In another camp, Bulengo, UNHCR asked MSF to intervene because no other health actor would have sufficient capacity to respond or even to detect cholera, should it be needed.

As the medicine becomes more specialized, the capacity gaps become even more obvious. The violence in Kitchanga in February 2013 is illustrative: MSF and MoH personnel treated 182 injured patients on site by MoH and MSF staff and then evacuated 70 patients either to the MSF-supported hospital in Mweso or (for the most serious cases) to the ICRC-supported hospital in Goma. Meanwhile, the other health actors in the town all evacuated, returning three weeks later when all the acute needs were met; in several cases, emergency functioning in the hospitals and health centres supported by these actors was assured by assistance from MSF. Similarly, in Walikale, one health actor supports 40 health centres across the territory (with only two supervisors), but evacuated preventatively before the violence in the town in July 2012.

Another discrepancy in the aid system's 'coverage' of health care in North Kivu is that some actors are implementing cost-recovery programmes, and others are providing services for free. This may lead to different health care centres in the same district operating on different models. Which centre operates which model is not related to the relative 'peacefulness' of the area (thus qualifying as a 'development' context) but rather, on the vagaries of donor funding cycles and models of intervention. This creates barriers for access to health and contributes to big variations in availability of healthcare.

In one sense, varying capacities are normal and can even foster complementarities, which could and should be the case in North Kivu. MSF has specialized itself to provide advanced medical care in extreme situations, while others have focused on primary or community level care which is much less technical. But the aspirations do need to be made explicit: are agencies primarily trying to support health systems, or is the primary goal the direct saving of the maximum possible number of lives? Further, regardless of the exact aspiration, the actual capacity to respond to emergencies should not be exaggerated, as this diverts resources and leads to uncovered needs.

Finally, agencies also appear to use claims of "coverage" to protect turf and contracts, again at the expense of real needs. In one case, in Masisi, MSF's interest in intervening in the district was nearly thwarted by another agency appealing to the MoH in Goma. In another case, an agency wrote to the province's chief doctor to protest about MSF providing assistance to primary health clinics it was "covering"; in this case, it was resolved by the two agencies agreeing a split of support for different centres²⁵.

This problematic – of claims of coverage being undermined by weak actual capacity – is not restricted to health either: actors informed us of similar problems in NFI distribution (where reportedly only a very small minority of the 30 cluster members can actually conduct distributions during an emergency) and in WASH (where again there are only a small number of actors in the cluster who can actually provide timely and at-scale assistance in an emergency).

²⁵ There is a long history of this type of activity in eastern DRC. See: Jezequiel JH (2009), *L'enfer: c'est les autres*.

Sexual violence: lots of attention, but to what effect?

Eastern DRC has been called the 'rape capital of the world' by the UN: in 2011, it was estimated that over 1000 rapes were committed each month in North and South Kivu²⁶. Sexual violence in North Kivu often peaks during military offensives, but even in 'normal' circumstances, it remains a constant. From November 2012 to January 2013, for example, at the MSF clinic in Mugunga 3, there were peaks in the weeks where the M23 retreated from Goma and in the area where the wood collection is done for the camp, where armed groups are present (although some of the peaks were accounted for by women coming for consultations after periods of inaccessibility of services). MSF's report²⁷ on the rapes during that period infers a positive connection between food distributions and reduced incidence of sexual violence, as fewer women have to search for firewood.

In this emergency there were also cases of mass rape. In Minova, 97 women and 33 girls were raped²⁸ by armed men during the days after the M23 took over Goma and when the FARDC retreated. These cases were treated mainly in the small health care centres at the edge of Minova, as the main hospital was filled by wounded soldiers. Ministry of Health staff provided medical care for these victims. MSF and Médecins d'Afrique staff had temporarily evacuated but returned within a week.

The humanitarian response to these events has been mixed. Although there does exist a protection sub-cluster on sexual violence, it is seen as a difficult topic to handle by the clusters as the response can involve many sectors such as health, protection, water and sanitation, food and also livelihoods. As such, attention to the issue is diffuse, and there is not a common approach within the agencies working in North Kivu. Although there has been a great deal of attention on the issue in North Kivu, and there are up to 20 different NGOs providing services to rape victims, very few NGOs provide medical care. Those that do have differing types of care. For example, for post-exposure prophylaxis to prevent HIV infection, a woman presenting to one NGO clinic might receive 'bi-therapy' (i.e. two antiretroviral medicines) whereas some of MSF's clinics provide 'tri-therapy' (three ARVs). Some agencies also provide incentives (non-food items, even cash) to report, while others don't, and so on.

