

# **No End in Sight**

**The human tragedy of the conflict in the  
Democratic Republic of Congo**

**August 2001**

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Oxfam GB has been present in the DRC for nearly 40 years. Since 1994, much of the support it has provided has been emergency-based, in response to the growing level of humanitarian need. Currently, Oxfam GB assists more than 500,000 vulnerable people meet their public-health needs, by focusing on water, sanitation, and hygiene promotion in all parts of the DRC.

Save the Children has been working in the DRC since 1994. It runs emergency and rehabilitation programmes, but also seeks to influence policy and practice with the aim of achieving lasting benefits for children within their communities. Currently, it works in the health, child protection, food security, and nutrition sectors in all parts of the country.

Christian Aid has worked in the DRC since the 1970s, supporting local partners in development and emergency work. Christian Aid is non-operational, and puts a lot of emphasis on building up the capacities of its local partners. The main activities are in food security, relief, peace and reconciliation, civic education, health (the fight against AIDS), and advocacy.

Front cover photograph: Anna Leader. Trésor, a street child in Kinshasa.

# 1. EXECUTIVE SUMMARY

In August 1998, the Democratic Republic of Congo (DRC) was plunged into a second war in less than two years. Today, exactly three years later, the country is still embroiled in a complex conflict, the effect of which is taking an unprecedented toll on the Congolese population. This report portrays the scale of the deepening humanitarian crisis, which is resulting in the death and suffering of millions of people. It also illustrates the huge gap between the level of humanitarian need and the current humanitarian response throughout the DRC. A war of this magnitude warrants a much stronger and better co-ordinated response among agencies, donors, and international leaders than has so far been the case.

Since January 2001 the political context has changed significantly. Following the assassination of the former President, a new government was formed in April under the leadership of his son Joseph. The government has opened itself to the outside world, granted greater access to the humanitarian community, allowed MONUC<sup>1</sup> deployment, and shown a willingness to implement the provisions contained in the 1999 Lusaka Peace Accords. It has also adopted a series of bold economic measures with no compensating social support. Despite these signs of progress, and the recent troop withdrawals from the frontline, conditions continue to become increasingly difficult for the population. Many Congolese are hovering on the brink between life and death.

Insecurity in the eastern parts of the DRC has worsened following the redeployment of troops from the frontline to mineral-rich areas. There have been upsurges of fighting between different armed groups. One of the current driving forces behind the conflict is a desire on the part of the warring factions to have access to, and control over, the vast mineral resources of the DRC. This greed has caused the suffering of millions of people, almost none of whom has benefited from the wealth being created. **The humanitarian consequences of the war are the primary concern of Oxfam GB, Save the Children UK and Christian Aid.** All three NGOs are unusual in managing programmes across all of the DRC. This work has provided us with an overview of the level of needs and a national political analysis.

Reliable figures for the DRC are difficult to obtain. Problems of access, and often funding, have meant that there have been no national studies based on data gathered since the beginning of the war which provide a statistical analysis of the humanitarian situation. While we encourage the UN and other agencies to launch initiatives to collect recent data, we also believe that there is enough information available to provide a good indication of the level of needs. This report brings together some of the information available from the authorities, the UN agencies, NGOs, and other sources from across the DRC. It looks specifically at the humanitarian situation, and does not examine issues of justice and human rights, which have also been affected by the conflict.

The humanitarian crisis in the DRC has been described as one of the worst in the world. The fighting has led to appalling levels of hunger, disease, and death, and to countless abuses of human rights. More than two million people are internally displaced, most of whom are in eastern DRC. They have sought refuge with friends, family, or strangers, straining resources to such an extent that many of their hosts are also dragged into abject poverty.

Women and children bear a disproportionate burden of suffering in emergency situations. Among the displaced are a large number of children, many of whom are separated from their families. The crumbling state infrastructure in health and other sectors has been completely unable to cope with the growing suffering of the population.

Poverty, accentuated by the conflict, is increasing people's vulnerability on a massive scale. It is estimated that more than one-third of the population (16 million people) have critical food needs. In Kinshasa, a growing number of people eat only once every two or three days. In areas under rebel control, the situation is even worse. Parts of the country which used to grow food for export, such as Ituri and the

Kivus, are now wracked by hunger; severe malnutrition rates among children under five have reached 30 per cent.

Poor diets, difficult living conditions, and the collapse of routine vaccination programmes have weakened people, especially children, to such an extent that preventable diseases such as measles, whooping cough, and bubonic plague are re-emerging as major threats. Malaria continues to be the most common cause of illness and death across the country. Water-related diseases, such as diarrhoeas, worms, and cholera, are on the increase. Conservative estimates suggest that health care is no longer accessible to at least 18.5 million people. Health centres and hospitals across the country are crumbling through lack of maintenance, and in the east, a large number have been destroyed in the fighting. Of those that are still functioning, many lack clean water, qualified staff, drugs, and basic equipment. Even when people can reach medical facilities, many cannot afford to pay for consultation fees or medicines. The lack of food and basic health care is so great that one international NGO has recently estimated that up to 2.5 million people have died in eastern DRC since the war began, many of them as a result of malnutrition and preventable disease.<sup>2</sup>

In addition to the immediate problems of food and health care, the current situation is sowing the seeds of medium- and long-term socio-economic crises in the DRC. At least four out of every ten children of primary school age are being denied their basic right to education as a result of their parents' inability to pay school fees, the dilapidation or destruction of school buildings, and population displacement. The DRC will be left with an unskilled and partially illiterate workforce ill-equipped to participate in the future development of the country. Furthermore, the war has created conditions conducive to a rapid spread of the HIV/AIDS virus. Population displacement, the collapse of health services, and rising poverty levels have all contributed to its spread. The full extent of the problem is not yet visible, but the effect on the population, especially children and the elderly, is likely to be devastating.

Current estimates suggest that there are more than 10,000 child soldiers enrolled in armies and armed groups in the DRC. There are now many thousands of children on the streets of the DRC's major towns and cities. They are often working in extremely hazardous conditions, at risk of sexual exploitation, and likely to end up in the armed forces.

The conflict in the DRC is a regional war. Internal and external actors are fighting for control of territory, especially areas rich in natural resources. In some cases, external actors are also resolving their own internal conflicts on Congolese soil. Of the six countries directly involved in the conflict, with troops in the DRC, four are suffering from internal strife: Rwanda, Uganda, Angola, and Burundi. A long-term, peaceful solution for the DRC is inter-linked with the search for peaceful solutions in these four countries, and in particular in Rwanda and Burundi. The region requires sustainable political settlements, not quick fixes, if there is to be any impact on the human suffering in the DRC and other countries.

The humanitarian consequences of the war in the DRC are horrendous, as shown by the body of evidence now available to the humanitarian community. To date, the humanitarian assistance provided by the international community has been totally inadequate when considered alongside the scale of human suffering, and when compared with the efforts made to address humanitarian crises in other regions of the world. Although the fighting along the frontline has more or less ceased, the human suffering has not. Furthermore, the east of the country continues to experience significant insecurity despite relative quiet on the frontline. A large proportion of humanitarian need in the country is not being met, and thousands of people who require assistance remain inaccessible.

## RECOMMENDATIONS

Given the scale of the crisis, Oxfam GB, Save the Children UK and Christian Aid make the following recommendations.

- 1. The DRC government and the warring parties should guarantee safe access to all civilians in need and allow the free movement of humanitarian personnel and emergency relief supplies throughout the DRC. The United Nations Security Council, and member states of the UN, should urge all parties to the conflict to uphold International Humanitarian Law and guarantee safe access. Furthermore, the UN should ensure the separation of civilian and military operations.**

The protection of displaced people and civilians – from attack, separation from their families, malnutrition, or death from curable diseases — needs to be prioritised. All belligerents must be pressed to respect humanitarian principles and human rights, and to ensure that all humanitarian personnel have access to vulnerable groups.

In order to improve access to the most vulnerable groups affected by the conflict, the international donor community should support initiatives that ensure non-military air transport for use by humanitarian agencies.

- 2. The UN should reinforce its leadership of humanitarian co-ordination with the financial support of the international community. The DRC government and warring parties should do everything possible to facilitate these initiatives.**

A concerted effort to improve the co-ordination of the UN agencies, NGOs, and donor governments is urgently required to address the scale of the crisis. Given the geography of the DRC, the difficulties of humanitarian access, continued insecurity, and the complex nature of the crisis, an exceptionally strong aid co-ordination capability is essential.

All parties to the conflict, including the DRC government, should actively support these initiatives.

- 3. Donor governments should substantially increase their funding of humanitarian assistance and protection, in recognition of the massive scale of human suffering in the DRC, one of the worst humanitarian crises in existence.**

Although there have been positive steps in the peace process, these have not resulted in an improvement in the lives of the majority of Congolese people. In fact, the gap between the level of human suffering and the response of the international community is still horrifying.

Greater support is urgently needed for local agencies, UN organisations, and international NGOs in the DRC, the latter through the 2001 UN OCHA Consolidated Appeal. Working with international agencies and their local partners, donors should aim to reach international standards in relief such as the Sphere standards,<sup>3</sup> and uphold the International NGO and Red Cross Code of Conduct for Disaster Relief. The DRC crisis highlights the inequity and unbalanced nature of the international community's response to suffering around the world. We seek a new commitment to equitable entitlement to humanitarian assistance and protection by donor governments.

- 4. Donors should recognise and prioritise the needs of the most marginalised people, especially children and women. Humanitarian aid must be provided in a timely fashion**

**according to need, with strong emphasis on the most vulnerable. There is also an urgent need for resources for basic infrastructure in health and education. Longer-term interventions, including those which build the capacity of national and local organisations, will be required if the country's needs are to be fully addressed.**

An effective donor strategy must support primary health care programmes and education initiatives for internally displaced children and women. A longer-term approach is required to address fully the needs of the Congolese population. During the last 40 years, churches and local organisations have played a significant role in providing health and education services. Continued support for these services is vital. While the humanitarian catastrophe in the DRC must be addressed now, there is also a need for longer-term rehabilitation and development aid.

**5. The international community should support the peace process in the DRC and other peace processes in the Great Lakes region, in order to find a lasting solution to the regional crisis. It should consider how best to use development aid in a strategic way to encourage the peace process. The United Nations Security Council and UN member states should be prepared openly to criticise any parties breaching agreements reached.**

The conflict in the DRC, which has caused such horrifying levels of human suffering, is also a regional war. Internal and external actors are fighting for control of territory, especially areas rich in natural resources. In some cases, external actors are also resolving their own internal conflicts on Congolese soil. There are six countries directly involved in the conflict and with troops in the DRC, of which four are suffering from internal strife – Rwanda, Uganda, Angola and Burundi. It is widely recognised that a long-term peaceful solution for the DRC is inter-linked with the search for peaceful solutions in these four countries, and in particular for the conflicts in Rwanda and Burundi. The region requires sustainable political settlements.