One of the perverse effects of having such attention to the issue has been that there has been a pressure to produce statistics and gather information and evidence for awareness raising and also for eventual prosecutions. This has led to widespread lack of care for patient confidentiality. Following the widespread incidence of rape in the town in November 2012, Ministry of Health staff members in Minova were pressured to hand over patient records to the MONUSCO Joint Human Rights Office. Later, when the FARDC ran its own military enquiry, it also requisitioned patient records from the Ministry of Health. MSF has held meetings with Ministry of Health and MONUSCO Civil Affairs staff in Bukavu and also in Kinshasa, and in March has handed over a letter protesting this, considering it a violation of patient confidentiality and a breach of medical ethics. MSF had a clear case to make to MONUSCO both in DRC but also at higher level in New York, but ended up taking a very low profile approach, only sending a letter of protest three months after the events, and choosing not to undertake higher level advocacy.

²⁶ Peterman A, T Palermo, and C Bredenkamp (2011). "Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo". *American Journal of Public Health*: June, Vol. 101, No. 6, pp. 1060-1067.

²⁷ Olivier C and C Michel (2013). *Rapport de visite GOMA, Département juridique, Février*.

²⁸ United Nations Joint Human Rights Office (2013). *Report on Human Rights Violations Perpetrated by Soldiers of the Congolese Armed Forces and Combatants of the M23 in Goma and Sake, North Kivu and in and around Minova, South Kivu Province from 15 November to 2 December 2012*. May 2013.

<http://reliefweb.int/report/democratic-republic-congo/un-denounces-sexual-violence-other-serious-violations-eastern-drc>

The concentration of many actors on sexual and gender-based violence has seemed to provoke a contradictory reaction in MSF: on the one hand, MSF is a principal provider of medical and psychosocial care to survivors. But on the other hand, the agency has reduced its public profile on the issue, seeing a disproportionate emphasis on SGBV as being at the expense of other, perhaps greater health problems, such as malaria which affects many times as many people.

MSF's communication on sexual violence has been inconsistent. Advocacy and communications on SGBV did occur: most notably on the problems of Mugunga III²⁹, where an MSF report noted the number of incidents and some of the circumstances of the events, and attempted to push humanitarian agencies to improve their protection and assistance efforts (unfortunately with little response from the UN). But there have also been some notable absences of advocacy and communications. A press statement on the mass rapes and attacks in Minova was not published for a variety of reasons (including the non-presence of the MSF team during the events themselves, as well as political and operational calculations about the likely effect of statements) but represented a lost opportunity, given the amount of attention on the issue in subsequent weeks. There is an apparent link between increases in rape cases and failures of protection (especially impunity for armed actors) and assistance (especially weak provision of food and firewood), which could have been the subject of legitimate efforts by MSF; however here also there is a lack of an overall strategy and agreement on how to present these issues to an external audience. Some have mentioned that the decision to avoid naming perpetrators has led to sexual violence being referred to in such an abstract way that it could be seen as 'an epidemic' or something that comes from above.

Overall MSF has not profiled itself publicly as a significant actor in responding to the consequences of sexual violence, and yet it provides significant medical services to a large number of women. Other health and protection actors have mentioned the relative lack of visibility of MSF in fora where issues about sexual violence are discussed in North Kivu (although again the efforts for Mugunga III are the exception). There is definitely the opportunity for MSF to share expertise with and learn from other NGOs that are providing other medical or complementary services in order to achieve a better quality service for these women.

Security: risk aversion and "authorized access"

The risk of serious security incidents involving humanitarian staff is a major constraint on the delivery of all forms of humanitarian assistance. Principal risks include ambushes on the road, armed robbery of compounds, getting caught in crossfire between armed groups and kidnapping. During the period under review, MSF suffered a number of serious security incidents. Further, the delivery of humanitarian assistance, and in particular distributions of "lootable goods" including food and non-food items, does imply risks to populations also, including the risk of being attacked and pillaged by armed groups after distributions. It is right for humanitarian agencies to carefully consider the security risks of the context and try to identify ways to reduce them.

The risk analyses and the mitigation measures do vary widely between agencies. In part, the variation can be explained by the different roles played and assistance provided by different agencies: an agency distributing "lootable goods" like food (and thus a likely target for armed groups) should have a different risk analysis, threshold and management strategy than a medical agency seeking to evacuate and treat war wounded, which in this setting is more likely to remain untouched by armed groups who might wish to avail themselves of its services.

²⁹ MSF (2013) DRC: High levels of sexual violence in Goma camps, January 16, 2013. <http://www.doctorswithoutborders.org/press/release.cfm?id=6566>

The effect of this can be serious. The overconcentration of humanitarian presence in and around Goma, in contrast to the far weaker presence in more peripheral areas such as Masisi, is most significantly due to the security-based reluctance of many agencies to enter the latter zones, although logistical capacities (such as airplanes) also play a role. Risk thresholds for humanitarian agencies seem to be set quite low, in general. During the *Prise de Goma*, most humanitarian NGOs evacuated all or part of their staff to Gisenyi, directly across the nearby border, although some continued to work cross-border; one agency even evacuated non-essential staff from Bukavu, away across Lake Kivu. Most also evacuated their staff from Walikale, Rutshuru and Masisi territories at the same time. Several UN staff commented that it was the first time they'd seen UN agencies stay and INGOs leave. MSF evacuated some non-essential staff from Goma to Gisenyi and Kigali, but remained operational in Goma; projects in most field locations continued uninterrupted, although in some locations outreach activities were briefly curtailed; the MSF team was evacuated from Minova during the initial occupation by the FARDC and from Walikale during the July fighting. The evacuations and down-scaling did have a negative effect on the humanitarian response in Goma and further afield; this was limited by the short duration of the M23's presence in Goma (11 days), but in some areas in the periphery even this caused weeks of little presence.

This low risk threshold was also seen during smaller conflict episodes, including for some medical-humanitarian agencies, which in different cases evacuated staff prior to the clashes in Walikale, during clashes in Kashuga in November 2012 and pulled staff out in the middle of the Kitchanga fighting. In each case, the insecurity and consequent evacuations did have serious effects on assistance, including disrupting or preventing distributions to displaced populations. MSF teams stayed on the ground throughout each of these incidents.

For UN agencies, strictures apply on where personnel can and can't go without armed escort from MONUSCO: certainly, presence in "red" (non-government-controlled) zones requires blue helmets. While not under such rules, and while not seeming to directly request armed escorts, humanitarian NGOs appear to have chosen to largely follow UNDSS rules in keeping to the larger towns and to the main axes which are considered secure, in particular because of MONUSCO bases and patrols respectively. Agencies mostly deny using MONUSCO patrols for protection (something that MONUSCO itself refutes), but it does appear that MONUSCO presence in an area is considered by many humanitarians to mean that it is "open" for presence.

One factor influencing this appears to be a falling-into-disrepair, especially among smaller humanitarian agencies, of the practice of negotiating access with all armed groups. This now seems to be the preserve of the largest, best resourced and/or the most "urgentiste" agencies: it seems no mistake that the agencies which did not evacuate during the *Prise de Goma* were those which have most maintained their emphasis on negotiating with all armed actors, including particularly ICRC, UN OCHA and MSF, and which have put resources into preparing facilities against such threats. Instead, some agencies appear to have adopted a stance which could be described as "authorized access" rather than negotiated access. For example, the M23 announced itself the "government" in Rutshuru in August 2012, with systems of taxes, permits and authorizations and attempts to present its actions within a "legal" framework; in Rutshuru, therefore, some agencies have assumed that following such systems can function in place of direct negotiations with the M23. Going further, some other agencies (or at least their headquarters) appear to have formed the belief that presence in a zone controlled by an armed group opposed to the government would reflect negatively on their neutrality – or that negotiating with groups specially designated by Western governments (such as M23 and FDLR) would be illegal or at least in contravention of their donors' contracts³⁰.

³⁰ Interview with security consultant, Goma, 18 April, 2013.

It is not clear that this risk aversion is connected to MONUSCO or the long debate in humanitarian circles about the “integrated mission”³¹. There is a degree to which all international agencies are associated with the UN peacekeeping mission (in camps foreigners are referred to as “Monique” by residents, referring to “Monuc” the old name of MONUSCO, but also referring to all foreigners or all aid-givers). However, on the whole, the levels of acceptance by populations and the willingness of armed groups to negotiate with humanitarians are much higher in North Kivu than in many other contexts. Rather, emphasis should be placed here on agencies’ own choices, in particular their choice to risk as little as physically possible (and especially not their international staff; national staff are another matter).

New mechanisms add some flexibility

Despite the enormous number of humanitarian agencies (87) officially working in North Kivu, and despite the province being affected by conflict, displacement and crises for 20 years, there seems to be little actual capacity to respond to emergencies, as the funding architecture remains, for the most part, quite rigid.