The international community should consider how best to use development aid incrementally to encourage the parties to move towards and surpass landmarks in the peace process.

## Key Facts at a Glance<sup>4</sup>

- More than two million people are internally displaced; of these, over 50 per cent are in eastern DRC. More than one million of the displaced have received absolutely no outside assistance.
- It is estimated that up to 2.5 million people in DRC have died since the outbreak of the war, many from preventable diseases.
- At least 37 per cent of the population, approximately 18.5 million people, have no access to any kind of formal health care.
- 16 million people have critical food needs.
- There are 2,056 doctors for a population of 50 million; of these, 930 are in Kinshasa.
- Infant mortality rates in the east of the country have in places reached 41 per cent per year.
- Severe malnutrition rates among children under five have reached 30 per cent in some areas.
- National maternal mortality is 1837 per 100,000 live births, one of the worst in the world. Rates as high as 3,000/100,000 live births have been recorded in eastern DRC.
- DRC is ranked 152<sup>nd</sup> on the UNDP Human Development index of 174 countries: a fall of 12 places since 1992.
- 2.5 million people in Kinshasa live on less than US\$1 per day. In some parts of eastern DRC, people are living on US\$0.18 per day.
- 80 per cent of families in rural areas of the two Kivu Provinces have been displaced at least once in the past five years.
- There are more than 10,000 child soldiers. Over 15 per cent of newly recruited combatants are children under the age of 18. A substantial number are under the age of 12.
- Officially, between 800,000 and 900,000 children have been orphaned by AIDS.
- 40 per cent of health infrastructure has been destroyed in Masisi, North Kivu.
- Only 45 per cent of people have access to safe drinking water. In some rural areas, this is as low as three per cent.
- Four out of ten children are not in school. 400,000 displaced children have no access to education.
- Of 145,000 km of roads, no more than 2,500km are asphalt.

## 2. INTRODUCTION

This report gives a picture of the human suffering being experienced in the Democratic Republic of Congo (DRC) as a result of the war. It also shows the size of the gap between the needs of the population and the current humanitarian response.

The situation prevailing in the DRC has been described as one of the world's worst humanitarian crises.<sup>5</sup> The country is divided in two, despite recent troop withdrawals from the frontline. The fighting has led to appalling hunger, disease, and death, and to countless abuses of human rights. More than two million people are displaced, and continue to live in a precarious situation, scattered across the country. There are also estimates of more than two million deaths attributable to the war, many of them as a result of preventable diseases.<sup>6</sup> The crumbling state infrastructure in health and other sectors has been completely unable to cope with the increasing suffering of the population.

One of the current driving forces behind the conflict is a desire on the part of the warring factions to have access to, and control over, the vast mineral resources of the DRC. This greed has caused the suffering of millions of people, almost none of whom has benefited from the wealth being created. **The humanitarian consequences of the war are the primary concern of Oxfam GB, Save the Children UK and Christian Aid.** All three NGOs are unusual in managing programmes across all of the DRC. This work has provided us with an overview of the level of needs and a national political analysis.

This report looks specifically at the humanitarian situation, and does not examine issues of justice and human rights, which have also been affected by the conflict. While Christian Aid, Oxfam GB, and Save the Children UK are working with their local partners, with other humanitarian organisations and with the UN agencies to reach the most vulnerable people, a large proportion of humanitarian need is not being met. As humanitarian access has opened up in western parts of the country, the difference between the scale of the suffering and the assistance currently being provided is becoming increasingly clear. **There is a huge gap between the level of humanitarian need and the current humanitarian response throughout the DRC.** A war of this magnitude warrants a much stronger and better co-ordinated response among agencies, donors, and international leaders.

Reliable figures for the DRC are difficult to obtain. Problems of access, and often funding, have meant that there have been no national studies based on data gathered since the beginning of the war which provide a statistical analysis of the humanitarian situation. The government has little information about disputed areas, and both rebel authorities and the government have lacked the capacity to make data collection a priority. There are many places which relief agencies have not been able to reach for years. A lack of information often leads many international donors and political leaders to question the impact of the war and the level of assistance required.

While we encourage the UN and other agencies to launch initiatives to collect recent data, we also believe that there is enough information available to provide a good indication of the level of needs. This report brings together some of the information available from the authorities, the UN agencies, NGOs, and other sources from across the DRC. Most of the government's figures (particularly the national health and education statistics) date back to 1998. Those provided by the UN and NGOs are based on recent surveys and assessments in locations to which the humanitarian community has had access. None of the information is therefore completely accurate or comprehensive, but our experience has been that it is usually very difficult to obtain reliable statistics in war situations. However, it is important to use what is available, and to build on it.

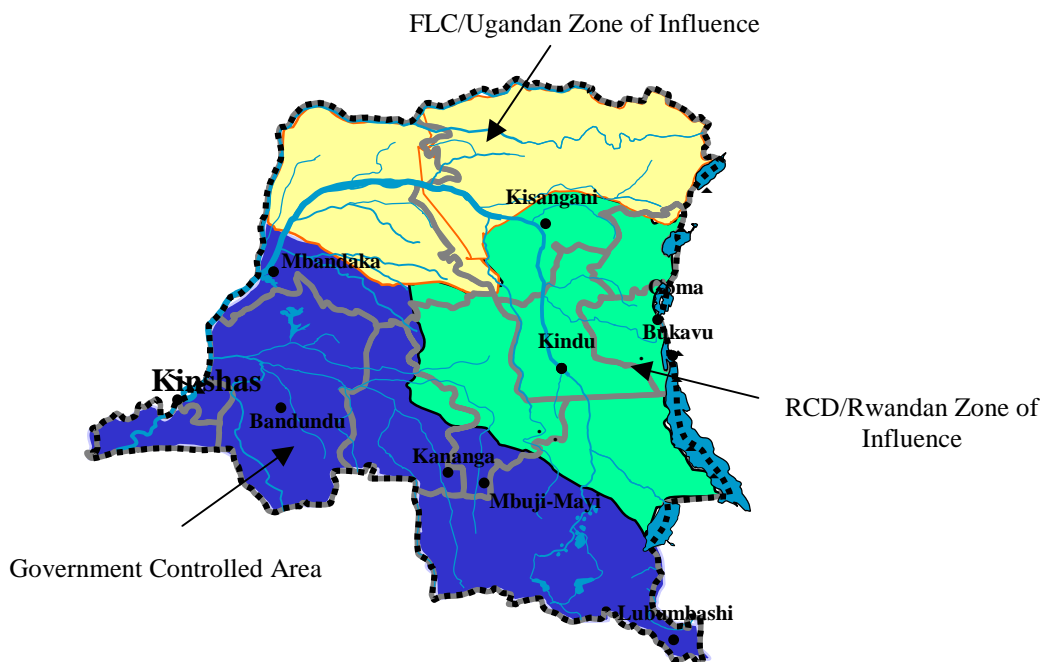
## 3. CONTEXT

There has been a significant shift in the political context in the DRC following the death of President Laurent Desiré Kabila in January 2001. The new Government led by the son, Joseph Kabila, has adopted a positive attitude towards the 1999 Lusaka Peace Accords and has renewed hopes for peace. Previous



isolationist policies have been abandoned in favour of investing considerable energy in discussion with the international community. A three-year suspension on the ban on political parties was lifted in May, and prominent opposition leaders have returned from self-imposed exile overseas. The new Government has accepted ex-President Masire of Botswana as the facilitator of the Inter-Congolese Dialogue, and the preparatory stage of this is now scheduled for 20 August, postponed from 16 July.

DRC remains a country split into three main zones of control. Most of the northern part of the country is under FLC (Front de Libération du Congo) control, with support from the Ugandans. Much of eastern DRC is controlled by the RCD (Rassemblement Congolais pour la Démocratie), with the support of the Rwandan army. The western and southern parts of the country remain under the government's control, with military support from Angola, Zimbabwe, and Namibia.<sup>7</sup> Since March 2001, fighting along the conventional frontline between these rebel movements and the government/allied forces has more or less ceased. UN military observers as part of the MONUC<sup>8</sup> force have been deployed to positions along the frontline and to other key locations. The cessation of hostilities between the major armies has given a boost to peace talks and the possible implementation of the Lusaka Peace Accords.



Despite the relative calm along the conventional frontline, the military and security situation has not substantially improved in the east of the country. On the contrary, eastern DRC has become increasingly insecure over the past six months. The pull back of troops from frontline positions has led to their redeployment to other areas of the DRC, such as Masisi. No foreign army has yet completely left the DRC; many have now reinforced themselves in areas where the extraction of mineral and other natural resources is taking place.<sup>9</sup> The proliferation of armed groups, newly formed militia, and ill-disciplined soldiers pose a greater threat to security and stability for the population in eastern DRC than the conventional war ever did. Humanitarian access is therefore sporadic in some places, and impossible in many others.

### Socio-economic context

The war has had a devastating impact on the country's 50 million people.<sup>10</sup> The DRC is currently ranked 152<sup>nd</sup> on the UNDP Human Development index of 174 countries: a fall of 12 places since 1992. This is particularly shocking in a country with considerable natural resources, such as diamonds, hydro-electric power, wood, and minerals. Since the period of colonisation by King Leopold, very few Congolese citizens have ever benefited from the country's wealth. UNDP reported that the DRC's per capita gross

domestic product (GDP) in 1998 was US\$110, compared with US\$160 in Burundi and US\$680 in the neighbouring Republic of Congo. More than half of the five million people living in the capital city of Kinshasa are thought to live below the World Bank's poverty threshold of US\$1 per day.<sup>11</sup> A recent socio-economic survey in North Kivu indicated average expenditure per person per day of US\$0.41; in other places like Kayna, this figure was as low as US\$0.18.<sup>12</sup> The rise in poverty levels has had a dramatic impact on the humanitarian situation in the country.

The little infrastructure that existed prior to the two wars of 1996 and 1998 has crumbled. Health and education systems are in a state of collapse, continuing to rely on support from the churches, local organisations, and international agencies to provide limited services to the population. The poor state of the roads all over the country, compounded by insecurity in the east, impedes trade and makes the delivery of humanitarian assistance difficult and costly. Of the 145,000km of roads, no more than 2,500km are asphalt. Many of the remaining roads are often impassable during the rainy season. The threat of armed attack leads many business people to abandon road traffic completely. River-transport connections along the Congo River and its tributaries, once the crucial highway of the DRC, have also been severed. In many places, access is only possible by air, putting many basic necessities, including medicines, beyond people's reach. The movement of food and other supplies from rural to urban centres has completely ceased, resulting in large food deficits in towns and reduced production in the rural hinterlands.