The principal issue appears to be the inflexibility of humanitarian agencies’ programming, which constrains and delays reaction in the event of an emergency. The donor contracts which resource agencies’ programmes in North Kivu generally constrain them to deliver “as is”, i.e. to deliver what is in the contract, nothing more and nothing less (why “as is” in DRC would not include emergency response when needed is inexplicable). In several cases, agency representatives spoke of little or no flexibility in their contracts to alter programmes to respond to emergencies. In other cases, agency staff said that they had worked out special arrangements with their donor to allow for some reallocations. But principally agencies must seek new contracts with donor agencies in the event of new needs. It is estimated that, in North Kivu, the length of time required to conduct an assessment, interest a donor, agree a project, sign a contract and begin operations is approximately three months at a minimum (for example, Pooled Fund monies take usually three-six months to disburse). However, even after getting donor approval for projects, some agencies struggle to mobilise the right staffing and logistics capacity.

Immediately before, during and after the Prise de Goma, with the eyes of the Security Council and the international media on the town, it was relatively easy to find funding for emergency programming, agencies said. This was principally the case for the Goma camps, due to the international visibility and the political desire of the international community to support the DRC government. Financing was not so easy for needs in the periphery that were, in any case, difficult to assess. Indeed, some agencies closed programmes in the periphery in order to reconcentrate on easier-to-fund programmes in and around Goma.

Further, the reactivity also depends on the functionality of the particular cluster, which is supposed to be responsible for filling gaps and for funding projects: a well-run cluster can expedite the allocation of effort and resources to an emergency, while a badly-run one, on the other hand, can delay everything. The health cluster was often cited as an example of the latter: one agency representative informed the health cluster of a donor interested in funding emergency health response after the Prise de Goma, but they never received a reply and instead approached individual health actors separately. Intercluster coordination was also difficult to manage, leading to some agencies trying to run NFI and food distributions, while others are attempting measles vaccination campaigns.

³¹ See Vogel C (2013). *The effects of MONUSCO and UN integration on Humanitarian Action in the Democratic Republic of Congo*. [MSF Briefing Paper.]

Then, the channeling of funds and decision-making through UN agencies can further delay operations, if (as is now usually the case) the implementation work is carried out by a sub-contractor, whether commercial or humanitarian. This chain of interlocking contracts has resulted in a well-articulated but inflexible and unwieldy structure which is prone to gridlock: a three-month contractual gap between UNHCR and UNOPS, who were contracted to conduct camp registrations, was a principal reason for 4-5 month delays for new arrivals to receive assistance. It also could have the effect of hollowing-out the smaller agencies; in order to reduce their margins, they move certain capacities out-of-house, leaving it to OCHA or other UN agencies, such as security analysis. This bureaucratisation is seen and known by the displaced themselves: *“Before, in previous years, the humanitarians would come quickly but today that’s all changed. It used to be that Solidarités would come and do the registration directly, evaluate and react and resolve problems all at the same time. Now, when you’re displaced, first Première Urgence do the registrations, then they send it to Comité National des Réfugiés, then it goes to UNHCR or UNOPS. It’s bureaucratic, more hierarchical.”*³²

One UN agency representative when interviewed said “Only five agencies have significant emergency response capacity: ICRC, Oxfam and the three MSF sections”. The mechanisms used by those three agencies to manage emergencies have some similarities. In the first instance, all three have considerable financial flexibility and freedom of decision and action: MSF because of its private funding, ICRC because its public funding is tied to the overall delegation in-country and can be freely reallocated, and Oxfam because of very flexible funding from a donor agency for an emergency response team of their own. ICRC has a partnership with the Croix Rouge RDC which ensures a widespread presence, allowing for quick alert, information gathering and response and has been able to mount operations of considerable speed and scale, such as its rapid assistance to the population of Kitchanga after the town was destroyed in February 2012 which was highly appreciated by the population. In North Kivu, Oxfam’s emergency WASH response fielded a team of 79 staff and provided water and sanitation to 220,000 people, mainly in the Goma camps.

MSF’s own emergency response operations during the 2012-13 crisis were relevant and timely. The principal reason was that MSF has maintained a more or less continuous presence in or near the major conflict and displacement zones, including Masisi, Rutshuru, Kitchanga and Walikale. Its strategic geographic spread has meant that it can respond to whatever needs arise, whether primary or secondary health care, or violence or epidemic related, in those zones. Further, MSF has a higher tolerance of risk than most other agencies, remaining in situ during many instances of fighting to provide emergency medical assistance to the wounded. This has very considerably enhanced its acceptance and perception by the population; many representatives told us of their gratitude that MSF had stayed with them during the most violent times. The interventions in the Goma camps were also launched quickly and achieved good scale and relevance; the three operational sections worked cooperatively to cover needs, including sharing human resources and medicines during particular emergencies.