Kindu, a major town in the interior, has been completely cut off from the rest of the DRC. Once a major river port, no boat has docked there since 1998. Jean, the chief engineer responsible for the port, has tried in vain to keep some of the machines and equipment working, in the hope that some day a boat may arrive. But the equipment has rusted, and soldiers have taken any working machines. Many other useful parts have been stolen or sold. Today there is not much left of the port, other than barely visible sunken ships and the towering hulks of the once-busy cranes. Jean has not received a salary for over three years, and he now survives by catching fish off the docks.

A combination of the impact of the current conflict and the previous government's monetary policy made the economy in the western part of the country even more fragile. The ban on the use of the US dollar in September 1999 dealt the final blow to some of the remaining foreign interests, and caused a rapid devaluation of the Congolese franc on the parallel market. The currency lost 284 per cent of its value on the parallel market between October 2000 and April 2001, and a further 33 per cent during the month of May 2001 alone.<sup>13</sup> Hyper-inflation stifled financial planning for average Congolese families. Any money they earned had to be spent immediately, before it lost its value. In order to increase the flow of available dollars, the government granted a monopoly on diamond dealing to an Israeli firm, IDI Diamonds, in August 2000. However, this weakened government revenue even more, as the expected income never materialised. Many dealers refused to sell to IDI Diamonds, and much of the trade was driven on to the black market.

In an attempt to halt the decline of the economy, the new government adopted a series of measures in May 2001. The diamond trade monopoly was broken, and on 29 May the official exchange rate (50FC=US\$1) was brought in line with the parallel rate (345FC=\$1). At the same time, the price of fuel, which had been fixed at 70FC, causing fuel shortages which paralysed the capital, was raised to 280FC.<sup>14</sup> There are some positive indications that this new policy is working. For the moment, many Congolese people are taking a 'wait and see' approach, even though their standard of living has been further eroded. The payment of civil service salaries, crucial to the success of this policy, still needs to be addressed. In the past, these payments have been sporadic, leaving much of the population to find other means to survive.

In the east, the rebel authorities have maintained a three-currency economy, including Nouveau Zaire, Franc Congolais, and US dollar. The split in the country has also affected monetary policy, and resulted in different exchange rates in each of the three main zones of control. The population in rebel-held areas has suffered less from hyper-inflation, since dollars are regularly used. However, the non-payment of state salaries, plus the almost complete lack of any budget for social services and infrastructure repairs, has made life increasingly difficult. In the health sector, for instance, doctors in six of the major health zones in Bunia have not been paid a salary for over six years. Many of them do not even know how much their salary is supposed to be.

## Population displacement and refugees

The most recent conflict has led to large-scale population movements within the DRC and over the borders into neighbouring countries. In March 2001, there were an estimated 2,040,000 internally displaced people (IDPs) within the DRC – an increase of 240,000 since November 2000. According to the Office for the Co-ordination of Humanitarian Affairs (OCHA), the war in the DRC has created the highest number of IDPs ever registered in Africa in the context of a single conflict.<sup>15</sup>

Approximately 1.6 million of the total number of internally displaced people are in rebel-held areas, and approximately one million are currently located in North and South Kivu, a figure that has risen from 400,000 in mid-1999. It is estimated that four-fifths of families in rural areas of the Kivus have been displaced at least once during the past five years, sometimes to less than a kilometre from their homes.<sup>16</sup> The distribution of the IDPs by province is as follows:

<i>Province</i>	<i>Number of displaced people</i>
North Kivu	620,000
South Kivu	373,000
Maniema	132,000
Province Oriental	220,000
Katanga	354,000
Equateur	170,000
Kasai Oriental	114,000
Kasai Occidental	29,000
Kinshasa	28,000
Total	2,040,000

Source: OCHA, March 2001

Less than half the internally displaced people have access to direct relief assistance, which means that more than one million people are displaced with no kind of external assistance or support.<sup>17</sup>

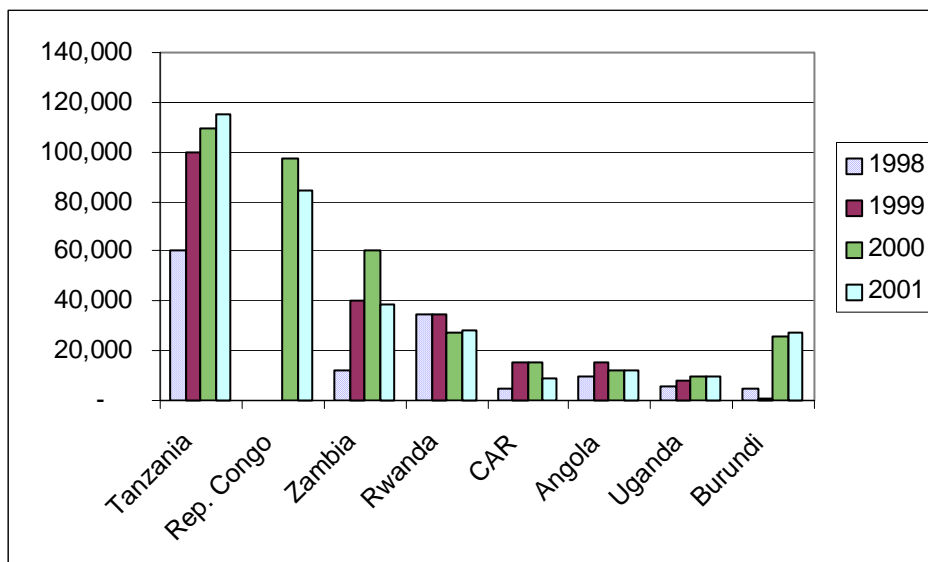
Displacement presents a number of protection concerns, especially for the most vulnerable members of the population. In conflict settings, a large percentage of displaced people are typically women and children. With the loss of large segments of the male population to the armed forces, between 60 and 80 per cent of the displaced population in areas such as Maniema, Kalonge, Bunyakiri, and Shabunda is reported to be made up of women-headed households.<sup>18</sup> Of particular concern for children is separation from their families during flight, placing them at greater risk of exploitation and abuse. In the DRC, separation and abandonment of children during flight has led to dramatic increases in the number of street children in all urban areas, including those which had previously not known such problems, such as Lubumbashi. In a conflict which has exploited thousands of children as soldiers, separation also dramatically increases the risk of recruitment into armed groups – not necessarily only by force, but by presenting what may appear to be the only viable economic option in which children can ‘voluntarily’ participate. There is no discrimination in the risk that separation poses for children in the DRC conflict. There were round-ups of street children in 2000, and recruitment drives in Kinshasa in 1998 attracting an

estimated 6,000 children seeking an income. In addition, the Interahamwe incorporated an estimated 8,000 Hutu children left behind by their refugee parents in 1996-97.<sup>19</sup>

Humanitarian agencies have noted that most displaced people have tended to remain close to their areas of origin, usually in nearby forests, and were relatively easy to find and provide with whatever assistance was available. However, since 2000, changes in the frontline and in the strategy of armed groups, particularly militias, have caused changes in the patterns of displacement, driving people much further from their areas of origin, and making their identification and the provision of assistance far more complicated. The majority of displaced people in the DRC do not reside in camps but take refuge with families or friends in other villages or towns. In many places, villages have doubled or tripled in size, placing a great burden on host communities. The host community in many areas has become as impoverished and destitute as the displaced. One of the most vulnerable groups of people includes those who have taken refuge in the dense forests, especially around Shabunda, Ituri, and along the Bokungu-Ikela axis in Equateur. These people are often from towns or villages, and are totally unequipped for life in such harsh conditions. Forced to eat wild plants and attempt to cultivate, they have no access to medical services or clothes. They are usually in a very poor physical state but are often too embarrassed to seek assistance, even when it is within reach.

Antoine is a tailor from a small village just outside Shabunda. One night, over a year ago, the village was attacked by armed soldiers who wanted to control the coltan<sup>20</sup> mines in the area. He and his family of five hid in the forest for three days before the fighting became a lot worse. He decided that he must flee with his wife and children, but just before leaving, picked up his sewing machine. He walked for over five days with the machine on his head before arriving in the town of Kalima. Here he was lucky to find a family willing to welcome him into their home. Quickly, he built a little shack out of plastic just outside the family's house and set up his sewing machine. Now he spends most of his time sewing small bags for traders to transport their coltan. It's a sad irony, but he manages to survive.

In addition to the internally displaced people, a large number of Congolese have left the DRC as refugees. The annual reports of the US Committee for Refugees show that by the end of 2000, approximately 340,000 people had left the DRC, compared with approximately 135,000 in 1998. The graph below shows the trends from January 1998 to the end of May 2001.<sup>21</sup>



## Humanitarian Access

Under international humanitarian law the principle of subsidiarity dictates that the primary responsibility for meeting the needs of the civilian population in an armed conflict rests with the warring parties which are in effective control of the territory on which the population lives. The Geneva Conventions permit humanitarian organisations to offer their services to assist in discharging this duty.<sup>22</sup> Once the relief operation is accepted in principle, the authorities are obliged to co-operate, for example by providing safe access.<sup>23</sup> Yet access to populations in need has been incredibly difficult throughout the DRC. Since the beginning of the war, many of those requiring urgent assistance have been in areas not accessible to the humanitarian community. It is likely that many people have died as a result of this lack of access. The latest IRC mortality survey conducted in April 2001 indicates that more than two million people in eastern DRC may have died since the outbreak of the war, many from preventable diseases.

In western DRC, humanitarian space was limited by the previous government's unwillingness to grant permission to foreigners to travel outside Kinshasa and Lubumbashi. Permission was regulated by the Ministry of the Interior, and was bogged down by bureaucracy and suspicion. International NGOs were almost never granted travel authorisations or the mining permits required for travel to designated mining areas, such as most of the two Kasai provinces. Unable to start programmes, given these constraints on access, agencies could provide only limited assistance to government-held areas. Between August 1998 and March 2001, very little humanitarian aid reached populations affected by the war in Katanga, Equateur, and the two Kasai provinces, despite a growing body of information about the level of need.

In March 2001, the new government changed this policy, approving freedom of movement for international personnel. Access to many areas has now improved, although expatriate staff still find travel to designated mining areas cumbersome. Humanitarian missions are being dispatched to government-held areas cut off for almost three years, and some of these have found very serious situations.

In May 2001, Oxfam GB participated in a mission to Ikela (Equateur Province), a town on the front line. Bazongo, a 22-year old student, told the team, 'When the fighting was at its worst, nearly all the 14,500 inhabitants fled Ikela. Only 500 of us remained in the town that was held by the government and allied troops. We were completely encircled by the rebels, so they had to airdrop supplies for the soldiers. When the supplies arrived, both the population and the soldiers rushed to pick up the bags. My mother and my brother stepped on a mine as they tried to pick up food for us to eat. They were both killed.'