However, those agencies which do have the strongest emergency response capacity have themselves struggled with how to ensure rapid emergency response while also running large and heavy permanent programmes, which can create a “business as usual” mindset which can ignore or overlook new needs. For example, MSF’s emergency response at the Mugunga I camp only began because one day a staff member on a movement to a regular programme decided to stop the car and ask the locals who all the straw shelters belonged to. This has included forming emergency units within MSF’s French and Dutch sections in North Kivu to provide a managerial framework.

The principal mechanism by which the UN-led cluster system has sought to escape its own inflexibilities is the RRMP, the Rapid Response to Population Movements. Donor funded and

³² Interview with displaced representatives, KaMonique camp, April 23, 2013.

administered by UNICEF and OCHA, the mechanism has been in place since 2006 and covers non-food items, water and sanitation, education and (as a pilot since 2012) health. In each case, an INGO is contracted and funded by UNICEF to maintain a full-time capacity to conduct assessments in the event of a displacement crisis and, if the relevant cluster cannot identify a responder, to initiate three-month emergency interventions, by which time a more permanent project should be in place. The agencies presently contracted are the Norwegian Refugee Council for NFIs and education, Solidarités for NFIs and WASH, and Merlin for health.

The mechanism has certainly augmented the capacity to conduct rapid assessments: 179 have been conducted between April 2012 and the time of writing, all according to a common and accepted methodology, making it comparatively easier for RRMP assessments to gain approval for projects from donors. It has also reportedly considerably assisted the quick reaction to new displacement needs, although admittedly many evaluations do not become actual projects. Further, there was some criticism made by donors in late 2012 of poor reactivity and of weak capacity to support projects, perhaps in part connected to the evacuation of many international personnel from Goma. The actual scale of the responses which can be mounted is also fairly modest: valued at \$35 million in 2012, or 6% of the \$569 million total financial size of the humanitarian system in DRC in that year. In health, for example, the RRMP contract allows for a permanent capacity of two mobile clinic teams; a third emergency cannot receive assistance until one of the other two is finished. While still quite limited in scope and scale, the RRMP does at least show a commitment to improve reactivity.

A withdrawn MSF

MSF plays a vital role within the humanitarian community in North Kivu, especially in its reactivity to emergencies, and is widely respected by other agencies as a result. It maintains a close dialogue with the major humanitarian agencies, in particular with ICRC and OCHA, and appears to have a good working relationship with the Ministry of Health. It maintains an observer status in the UN-led cluster system; in the health cluster, it participates and shares information while not assuming any responsibility for its management. MSF has engaged in a responsible manner.

The scale and severity of protection abuses by armed groups in the past year has led to a relatively large number of press releases by MSF which condemn these actions in 2012. From September 2012 to January 2013 there were 10 press releases. These press releases report on violent events in a locality and describe the MSF response. The MSF Congo twitter account was started in 2008 during the 'Condition Critical' campaign and has gained almost 3000 followers, amongst them aid workers and agencies working in the Congo. It allows straightforward information to be put out in a quick way. Overall, the press releases are well appreciated by the humanitarian community who find MSF's voice to represent what really happens in the field.

Further, there was at least one instance in which MSF sought to reduce the levels of violence – when it presented the results of its medical work at Mugunga III camp on the patterns of sexual and gender-based violence and attempted to pressure UN agencies into improving their protection and assistance efforts in the camp in order to reduce the incidence of sexual violence.

Nevertheless, MSF could be using its voice more to speak out against protection violations. The clearest instance was the mass rape of women in Minova. Despite having a project in place, and supporting the Ministry of Health personnel who treated the women, MSF remained completely silent. This silence wasn't due to a lack of will but rather a coincidence of factors which delayed and eventually outdated the communication. Firstly, the team was evacuated during the actual events and thus had to rely on second-hand testimonies, so it was decided to do an interview with the field coordinator rather than a press release. Then there was an internal debate about whether to name the perpetrators, but by the time this was resolved, the UNJHRO investigation was on-going in

Minova and it was felt that a communication by MSF then would be outdated and would risk us being associated with the enquiry, so it was shelved. The breach of medical confidentiality by investigators was also only met by a late and meek reaction from MSF, featuring no public communications.