In rebel-held areas, the main impediment to humanitarian access has been insecurity. This has been a consistent problem since the start of the war in 1998, with threats being posed by occupying armies as well as by non-state armed groups in conflict with Rwandan troops, Ugandan troops, the RCD, and the FLC. Fighting around resource-rich areas has been most frequent, leading to a reduction in humanitarian access. It is often difficult to know who is the controlling authority for a particular area, and whether that authority can provide any guarantees of security. The situation is unpredictable and dangerous. Attacks against humanitarian workers are frequent and sometimes fatal.<sup>24</sup> Even though the war along the conventional frontline has more or less ceased, eastern DRC has suffered an increase in violence. Humanitarian access is therefore often sporadic, depending on the security of particular areas.

There are hopes that the implementation of the Lusaka Peace Accords will have a positive impact on humanitarian access. As armies retreat and military observers spread out to strategic areas, access to vulnerable populations should become easier. This has been the case in towns like Kabinda and Ikela, to which humanitarian missions have recently had access for the first time in years. However, experience has so far indicated that the increase in access to government-held areas has been at the cost of a decrease of access to rebel-held areas. In recent months, parts of North Kivu, such as Beni and Rutshuru, and much of Ituri have become inaccessible due to violence and fighting. The implementation of the next stage of MONUC's mandate (Stage III) involves the withdrawal of foreign armies. This may leave areas devoid of a military presence which MONUC itself does not have the capacity or the mandate to protect. There is a risk that the vacuum may be filled by non-state armed groups, possibly connected to the exploitation of natural resources, which will make access just as difficult as in the past.

Military and political considerations aside, a major factor governing the access of the humanitarian community to the whole of the DRC's territory is financial. The country's sheer size and lack of transportation infrastructure make it an expensive place in which to run humanitarian programmes. Access to many areas is only possible by air, which is a costly way to transport goods. Many donors are reluctant to cover the cost of funding these operations. The low levels of funding that have been made available to humanitarian agencies are severely limiting, and will leave a large proportion of vulnerable people in both government-held and rebel-held areas unassisted, even if full access were made possible tomorrow.

#### **4. CHILD SOLDIERS**

It is estimated that more than 10,000 children are under arms in the DRC, although the precise number is impossible to verify. All parties to the conflict are alleged to be making extensive use of child soldiers. Despite declarations by both the DRC government and the RCD-Goma to cease recruitment and commit to the demobilisation of child soldiers, their use and recruitment continue. The April 2001 report of the UN Secretary-General to the Security Council on the MONUC operations stated that MONUC confirms regular sightings of child soldiers across the country.<sup>25</sup> Reports to MONUC indicate that between 15 and 30 per cent of newly recruited combatants are children under 18; substantial numbers of these are under 12.

A variety of recruitment methods are employed. A significant minority was recruited by force, while armed groups or local authorities have enrolled many others through various forms of community coercion, such as the imposition of quotas. Many child soldiers claim to have joined the forces voluntarily. However, given the pressure that can be brought to bear by recruiting groups, the term 'voluntary' is open to question. The principle motivations behind their initial enrolment have been to seek an economic livelihood, to seek revenge, to seek personal physical security, and to protect family and community. Others simply cite the lack of anything else to do in a village where economic activity has been paralysed by insecurity, and where penury bars a child from access to education. For most child soldiers, all of these factors played a part, with economic necessity being, in general, the single most important driving force. There is a close correlation between the level of a child's poverty and their vulnerability to recruitment.<sup>26</sup> Even without the offer of a regular wage, membership in any armed group offers the prospect of taking part in looting and extortion. For many children, even the prospect of being fed was incentive enough to join. Given the continuous deterioration in the country's socio-economic conditions, it should not be assumed that all child soldiers are eager to return to civilian life.

Testimonies from former child soldiers strongly suggest that they are used excessively in combat, and suffer a disproportionate number of casualties, while being the least likely to receive medical attention when sick or wounded. Severe physical beatings and other punishments are routinely meted out to child soldiers, both during training and in general service. The treatment received from superiors is an important reason for seeking to leave the forces, as are lack of pay or food and the fear experienced in combat. In contrast to some other places, and although their lives are harsh, it would appear that little

systematic or deliberate effort is made by the various forces to brutalise or dehumanise child soldiers by forcing their participation in heinous acts.

The recruitment and use of girls by the different armed groups is difficult to assess. The presence of girls has been noted in RCD and FAC forces.<sup>27</sup> Although some receive military training, it appears that few, if any, see combat. Girls are typically used for domestic work and sex, primarily by commanders, which implies that their number is relatively low compared with boy recruits. Many girls remain 'wives' of military commanders, even returning to the countries of origin of foreign forces. Many others resort to prostitution to support themselves and their children after being abandoned or widowed by their military partners.

Despite initial encouraging signs that the demobilisation of child soldiers would proceed, the process has failed to materialise, and the authorities have not been forthcoming with the numbers or locations of the child soldiers in their forces.<sup>28</sup> However, influence and persuasion exerted locally on some military commanders, coupled with community-level awareness-raising, has shown some successes, particularly among the higher-ranking career officers who may be more sensitive to public opinion, and more interested in maintaining professional standards of conduct. Enforcing compliance with demobilisation orders from Chiefs of Staff among lower ranks, and influencing the irregular forces (Mayi-Mayi, FDD, Interahamwe) which fall outside the framework of the Lusaka Accord, remain important constraints.

While a small number of children have been formally released by the military, unknown (but certainly much larger) numbers have chosen to leave and returned home on their own. The government of the DRC views these children as *deserters*, placing additional protection concerns on their reintegration to community life. They have been the focus for some child-focused local organisations, and have benefited from small-scale socio-economic reintegration programmes, which assist their families in developing self-reliance, and which offer opportunities to access basic services.

## 5. HEALTH

Prior to start of the conflict in 1998, available health data showed that the existing infrastructure was already failing to deliver quality, affordable care to the majority of the DRC's population. The war has made this situation even worse. Hospitals, clinics, and health posts have been destroyed, medication cannot be delivered, and routine vaccination programmes have been disrupted. Many people struggle to pay for health services; some cannot afford to pay at all. Moreover, many people now live in such difficult conditions that they run a much greater risk of falling ill.

### Access to health care

A dearth of recent statistical data from across the country makes a full assessment of the population's access to health services difficult.<sup>29</sup> However, conservative estimates of the coverage of health facilities show that at least 37 per cent of the population, or approximately 18.5 million people, have no access to any form of formal health care.<sup>30</sup>

In government-held areas, the share of central government expenditure allocated to the health sector is less than one per cent – and has been barely more than this since Independence in 1960. As a result, the health system has always been run as a 'private' service, with patients required to pay. In areas under RCD control, there is no budget for health services. Additional support to the 307 Health Zones into which the country is divided comes mainly from churches and other organisations. However, in 2000, 100 Health Zones received no external assistance, either from the government or from outside agencies. In addition, there is a severe lack of human resources. In 1998 there were only 2056 doctors for a population of 50 million people, and of these, 930 were in Kinshasa.<sup>31</sup>

A doctor working in a Health Zone in Province Oriental is the only doctor in the region, and is responsible for an astonishing 350,000 people. He admits that it is impossible to attend to the needs of many of those in his care. He works seven days a week at the central hospital, caring for patients, with minimal equipment and almost no medicine. Some of the health posts in his zone have not been reached for more than two years, due to an inter-ethnic war between the Hemas and the Lendus. 'I do not know where these people are getting medical assistance. I know many of them have been driven into the forests and have probably died. There is just too much to do and not enough of us around to do it.'

In the west of the country, state salaries (when paid) for the few well-qualified medical practitioners are so derisory, (4,700FC, or US\$14 per month), that they charge their patients for treatment. In order to make a living, they also work in unregulated private-health institutions alongside their jobs in the state service. Staff are so demotivated that patients in need of attention – even life-saving assistance – are frequently not attended to until they, or their families, can provide payment and the necessary drugs. In eastern DRC, many medical staff cannot remember when they last received a state salary.

The increase in poverty has meant that a high percentage of people cannot afford essential medicines. On the outskirts of Kisangani, the staff at the Segama health centre estimate that only 40 per cent of the population can afford to pay the US\$0.15 consultation fee. Of these, only one in four can afford US\$0.11 to buy the medicines that are prescribed. As a result, many people resort to trying to treat themselves, which can have disastrous consequences. In Kimbanseke, a poor commune in Kinshasa, four per cent of the population is deaf, significantly higher than the international average of two per cent.<sup>32</sup> One of the reasons is abusive self-medication of drugs such as the antibiotic called gentamycine. Rather than spend money on going to a health centre, people buy the drug in local pharmacies or the market and treat themselves. Incorrect use of the drug can cause deafness.

### **Health Infrastructure**

One of the main problems with the health system is its infrastructure. The complete lack of investment has resulted in hospitals, clinics, and health posts falling into an increasingly dilapidated state. Many lack essential medical equipment, sanitation, and even clean water. This is true in major towns as well as in the more remote rural areas. The hospitals and health centres are often places where disease is spread.

In Mbuji Mayi, where Oxfam GB is currently rehabilitating health centres and providing clean water, many hospitals lack the most basic hygiene requirements. There are no washing facilities, latrines, septic tanks, or incinerators. Roofs and ceilings are falling down, walls are cracked, termites have destroyed carpentry, and the buildings are inhabited by rats and birds. The Miabi rural hospital, which serves 45,000 people, receives only one or two new cases a day, partly because of the unbearable smell caused by bats living in the roof. In Bas Congo, the hospital in Ngidinga is reduced to collecting rainwater, because REGIDESO no longer provides water to the town.<sup>33</sup> In Gombe Matadi, the hospital relies on unprotected springs a kilometre away. In Ituri (Province Oriental), 15 health centres serving a population of more than 120,000 people have no access to water at all.

A small, precarious building (6m x 3m) made of mud bricks is the maternity hospital in Bipemba, Mbuji Mayi. It was built by Catholic nuns because the nearest state-run hospital is 6km away. Of the three small rooms, one is used



for the women who have just given birth. There are four beds, each of which is occupied by at least three, sometimes four women. As the roof is made of corrugated iron and there is no ceiling, the room becomes unbearably hot. In order to protect the babies from the heat emanating from the roof, the mothers place them on cloths on the floor under the beds. Because of the number of visitors, the cement floor gets dirty, covered in mud and dust. The conditions are so poor that the women insist on going straight home, thereby running the risk of infections, and without the rest and follow-up care they need.