This is not the only instance in which MSF has failed to play its proper role, namely to provide a strong voice for the health of the people of North Kivu; similar points could be made about the agency's response to events in Masisi or Pinga. Despite widespread dissatisfaction by MSF teams with the level of assistance being provided in the domains of health and sexual violence, MSF plays no significant role in prompting greater quality of service provision from other actors and makes no attempt to change the status quo.

What is most felt within MSF is that there is a lack of an overall advocacy strategy, or indeed anything pertinent, systematic or strategic to say about the needs of the Congolese people. There are considerable obstacles for this, not least the dynamic of having five operational sections working in eastern Congo, which makes it not only harder to agree on what to say but even to draw a complete picture, given differing contexts, experiences, assessments, even data systems between the five sections. But there is also the difficulty of trying to really present new and interesting information, when the country is full of local-level contextual specificities which defy countrywide generalization, and when there is a tiredness about DRC which leads to some facile characterisations in the media and in reports. Some say that within MSF there is also 'Congo fatigue'.

Internally there is a push from the highest levels to speak out more in DRC and to document the situation better (certainly not the first such push, probably not the last). Others within MSF talk of a need to understand not only what is going on but also what people are going through. Every section at all levels, field, desk and direction, wants to have a better and deeper communication and advocacy on DRC but there is little agreement on how to do this and, more worryingly, whether there is a shared analysis of the issues and a vision forward. This lack of internal cohesion has led to a silence on the suffering of the Congolese which can only be considered troubling.

Discussion

How much impact did the humanitarian response have?

In terms of lives saved, there is no data on mortality in North Kivu during 2012-13 which would allow an evidence-based assessment. There was only one survey of mortality conducted during this period³³, in the area around Walikale, which interviewed 4157 individuals and found a crude mortality rate of 1.2/10,000/day (95% confidence interval: 1.0-1.4), which is above the "emergency threshold". In the three areas prioritized for humanitarian intervention, around Goma, Masisi and Kitchanga-Pinga, community leaders, government authorities and humanitarian agencies did not reveal high levels of concern about mortality levels above emergency thresholds – although it is highly likely that the highest rates of excessive mortality occurred among more vulnerable groups whose deaths might not have been noted. Factors which could have kept death rates down include the short timeframe of many displacement events (e.g. several months only in the case of many of those fleeing Rutshuru in April-July), the severely strained but evidently still functional coping mechanisms (including food production) of *familles d'accueil* in many areas, the relatively lower prevalence of malaria in the major zones of displacement (for example, Masisi territory in comparison to Walikale territory), as well as the assistance provided by humanitarian agencies.

³³ Carrión AI (2013), *Retrospective mortality survey in the MSF catchment area of Walikale, North Kivu, DRC*. [Powerpoint presentation.]

It is impossible to measure how significant the impact of the humanitarian response was in lowering levels of excessive mortality in the areas of its intervention. However, those areas of intervention were severely restricted, and so whatever benefits did accrue to some were denied to many. Assistance was focused above all on displaced persons in official camps around Goma; the less official the displaced person's status, and the further from Goma, the more vulnerable and unaided they became. The food aid provided by WFP and its implementing partners is the best possible example of this: it was tremendously important in allowing several hundred thousand people to maintain their health and nutritional status, but it addressed only a small proportion of those who needed it. Other forms of assistance followed a similar pattern: relevant and appropriate, but only for those "lucky" enough to be in a location which received it. Poor coverage was the most significant limiting factor for the impact of humanitarian assistance.

The timeliness of assistance also seemed to recede the further away from Goma the population was. The complaints from displaced persons in camps around Kitchanga and Kashuga centred, again, on the period of their greatest need, immediately after their displacement or after the looting of their effects during conflicts. Quality suffered likewise: the further from Goma, the weaker the supervision provided by humanitarian agencies over government or even their own staff, and the poorer the assistance offered. Health care provision was an obvious example here.

Difficult supply lines in the periphery and serious security risks were highly significant in limiting humanitarian presence, as was the obvious factor of resourcing (as always, more resources would have meant more assisted). But humanitarian agencies have "over-adapted" to these constraints and have seemingly come to accept them. The pattern of early evacuation is a case in point: at the point at which they're most needed, during or immediately after a conflict or displacement event, most agencies have lost presence and operationality, and adopted a model approaching "remote control" which appears excessive for the context. Another case in point is the decline in priority, resourcing and expertise attached to negotiating humanitarian access with all armed actors. As a result of both these factors, the pattern during this period was for more-needed programming in the periphery to be abandoned in favour of needed but much easier programming around Goma.

Models of assistance: broad and shallow, or narrow and deep?

Identifying what assistance strategy is needed in North Kivu is deceptively complex. Aid agencies "fudge the issue" so that there are development and humanitarian actions going side by side, each based on a completely different and sometimes contradictory approach. In the same health zone, one actor may for example work on supporting health systems with a cost recovery approach while another is based on substitution and provides free services. With so many Congolese experiencing such great needs, being displaced over and over again, there is a temptation to try and move towards longer term programming and it is attractive to think about "resilience" as an ideal approach. Yet this long term thinking is creating unrealistic expectations about what aid can do, and undermines emergency assistance: One MSF head of mission described a truck full of seeds driving by a camp full of hungry displaced people.

Yet both approaches have their shortcomings. Substitution has its limits, and when MSF has been in place for 30 years, providing the same kind of services, it does create an artificial situation. MSF has been told "when you leave, *c'est la catastrophe!*" and certainly the level of service, inputs and funding contributed by MSF is very high – although MSF's contribution to "capacity building", including training Congolese doctors and nurses with strong technical skills and work ethic, is often underestimated in this context. But similarly the "support to systems" approach has major limitations – many Congolese say they are tired of continuous capacity building and exclaim "*Jusqu'à quand la formation?*" and feel they're only being given enough to keep a system running at quarter speed.

The poor coverage of needs during the 2012-13 crisis is ironic given that many agencies have adopted a model which prioritises geographic “coverage” – for example, by supporting every health centre in a health zone. The logic behind such a model is clear: many easily preventable deaths are caused at primary level by the absence of even the most basic facilities. But the agencies that chose such a model showed that they were not very capable of actually supporting such programmes during emergencies. Rather, referral centres and base-level health facilities went unsupported by their designated humanitarian partners during the worst periods of emergency. Similar points seem to apply for registration, NFIs and food assistance in the camps. For camp management, one agency functions as implementing partner for UNHCR in the official camps and IOM in the spontaneous sites, covering more than 60 locations – a dizzying administrative challenge. But the results include delays of many months before newly displaced persons receive their first material assistance. For food assistance, similarly, many camp populations wait months between distributions of 15-day rations.

In trying to cover everybody (within the camps) with patently insufficient resources, major gaps have appeared, including for the most vulnerable. What results is a thin veneer, which gives the appearance but without much of the substance of humanitarian assistance.

MSF’s own choices also have their downsides. Its hospital programmes are very resource-intensive, in people, money and logistics; they create bubbles of their own, in which those lucky enough to be in Mweso, or Masisi, or Rutshuru receive something that people in similar or greater need in countless other towns do not; and their sheer management heaviness can retard reactivity to needs occurring outside the zones they cover. And yet these programmes have managed to maintain a high level of presence, operationality and reactivity during the worst moments, provided a referral centre and a base from which to launch emergency operations into other areas, and built far greater acceptance from populations and armed groups than most other humanitarian agencies’, offering them a degree of protection from attack which belies how exposed they are. They’ve provided an almost-permanent lifeline (“you were always here with us” said more than a few displaced people), which is surely what humanitarian assistance is all about. If the advantages of this rather heavy model can be combined with even greater reactivity, then it could be of very great impact.

Conclusions

The picture that emerges is of a humanitarian system which, despite its size and long presence in North Kivu, is surprisingly brittle and inflexible. It can mount large-scale operations, and it can do so in an emergency. But it can only do so within narrowly defined limits – and only for a small proportion of those actually in need. If people in need are close to the major towns where humanitarian agencies are based, if their places of refuge fall within the correct, rather arbitrary categories (“official camps”), if there is minimal insecurity and armed actors allow presence, if the roads are good enough, and if humanitarian agencies’ own contracts and programme designs allow them to, then, and only then, can an effective emergency response be mounted.

This is a far cry from the picture that humanitarian agencies like to present of how they work (“experts on the frontline”, “working around the clock”, “multi-faceted” “rapid response”). Partly this is the work of agencies’ marketing departments, but it does also seem that humanitarian agencies have exaggerated their capacity to respond to needs and emergencies as a (perhaps desperate) strategy to win contracts for new and ongoing programmes. This is surely the case in health where claims that this or that agency has “covered” needs in a large geographic area simply don’t translate from the donor report onto the ground.