In rebel-held areas the situation is even worse, because a large number of the medical facilities in areas which were already under-resourced have also suffered war damage. In Masisi (North Kivu), 40 per cent of all health infrastructure has been destroyed, including the hospital in Mweso which was gutted and used by soldiers. In the Djugu territory in Ituri, many health centres were completely destroyed as the inter-ethnic war raged through its towns. All that now remains is rubble, medical staff having fled or been killed. In rebel-held parts of Kabinda Health Zone (Kasai Oriental), the disengagement of warring parties in March has allowed medical staff from health outposts to reach the town for the first time in more than a year. They reported that in 12 areas only one of the health centres has any medicine, and the rest are not functioning at all. Many have been looted, and have little or no essential equipment.

### **Death rates in the DRC**

The mortality rates in the DRC are among the highest in the world. In 1998, the national infant mortality rate was 127 per 100,000 live births, and 138 per 100,000 live births in rural areas. It is highly unlikely that these averages will have improved during the past four years, particularly given the situation in the east of the country.

Five mortality surveys conducted by the International Rescue Committee (IRC) in different areas of eastern DRC found that children have been particularly badly affected by the conflict.<sup>34</sup> Mortality rates for children under the age of one ranged from 19 per cent per year in Lubunga (Kisangani) to 41 per cent per year in Kalima (Maniema Province). The survey found that there was a dearth of very young children in the populations studied, with fewer one- and two-year-olds than three- and four-year-olds. The death of a large number of children in this age group is consistent with a severe deterioration of the situation since the conflict began in August 1998.

The mortality rates among children under five were also found to be extremely high. In three of the five locations studied, death rates were higher than 10 deaths/1000/month:

Katana (South Kivu):	12.9
Kalima (Maniema):	17.1
Kalemie (northern Katanga):	23.8

These high rates appear to have been experienced for a number of years. The main causes of death were reported to be malaria, malnutrition, and measles. A continuous under-five mortality rate of 10/1000/month would result in 60 per cent of children dying before their fifth birthday. Surveys by Nuova Frontiera in March 2001 in Kiambi and Manono, northern Katanga, also found shockingly high mortality rates among under-fives. In Kiambi the rate was 34.95/1000/month, and in Manono 20.49/1000/month.

In Kalima, Therese sits in a feeding centre, with a two-year-old child in her lap. She does not know the child's name, but has called her Beatrice for now. Beatrice is severely malnourished. One morning a woman quietly left the

young child by the door of Therese's hut before running quickly back into the forest. Therese knows that there are many people living in the forest who have been forced to flee from the fighting in Shabunda and are now too frightened to return home. She has heard stories that many have died. She hopes that Beatrice will not, and that one day she can be returned to her mother. But she is not hopeful. 'If she left her with me, a complete stranger, she must be very desperate. No mother wants to see her child die. Maybe she thought this was her only hope.'

On the basis of mortality data collected among the sample populations, and through extrapolation, the IRC has calculated that 2.5 million people died between August 1998 and March 2001 in eastern DRC as a result of the conflict. Of these, 350,000 died as a result of direct violence, and the remaining 2,150,000 from malnutrition and disease. While the accuracy of data extrapolated from such a small sample is open to debate, the magnitude of the suffering caused by the conflict is clear.

Maternal mortality rates registered in the DRC are among the worst in the world, and a clear indication of the total collapse of the health system. In 1998, the national maternal mortality rate was 1837/100,000 live births, a situation which can only have deteriorated in most parts of the country.<sup>35</sup> The rates recorded in Uganda and Zimbabwe for the same year were 510/100,000 and 400/100,000 respectively. Moreover, since maternal mortality is recorded only in hospitals and some health centres, the number of maternal deaths is almost certainly much higher.

The conflict has caused a large increase in the numbers of women who can not get adequate health care when they deliver, many of whom die at home. In Rethy (Ituri), maternal mortality rose from 50/100,000 live births in 1997 to 905/100,000 in 1999, indicating that many mothers get to hospital in difficulties owing to prolonged labour.<sup>36</sup> In the Kivus in 2001, the rates are as high as 3000/100,000 live births.<sup>37</sup>

This problem is by no means confined to rural areas and to the east of the country. A study on maternal mortality in Kinshasa published in June 2001 found that the rate during 2000 was 1393/100,000 live births (representing 20 deaths per day), and that the main cause of death (31 per cent) was haemorrhaging.<sup>38</sup> The cost of travel, in addition to the hospital fees upon arrival, often prevent women from seeking assistance unless a serious problem occurs, at which point it can be too late for relatives to find enough money to pay the fees and purchase the necessary medicines.

Lack of training and pay for health staff also increases the level of maternal mortality. In 1999, the state maternity hospital in the Kintambo quartier of Kinshasa was registering a maternal mortality rate of 1500/100,000 live births.<sup>39</sup> Although no funds were available for new medical equipment or staff salaries, a training programme designed to retrain and remotivate the medical staff resulted in the maternal mortality rate falling by 74 per cent to 400/100,000 live births.

An additional problem faced by women and the wider population is the proliferation of private health structures, which are replacing the non-existent or non-functional state services. More than 63 per cent of people in Kinshasa use private services which are ill-equipped and staffed by poorly trained personnel. The effect of resorting to these unregulated clinics can be fatal.

Mireille was 17 when she became pregnant. When her baby was three months old, he became ill with a high temperature and convulsions. As Mireille did not have enough money to take the baby to the hospital, she took him to a private clinic in the neighbourhood. The attendant told her that the child had malaria and proceeded to give the baby a quinine injection. Shortly

afterwards, the baby had huge convulsions, stopped breathing and died. The attendant did not have enough training to know that babies are treated for malaria with quinine syrup, and that injecting quinine directly into the vein would cause heart failure. He told Mireille that it was her fault that the baby died, as she had not sought medical attention soon enough.

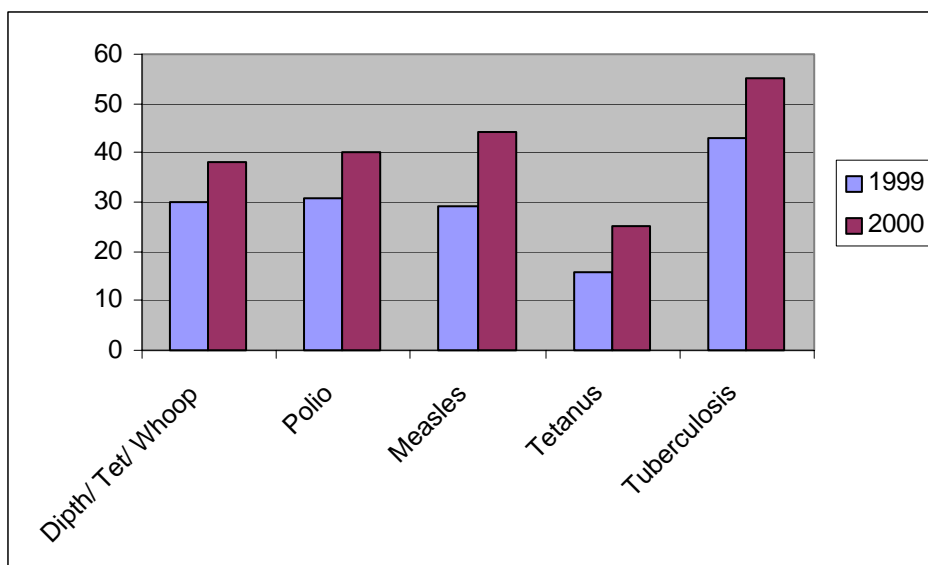
## **Disease in DRC**

As a result of difficult living conditions and lack of access to health care, diseases which had almost been eradicated, such as bubonic plague and whooping cough, are now being recorded. There have also been numerous epidemics of measles and cholera, and reported cases of haemorrhagic fever, monkey pox, and meningitis.

The prevalence of tuberculosis, already a serious problem before the war, has risen. The increase in the number of cases of tuberculosis can be attributed to malnutrition, a lack of access to drugs, HIV/AIDS, and cramped living conditions which promote disease transmission amongst the urban population, the displaced, and refugees. Government figures show that 59,513 cases of tuberculosis (of all forms) were treated in 1998, although the WHO estimates that the number of cases is at least double those registered. The number of people with tuberculosis in Kinshasa has risen from 7000 in 1996 to 20,000 in 2001.

In some areas, cretinism is also on the increase. One in 25 children in Bas-Uélé (Province Orientale) suffers from this disease, which is caused by iodine deficiency, and which leaves the child extremely stunted (half the size of an adult) and severely mentally retarded.<sup>40</sup> All that is needed to prevent this devastating condition is iodised salt. Yet because of underdevelopment, the breakdown in the economy, the lack of health facilities, and the war in eastern DRC, it has been impossible to stop more children developing the disease.

Routine vaccination programmes in many areas of the country have been interrupted by the conflict, leading to the re-emergence of epidemics of diseases which could otherwise be controlled, particularly among children under five. Measles epidemics have devastated the under-five population in many parts of the country. Health staff in Kabinda health zone (Kasai Oriental) report that measles has killed thousands of children. In Kifuenkese, 60 per cent of children are reported to have contracted measles, of whom two-thirds died. In some villages of Ngombe Nyama, more than 50 per cent of children are reported to have died from the illness.

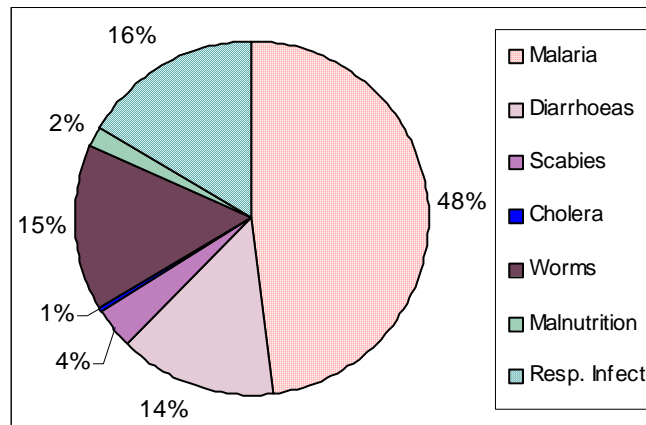


During the past two years, UNICEF has been working to increase routine vaccination coverage for seven different diseases, as shown in the above graph. The proportion of people benefiting from full vaccination protection is estimated to be only 29 per cent. Through the efforts of UNICEF, the WHO, the health authorities, and NGOs, it is estimated that approximately ten million children have been vaccinated against polio.

The Ministry of Health's 2000 report on diseases with epidemic potential,<sup>41</sup> although incomplete given the difficulties in obtaining regular information from all 307 Health Zones, provides an idea of the situation across the country. Of the 12 diseases monitored by the programme,<sup>42</sup> malaria is responsible for the greatest percentage of illness (92.3 per cent of recorded consultations) and death (52.4 per cent of recorded deaths), particularly among children under five. While malaria is endemic in nearly all parts of the DRC, the current situation has made the population even more vulnerable. In 1998, it was estimated that only 8.1 per cent of the population either lived in homes that were protected from insects, or used mosquito nets. Growing poverty means that people are unable to afford medication, even if functioning health services are within reach, leaving them exposed to greater risks and allowing malaria to spread. In addition, displaced people are usually living in conditions which offer little or no protection against mosquitoes, both in terms of shelter and clothing.

In Katana, South Kivu, Françoise was displaced with her children when the Interhamwe attacked her village one night. She was forced to flee with only the clothes she was wearing, and left behind all her worldly possessions. She has not seen her husband since that night and thinks he is probably dead. She saw her best friend raped and killed and has now taken on her two children, as well as her own four. The children suffer regularly from malaria, sometimes as often as every two months. Last month, her youngest daughter died from the disease. She knows that a mosquito net would help to reduce the risk of catching malaria, but she had to leave behind the one she owned. She has no money, and cannot afford another one, nor the medicine to treat malaria. Even when she manages to scrape together a little money, she uses it to buy food for the children. 'We hope to survive malaria but we cannot live long without food,' she says.

The pie chart below shows information provided by the Zonal health authorities in North Kivu about the people using state health services between June 2000 and March 2001. Although not everyone living in North Kivu can afford to use the health centres and hospitals, the chart does give an indication of the relative incidence of the most common illnesses.



The experience of the authors of this report in implementing water, sanitation, and health activities in North Kivu is consistent with these findings. Malaria is by far the largest public-health risk facing the population, followed by water-related diseases such as diarrhoea, scabies, cholera, and worms. In North Kivu, the four water-related diseases combined are responsible for 34 per cent of all cases recorded at health centres. It is for this reason that the provision of sufficient potable water, sanitation facilities, and education about good hygiene practices is so crucial to improving the health of these vulnerable populations.

Assistance to the health sector is a major focus for most of the organisations providing humanitarian assistance to the DRC. Despite this, contributions to the health sector of the UN Consolidated Appeal, which totalled US\$4.6m, represent only 54 per cent of needs. A joint mission by the WHO and UNICEF in June 2001 estimated that the minimum initial investment needed to halt mortality and definitively reverse health indicators would be US\$350m a year, of which US\$50m is for putting health workers back to producing essential health services.<sup>43</sup> Some of the main donors to the health sector, and indications of the level of support, are shown in the table below.

Donor	Amount	Period
USAID/OFDA	US\$ 18.84 million	Oct 2000- Sep 2001
EU/ECHO (incl wat/san)	US\$ 12.65 million	2001
EU/PATS <sup>44</sup>	US\$ 45 million	1998-2002
Belgian Govt	US\$ 4.6 million	Jan 2000-April 2001
French Govt	US\$ 1.1 million	2001

These funds have ensured the delivery of crucial assistance to some sections of the population. However, they fall desperately short of the amount required to ensure that the full range and scale of the problems facing the health system are met. In particular, funding for activities which are not perceived as being in direct response to an emergency, such as malaria prevention initiatives, is difficult to find. A greater effort needs to be made to ensure that access to appropriate, affordable health care is provided across the country, and that more lives are not lost to preventable diseases.

## 6. ACCESS TO SAFE WATER

The DRC has enormous water reserves, and the Congo River has the potential to produce enough hydro-electric power to supply the whole of southern Africa.<sup>45</sup> Yet the majority of its own population lack access to clean drinking water. Water-related disease, in addition to poor hygiene and sanitation, is one of the main causes of illness in the DRC. In 1999, UNICEF estimated that in the DRC as a whole, only 45 per cent of the population had access to safe drinking water.<sup>46</sup> In rural areas, the percentage was thought to be as low as 26 per cent. These percentages are expected to be substantially lower today.

Oxfam GB's research in rural areas of the country, prior to undertaking water and sanitation work, supports these estimates. In Banalia Health Zone (north of Kisangani), only 2144 people out of a population of 65,000 (three per cent) have access to safe water, leaving the majority to collect drinking water from unprotected springs and wells, rivers and streams. In one area, 11 of the 28 villages rely on river water that is reported to be a dirty colour, and contaminated by human and pig faeces. In Kindu Health Zone (Maniema), 91 per cent of water points are not protected. Most people use the river or contaminated springs and wells, while others walk for between three and six hours in order to collect water from a protected spring. In Ituri (Province Oriental), a survey covering 36 Aires de Santé showed that 65 per cent of the 583 springs and wells used by the population were not protected; in seven Aires de Santé there were 48,045 people with no access to safe water at all.<sup>47</sup>

In urban areas, access to safe water has reduced as substantially over the past decade. In many provinces, the production plants belonging to the parastatal body responsible for water production and distribution (REGIDESO) have not been functioning for years, as capacity has been outstripped by the growth in urban populations. The primary problem is access to diesel to power the turbines, which is compounded by the lack of chemicals, spare parts, and dilapidation of the networks.

Of the five water production plants in Kasai Oriental, four are not operational. Only Mbuji Mayi is working at 30 per cent capacity, providing water sporadically to 20 per cent of its two million inhabitants. Of the 1.6 million people with no access to the city's water supply, most have to buy water from MIBA<sup>48</sup> employees, who are supplied free of charge by the company. Many walk six or seven kilometres to collect unclean water from springs. In the rainy season, women have been seen collecting stagnant water from puddles on paths and from potholes in the road.

The situation in other provinces is the same or much worse. Of the six production plants in Kasai Occidental, only Kananga is working at ten per cent capacity, providing water to five per cent of the population. In Kikwit there is no production at all, and in Bas Congo, hydro-electricity rather than diesel powers the only two functioning plants. In the east of the country, the towns of Goma and Bukavu have partial coverage, but towns such as Kindu in Maniema have not had an operational water system since early 1999.

Christine used to have access to water from REGIDESO in Kindu, but since the war started her tap has dried up. Christine now walks half a kilometre each way to collect water from the river. She knows it is not clean, but it is the closest source of water. When she has time and energy, she walks to the spring that is three kilometres away. She carries as much as possible, but it is only enough for two days drinking water for the family. Since she is often tired, they drink the river water when the situation is desperate. She tries her best to clean the dirty water by filtering it through an old piece of cloth. She knows it is not enough, but it is all she can do.

In Kinshasa, REGIDESO supplies the central communes, but the more recent communes are only partly covered. The inner-city infrastructure is so old and badly maintained that 53 per cent of its water is lost through leakage before reaching the user. Pressure is so low that the outlying parts of the city receive no water at all. While approximately 65 per cent of people have a water connection, only half receive water regularly. Fifteen per cent of people receive water for only a few hours twice a week. More than two million people have no access to the city's water supply, relying exclusively on wells and springs, of which over 60 per cent are contaminated.<sup>49</sup>

Diwa Vova lives in Kimbanseke with his wife, mother, and seven children. They used to collect unclean water from a spring next to a cemetery. At least twice a year, each of the ten members of the family would fall ill with stomach ache and diarrhoea, and had to go to the clinic for tests and treatment. They did not realise that it was because of the water that they were falling ill. Oxfam GB provided a well for the community, and Diwa's family started drawing their water from it. After a few months they realised that no one had been ill, and that they had saved money on medical treatment. Diwa also owns a field 100kms from Kinshasa. The first time he went to it after the well was built, he became ill. Now he takes enough clean water with him for several days, and returns to Kinshasa when he has none left.

Poor access to water of sufficient quality and in sufficient quantity has serious health consequences. In Kinshasa, 30 per cent of all diseases registered by the health authorities in 1998 were water-related. In rural areas, the percentage is even higher. Among groups of people who are living in particularly insanitary conditions, such as the displaced, the lack of access to sufficient water, in addition to their inability to buy soap, has led to severe outbreaks of scabies. Cholera epidemics have been notified in many parts of the country. However, Oxfam GB's activities in Kitshanga (North Kivu), an area in which 79 per cent of the population is internally displaced, show that the disease can be managed if the resources are available. Prior to the implementation of water, sanitation, and hygiene activities in June 1999, the health authorities had registered two cholera epidemics per year. Since June 1999, none has been reported.<sup>50</sup>

In addition to health problems, the time required to walk to a water source or to queue at a busy water point has a significant impact on women and children, particularly girls, who are responsible for collecting water for the household's daily needs. Time spent performing this task takes women away from caring for the family or carrying out income-generating activities, and takes girls away from school. In Kisenso, a poor area of Kinshasa, urban families spend two and a half hours each day collecting water. Furthermore, the amount that they collect is insufficient to maintain adequate hygiene standards in addition to that needed for drinking and cooking.

Elise is 55 years old and supports a family of 14 grandchildren and two of her daughters. She lives in the mountainous area of Masisi, North Kivu. Every morning at 4.00, Elise and four of her granddaughters start the tortuous journey down the mountainside to fetch clean water from the spring in the valley. It takes them one hour to walk down and over two hours to walk home. Three of them carry a 20-litre jerry can on their heads, while the smaller children carry a 10-litre bucket. When it rains, the path down the mountain is very slippery, and Elise, who is no longer very agile, often falls. She used to have water closer to home, since the local priest had built a water system. But attacks by armed groups last year destroyed the system's pipes and it no longer works. She needs her granddaughters to help her collect

water for the family and knows that this means they cannot go to school. It is a hard decision, but she has no choice.

Access to safe water in urban and rural communities is therefore one of the greatest challenges facing the DRC in achieving a significant improvement in people's health status. The scale of need is such that water provision must remain high on the donor community's agenda for many years to come.

## 7. ACCESS TO FOOD

Many people in the DRC spend each day thinking about where their next meal will come from. During the past three years, people's ability to grow and/or purchase food of sufficient quantity and quality to lead healthy lives has been substantially reduced. In November 2000, the UN World Food Programme (WFP) estimated that 16 million people (33 per cent of the population) had critical food needs as a result of prolonged displacement, isolation, lack of market outlets, severed food supply lines, price increases, and declining purchasing power.

In eastern DRC, the war has reduced the poorest sections of the population, both displaced and host/local communities, to an extremely marginal existence. Conflict continues between the various armed groups and insecurity has worsened, particularly in rural areas. The devaluation of the currency and rise in the cost of imported goods such as kerosene and salt has eroded people's purchasing power. In isolated areas of rebel-held territories, such as Shabunda, Kindu, and East Kasai, which can only be reached by air, the cost of items such as salt, oil, soap, and even clothes has become even more prohibitive.

Agricultural production has dropped across the east of the country, meaning that some formerly surplus producing areas no longer grow enough to feed their populations. Insecurity, limited access to markets, cassava blight,<sup>51</sup> and difficulties in making enough money from the sale of crops, all discourage people from cultivating. An initiative by Save the Children UK to rehabilitate sections of minor roads demonstrated the financial impact of the difficulties farmers experience in reaching markets. The repair of a 12km stretch between Bihambwe and Kibabi in Masisi enabled them to take their 100kg sacks of potatoes to a larger market where they sold for US\$11 per sack, rather than the price of US\$3 per sack which they obtained in their villages.<sup>52</sup> In mineral-rich areas such as Walikale, Punia, and Kalima, the short-term benefits of mining have also encouraged some farmers to abandon agriculture. Instead of working in their fields, they prefer to dig for coltan, gold, or diamonds. This will have long-term implications for communities' access to food.