The principal emergency response capacity sits within a small number of large agencies whose emphasis is on direct service delivery: most specifically, ICRC, MSF, Oxfam and WFP. The role of the

other large UN agencies in emergencies, especially UNHCR and UNICEF, is attenuated by their operational model: these agencies act principally as needs identifiers, policy-setters and funders, while the actual work on the ground is conducted by humanitarian or commercial contractors. The tight contract structures and the high internal bureaucracy levels certainly retard the reactivity of these large agencies and their “implementation partners”, while the cluster system’s capacity to coordinate and respond quickly is highly dependent on the agency (and individuals) in the lead. The RRMP has added a higher degree of reactivity to emergency needs, allowing its three implementing partners Norwegian Refugee Council, Solidarités and Merlin to mount some effective and rapid responses. However, while useful and important, the existence of the RRMP is an admission of systemic failure: it is effectively an “anti-cluster” device, a proof that the UN-led system cannot respond well to emergencies and has to be circumvented. If UN agencies and their INGO partners could react well to new needs, then the RRMP would not be needed.

During the “M23 emergency”, MSF did manage to use several of its advantages to good effect, in terms of delivering assistance to populations: its greater degree of access to conflict zones allowed for large-scale hospital programmes which provided assistance near-at-hand and a base from which to launch emergency responses; its independent and flexible funding sources allowed for quick reprioritization of programming; and its size and scale allowed for relatively large populations to be catered for across a wide range of medical needs. However, this was largely a withdrawn MSF, focused narrowly on its own medical operations and not much else, its voice quiet or even silent. But any concept that MSF could fight for better for its patients, even from within the humanitarian community, seems to have been neglected.

Humanitarian INGOs have themselves made choices which have undermined their own capacities to respond rapidly and effectively to emergencies. They have locked themselves into programmes which are hard to change and redirect; they have adopted models of service delivery which evaporate during emergencies; they have chosen an approach to security risk which is not well-suited to the setting; and they’ve oversold and under-delivered.

The political, military and humanitarian situation in North Kivu is complex and ever-changing; it never has been an easy region to work in and never will be, with a prognosis that cannot be considered encouraging. This will constrain humanitarian operations for the foreseeable future. But perhaps it is time for humanitarian agencies to stop using the complexity of a context as an excuse for poor service delivery. After all, if a context was not complex, would international humanitarian assistance even be needed?

Annexes:

List of people interviewed

MSF:

1. MSF OCA (10 people interviewed, in Goma, Mweso and Kitchanga)
2. MSF OCBA (4 people interviewed in Minova)
3. MSF OCB (6 people interviewed in Goma, Kinshasa and Brussels)
4. MSF OCP (3 people interviewed in Goma)
5. International Office (2 people interviewed in Geneva and New York)

INGO:

6. INSO
7. International Rescue Committee
8. Mercy Corps
9. Merlin
10. Merlin
11. Oxfam
12. Premiere Urgence
13. Solidarités
14. Save the Children UK

Red Cross:

15. ICRC (2 people interviewed in Goma and Geneva)
16. Croix-Rouge Congolaise (2 people interviewed)

Representatives of IDPs and local communities:

17. Mugunga III Camp
18. Buhimba Spontaneous Site
19. Bulengo Spontaneous Site
20. Kitchanga civil society
21. Kahe camp, Kitchanga
22. Kitchanga Hunde community (3 people interviewed)
23. Mungote IDP camp, Kitchanga (focus group)
24. KaMonique camp, Kashuga village (focus group)
25. Rujagati I camp, Kashuga (focus group)
26. Ibuga camp, Kashuga

DRC government officials:

27. Ministry of Health (2 people interviewed in Goma and Mweso)
28. Commission Nationale pour les Réfugiés (2 people interviewed in Goma and Kitchanga)

United Nations:

29. OCHA
30. UNICEF (2 people interviewed)
31. UNHCR
32. WFP
33. MONUSCO (2 people interviewed)
34. International Organisation of Migration (IOM)

Donor agencies:

35. ECHO

36. DFID

Also, attended a working group on spontaneous sites meeting at IOM (PU, UNHCR, World Vision, Comite National de Refugies, UNICEF, Solidarites, NCA, IRC attended), April 22, 2013

Itinerary/Programme

Date	Sandrine Tiller	Sean Healy
Mon 15/4	Travel to Goma	Travel to Goma
Tues 16/4	Goma	Travel to Goma
Wed 17/4	Goma	Goma
Thurs 18/4	Goma	Goma
Fri 19/4	Mugunga III	Travel to Mweso
Sat 20/4	Minova	Kitchanga
Sun 21/4	Minova	Mweso
Mon 22/4	Goma	Mweso
Tues 23/4	Buhimba/Bulengo	Travel to Goma
Wed 24/4	Goma	Goma
Thurs 25/4	Goma	Goma