Loss of purchasing power among the poorest people in rural areas means that they struggle to eat a nutritionally balanced diet. This has led to an increase in the incidence of kwashiorkor,<sup>53</sup> a condition that has always been endemic in areas of the Kivus, but has now become much more widespread across the Eastern Provinces. The poorest people in towns such as Bukavu are also living in a precarious situation, since they cannot find as much work as in the past. Insecurity has meant that landowners are no longer farming their land in rural areas and do not need casual labour. A reduction in trade has also reduced work opportunities. Buying sufficient staple food to ensure that the family does not go hungry means having less to spend on health, school fees, and basic items such as soap and salt. Any disruption, such as displacement or illness, pushes people over the brink into a situation of malnutrition. Reports from North Kivu (Masisi and Rutshuru) paint a similar picture. The poorest groups are forced to buy food of increasingly low nutritional value, such as beer bananas, in addition to consuming some wild plants. In certain areas of South and North Kivu there is the additional problem posed by armed groups from all sides, who sustain themselves by stealing food and crops from communities which are already struggling to survive.

Most of the estimated one million displaced people in eastern DRC are particularly vulnerable, although those living with host families are often no worse off than their hosts. Many of those still close to their



fields continue to harvest, or even cultivate in the short term, despite the risk of meeting armed groups. Those who no longer have access to their fields place a greater strain on the families with whom they live, who stretch their own resources to provide support. This often results in both groups having too little to eat. Among the large number of people displaced to the forests in areas of South Kivu and Rethy in Ituri, their diet consists almost exclusively of cassava and cassava leaves. Purchasing oil and salt is virtually impossible. This, combined with a lack of access to health care, and the rigours of living in the forest, accounts for the poor nutritional state of these groups when they emerge.

‘We have a displaced family living with us. People have started stealing the crops from our field, and what with the extra numbers, we no longer have enough food. We only eat once a day, and often not at all. Both our families are now suffering from malnutrition.’ Alice, Kalima (Maniema).

In other areas of the country, the war has made the chronic economic crisis even more acute. Rural communities are affected, as are the populations of the urban areas which they traditionally supply. Despite huge agricultural potential, production is continuously falling, as farmers cannot purchase seeds and tools and have great difficulty in taking their produce to market. Traditional supply routes have been cut and as a result, large cities such as Kinshasa and Kisangani face constant food deficits. Small-scale initiatives have been started to help urban populations cope. After the six-day war in Kisangani in June 2000, during which the population was confined to their homes, they realised the value of growing vegetables next to their houses. With FAO’s support, onions and beans can now be seen growing in many people’s yards.

In 2000, Kinshasa alone had a food deficit of one million tonnes. The capital used to be supplied by areas all over the DRC, but the effective partition of the country has forced Kinshasa to buy most of its food from areas such as Bandundu and Bas Congo. The poor condition of the roads, problems with food supply, and reliance on agricultural cycles in fewer regions, has meant that food prices are no longer stable throughout the year, but subject to large fluctuations. These factors, coupled with the cassava disease that has devastated crops in many parts of the country (particularly in the west), have meant that the price of a kilo of rice has been comparable to a kilo of cassava, despite the fact that the rice is imported from Thailand. Food has been imported to meet the deficit, thereby further impoverishing the rural interiors. The price of basic commodities can be 50-150 per cent higher than in other countries.

The impact on households that are already impoverished and marginalised is dramatic. Purchasing power rapidly declines. The FAO estimates that more than half of the population of Kinshasa lives on less than US\$1 per day. The Kinshasa price index prepared by the Central Bank of Congo leapt from 39,236 to 171,392 between January and December 2000 (August 1995 = 100), peaking in April 2001 at 282,664.<sup>54</sup> However, salaries were not adjusted during this period. While a teacher’s monthly salary in September 2000 could feed a family of seven for a week, by January 2001 it could only feed them for 3.1 days. In the poorer areas of the city, people with an income have meals twice a day, eating bread in the morning and cassava in the evening. However, a growing number of people eat a proper meal only once every two days.

The situation in other parts of the country is no different. In Demba (Kasai Occidental), 94 per cent of households eat barely one meal a day. IDPs eat only one proper meal once every three or four days. In Bandundu, a province which was seriously affected by the 1996-7 conflict, the local population can no longer afford to buy locally produced food. By using river access, traders purchasing goods for urban areas are able to set prices which exclude local buyers. Equateur, which in the past had a substantial agricultural industry, has reverted to traditional subsistence agriculture. The populations living in areas near the frontline, who have often been displaced, are reported to have reached alarming levels of poverty.

While the international community is starting to acknowledge the scale of the problem in accessing food, donor support for agricultural activities has in no way approached the level of need. There is a reluctance to invest in interventions which are perceived as being longer term in nature than an immediate humanitarian response. This means that initiatives designed to enable vulnerable communities regain an element of self reliance remain under-resourced. And yet, unlike other areas of Africa with very low agricultural potential, the DRC could solve its own food deficit problems given sufficient support. Contributions to the agriculture sector of the UN Inter-Agency Consolidated Appeal stood at US\$1.7 million in July 2001, representing only 16.7 per cent of the US\$10.28 million requested. Donors which have been prepared to support the sector include ECHO (US\$7 million), and the governments of Belgium, Sweden, and France. Such support needs to be encouraged, in order to break the cycle of food insecurity, which in many parts of the country drags the most vulnerable into situations of malnutrition.

### **Malnutrition**

While chronic malnutrition has been a problem in parts of the DRC since before the war, the situation has become much worse during the past three years. In many parts of the country it is now critical. It is difficult to obtain an overview of the severity of the problem in different parts of the country, because agencies have been able to carry out few surveys. However, enough information has been produced by organisations specialising in nutrition interventions to report on a number of locations, and to give an impression of the situation which is likely to prevail in other areas. A table showing the results of surveys carried out over the past 12 months can be found in the Annex.

In rebel-held areas, the rates of global malnutrition among children under five reported in the past year have reached 41 per cent,<sup>55</sup> with severe malnutrition rates of up to 25.79 per cent.<sup>56</sup> These figures were recorded at the point at which the humanitarian community gained access to previously isolated communities. Consequently, it is reasonable to expect that in areas of the east which continue to be too insecure to allow any form of assistance to be delivered, the situation is at least as bad, and possibly worse. Displaced populations inaccessible in the forests are in a particularly bad nutritional state, as illustrated by WFP's figures for South Kivu, which show that 75 per cent of malnourished children currently registered in feeding centres belong to families which have just emerged from the forests. When Manono and Kiambi (northern Katanga) became accessible in January 2001, Nuova Frontiera conducted a nutritional survey which found a global malnutrition rate among under fives of 32.07 per cent and a severe malnutrition rate of 25.79 per cent.

Although displaced people are the most vulnerable, many host communities have suffered from the additional strain imposed by providing for the displaced. In Kioko (northern Katanga), Nuova Frontiera did not find that the global malnutrition rate among under fives was significantly higher in the displaced population (24.6 per cent of the sample) than in local communities. Other factors affecting the malnutrition rate have been the high incidence of diseases such as measles and malaria.

Nor have parts of the government-held territories been spared. Global malnutrition rates reported over the past eight months range from 4.6 per cent in Bas Congo to 30 per cent in the Kasais and border areas. Kinshasa shows worrying levels, both in the overcrowded central areas such as the Commune of Selembao, and in the semi-rural peripheral areas such as the Commune of Kimbanseke. These urban populations are living an extremely precarious existence, and cannot withstand sudden changes in circumstance such as illness or loss of employment. A survey conducted by Save the Children UK in the poorest parts of the Commune Kimbanseke in April 2001 found that 42 per cent of children are chronically malnourished, and that global malnutrition rates had reached 18.3 per cent.<sup>57</sup> The severe malnutrition rate in these areas was also found to have tripled between September 1999 and January 2001.<sup>58</sup>



Régine Kajenga is 65 and lives in Kimbanseke on the rural periphery of Kinshasa. Her daughter made a visit to Mbuji Mayi just before the war to earn some money through petty trading, leaving the two children with their grandmother. Because the war broke out, she was unable to return to Kinshasa. As the children's father has died, Régine is looking after Bidiuwa who is eight and Katende who is six. She has no way of earning a living, and is totally dependent on her niece who sells food at the local market. As her niece has 11 children of her own, she is not able to offer them much support, and they often have no food at all. Both children are now suffering from severe malnutrition and have been admitted to the therapeutic feeding programme.

WFP planned to provide emergency food assistance to 1.4 million people during 2001, but only 43 per cent of the US\$61 million required had been provided by July. ECHO is providing US\$3 million support to nutrition programmes, and other donors include the US, Canadian, Dutch, and Belgian governments. However, the level of assistance is insufficient to provide food to malnourished people in accessible areas, let alone being enough to alleviate the appalling situations discovered in areas which are now becoming accessible.

## 8. HIV/AIDS

The DRC was one of the first African countries to acknowledge the HIV/AIDS epidemic, and began conducting awareness-raising campaigns as early as the late 1980s. Although these initiatives stopped when structural aid was suspended in 1992, they contributed to the DRC being spared the extremely high prevalence rates seen in neighbouring countries. However, the effects of the current conflict have significantly increased the population's vulnerability to the HIV virus.

The national prevalence rate at the end of 1999 was stated by UNAIDS as being 5.07 per cent. However, the situation is now almost certainly much worse, particularly in rebel-held areas, where the Ministry of Health has estimated a prevalence of 10 per cent. Surveillance centres and hospitals in government-held areas report that the rates in Matadi and Lubumbashi doubled between 1997 and 1999, rising from 5.1 per cent to 10 per cent, and 4.8 per cent to 8.6 per cent respectively. More worryingly, the results of a small survey of blood donors in Goma conducted in 1998 showed that between the influx of Rwandan refugees in 1994 and 1997 the rate had quadrupled, increasing from 4.2 per cent to 16.3 per cent. Although no reliable surveys have been conducted in the Kivus since 1998, Save the Children UK collected information from health centres they support on the incidence of HIV-positive samples among blood donors. The following table shows a selection of the results.

Location	Period	Type of donor	Sample size	Rate of HIV + samples
Goma blood bank (North Kivu)	Jan – Dec 2000	Regular donors	1326	3.6%
Kalemie Hospital (N. Katanga)	Mar 2001	Regular donors	188	6.9%
Bukavu AIDS prevention project (South Kivu)	Sep – Dec 2000	Prostitutes in Bukavu	35	42.86%

UNAIDS estimates that at least 90 per cent of people who are HIV-positive are not aware that they are infected. Since a test costs US\$10, it is unaffordable for the majority of the population.

In both government- and rebel-controlled areas, the population has suffered greater exposure to infection as a result of the conflict. People who are internally displaced, or who have lost all means of earning a livelihood, do not have the resources to protect themselves from infection, nor access to information about HIV/AIDS transmission. Health structures have limited capacity to test patients for HIV or to screen blood used in transfusions. Women living close to military camps, with no source of income, have turned to prostitution, despite the risks involved, in order to support themselves and their families.

Human rights organisations have also registered many cases of soldiers raping women. In addition to mental and physical injury and the risk of pregnancy, rape victims are particularly vulnerable to contracting HIV because body tissues are more likely to be torn. There are six foreign armies fighting on Congolese soil, and on average, soldiers' rates of infection can be up to four times higher than those of civilians.<sup>59</sup> HIV infection rates vary from 50 per cent of Angolan soldiers to 80 per cent of Zimbabwean soldiers.<sup>60</sup>

Bernadette Mulelebwe, the Director of Christian Aid's partner Fondation Femme Plus, told of a woman who came to her office in Kinshasa. 'She came here from the east with her children. She had been raped six times – at six checkpoints she had been raped. Now she is HIV-positive and her little daughter is also infected. How many other women have been in that situation?'

In Kabinda, where Zimbabwean troops are stationed, the local health centres are reporting a very large increase in the incidence of more easily detectable sexually transmitted diseases, such as syphilis and gonorrhoea. It is expected that a survey to be conducted later this year will also show a significant rise in the prevalence of HIV.

People who have left the DRC as refugees in neighbouring countries have found themselves in areas with considerably higher prevalence rates. In Zambia, the Central African Republic, and Tanzania, the three countries hosting the majority of Congolese refugees, prevalence rates in 1999 were 19.95 per cent, 13.84 per cent, and 8.09 per cent respectively. They were even higher in 1998. This presents a future threat when these refugee populations are able to return home.

Tumba is a 25-year old prostitute living in Bunia. 'I was married in Beni when I was 15. My husband lived from begging, and after putting up with that for seven years I left him and came back to Bunia two years ago. I've been a prostitute for ages. I don't have a fixed price, but take what I am given – anything between US\$1 and US\$5. I have to look for men in the bars, but I bring them back to my place – I pay US\$5 a month for my house. I hate the life I lead. I tried to quit, but I had no money to pay my rent and buy clothes, so I went back to prostitution. I hope to get another job one day to help me survive. I'm really scared of AIDS – but what choice do I have – die of hunger today or of AIDS tomorrow?'

Unlike most other diseases, AIDS affects adults of child-bearing age particularly, leaving the very young with no one to care for them. There are officially between 800,000 and 900,000 children orphaned by AIDS in the DRC, although the government admits that the figure may now be closer to one million.<sup>61</sup> Some of these children have even suffered the death of several carers, as relatives who had taken them in

also succumb to the disease. With no support at home, a high proportion of these children are malnourished, almost all are denied an education, and many end up living on the streets.

The increase in the prevalence of HIV/AIDS amongst the Congolese population has been described as a time bomb. It will have a profound effect on the country's future, as has been observed in other parts of sub-Saharan Africa. Given that the 15-49 year old age group is the most vulnerable to infection, the productivity of the workforce will be severely affected and expenditure on health care will place an even greater strain on family incomes. Children will bear the brunt of the suffering, both those who are born with the virus and those who are left as orphans.

## 9. EDUCATION

The conflict in the DRC has had a terrible impact on an education system that was already failing. In 1998, the Ministry of Education reported that 40 per cent of children of primary school age were not attending school. The situation for girls was even worse. Nationally, half of all girls were not in school; in North Kivu, the figure was 69 per cent.<sup>62</sup> The investment that was made in the Congolese education system in the 1970s and 1980s has been squandered. School enrolment rates plummeted from 94 per cent in 1978 to an estimated 60 per cent in 2001. Adult literacy rates fell from 74 per cent in 1992 to 58.9 per cent in 1998. There are no reliable figures for 2000/2001, although UNICEF estimates that there are currently between 3 and 3.5 million children aged between 6 and 11 who are not receiving any formal education. This figure exceeds the total population of the neighbouring Republic of Congo. Of these children, approximately two million are girls.<sup>63</sup>

In eastern DRC, insecurity, poverty and the frequent closure or destruction of schools will have reduced attendance to a fraction of the 1998 figures. Many parents can no longer afford to send their children to school. The figures in the table below, collected from 100 primary and secondary schools in 11 areas of Ituri (Province Oriental) in April 2000, show the scale of the problem in eastern parts of the country.<sup>64</sup>

Area	No. schools	Attendance Before war (1998-9)	Attendance 1999-2000	Loss of students	%	Comments
Dz'n	10	2844	0	2844	100%	Schools burnt down
Mbr'bu	6	1803	0	1803	100%	Schools burnt down
Linga	7	2236	0	2236	100%	Schools burnt down
Dhendo	17	2631	0	2631	100%	Schools burnt down
Laudio	4	1206	0	1206	100%	Schools burnt down
Laddedjo	4	1346	0	1346	100%	Schools burnt down
Ndjukpa	4	1612	0	1612	100%	Schools burnt down
Ugwaru	7	1688	1175	513	30%	
Uchoni	13	3144	2306	838	27%	
Zabu	18	3936	2737	1199	30%	
Bura	10	2109	469	1640	78%	
<b>Totals</b>	<b>100</b>	<b>24555</b>	<b>6687</b>	<b>17868</b>	<b>73%</b>	

Displaced children in particular have little or no chance to continue with their education. Of the two million displaced people, approximately 400,000 are thought to be children of primary school age. These children have no access to any form of basic education, prejudicing their opportunities later in life, and increasing their risk of enlistment into armed forces in search of a better situation.



Christine is a school director who managed a school of 500 students just north of Fataki in north-eastern DRC. When her village was attacked in August 1999 she was forced to flee, and is now living along with 5,000 other displaced people on the church premises in Fataki. Her home is a small corner of a disused room that she shares with ten other families. Many of her students are also displaced. It has now been nearly two years, and she knows that the children have not been to school at all since they fled. 'They are losing their future and I cannot bear it', she says. 'I want to restart the school, even if under a tree. All I need are some materials and we will make do.' But there are few donors around who will fund this kind of work.

In difficult conditions, some schools continue to try to operate. In Nyunzu (northern Katanga), 6 of the 11 primary schools are functioning, despite the lack of teachers, teaching materials, pens, and exercise books. In Kalima, the local church has set up a rotating system through which regular schools end early each day, and short classes are provided for displaced children for a few hours in the afternoon. However, the drop-out rate among students is high. In Kalemie, 50 per cent of children who started school in 2000 did not complete the year, because their parents could not afford the fees.<sup>65</sup>

In government-held areas, economic pressures have also had a negative effect on children's education. In some peripheral areas of Kinshasa, up to half of the children do not attend primary school at all, because their parents cannot afford the fees of US\$2.5–US\$3 per term. Classrooms are overcrowded at the beginning of term, but the numbers soon fall, often by more than 50 per cent as the academic year progresses. Children who are indebted by the second and third terms are forced to drop out, or are not awarded their exam results, and therefore the right to graduate into the next class, until their debts are settled. In one school in Kisenso, children denied entry hang about on the school premises in the hope of being able to sneak into the classroom when the teacher is not looking.

Even when children do attend school, school buildings are often so dilapidated that they present a health hazard. They offer little or no protection against the sun, and during the rains pupils are often sent home. Desks and benches are old, insufficient, or totally lacking, forcing children to sit on the floor or on large stones. Many children have no exercise books or pens, and teachers struggle to purchase chalk. A recent mission to Boende in Equateur reported that the teachers had resorted to writing on blackboards with cassava root. Many schools do not have access to books, for either the staff or students. In May 2001, a UNICEF staff member who visited a school near Mbuji Mayi reported that a student in the final year of primary saw his first text book ever during the visit.

Teachers' salaries, when paid, are too meagre to afford a living. This causes many teachers, particularly women, to leave the profession. In Kinshasa in May, the government increased primary school teachers' salaries from US\$4 to US\$8 per month. In Ituri, teachers last received a regular salary in 1992, except for the five months before the war started in 1998. Despite this, a proportion of the teaching staff who are in reality too old to be teaching are forced to continue, due to the state's inability to pay pensions to those who retire, and the lack of new people joining the profession.

Gérard Biyela is 63, and the head of the primary school in Kisenso, Kinshasa. He lives a long way from the school to which he was posted, and walks for three and a half hours to get to work in the morning, and then the same distance home. He can only afford to eat once a day in the evening. He earned 2000FC per month (US\$6) before the May salary adjustment, and now earns 4000FC per month (US\$12). His wife was also a primary school teacher, but the salaries are so low that she has stopped teaching and now grows vegetables. They have five children, of whom three would now be at University if they had the money for the fees. His two daughters have sickle

cell disease. Their medical costs put a heavy burden on the family income, which means that they are currently heavily indebted.

The state of education in the DRC can only be described as disastrous, and at the moment there are few prospects of the situation changing. While the government dedicated 26.4 per cent of its budget to the education sector in 1972, the share of the national budget is now less than one per cent. In addition, very few external donors are prepared to fund education. USAID provided US\$450,000 in support of girls' education in 2000/1, and is about to provide a further US\$2 million for school rehabilitation and technical training. The EU gave three million euros for the supply of text books to secondary schools and further education institutions in 1999/2000. UNICEF has a 2001 education budget of US\$3 million, but to date has only received US\$600,000.<sup>66</sup> A small number of NGOs, including Save the Children UK and Oxfam GB (with US\$350,000 of DFID support), are also rehabilitating a limited number of primary schools in their areas of intervention.

The assistance currently being provided is a mere fraction of the support required. As a result, generations of Congolese children are being denied their basic right to education, leaving the country with an unskilled and introspective workforce, ill-equipped to compete in the global economy. It is crucial that the humanitarian community change its perspective on the value of supporting education, in order that millions of children are not deprived of their futures. This would also increase the chance of restoring peace to the region.

## 10. CONCLUSION

The conflict in the DRC is a regional war. Internal and external actors are fighting for control of territory, especially areas rich in natural resources. In some cases, external actors are also resolving their own internal conflicts on Congolese soil. Of the six countries directly involved in the conflict, with troops in the DRC, four are suffering from internal strife: Rwanda, Uganda, Angola, and Burundi. A long-term, peaceful solution for the DRC is inter-linked with the search for peaceful solutions in these four countries, and in particular in Rwanda and Burundi. The region requires sustainable political settlements, not quick fixes, if there is to be any impact on the human suffering in the DRC and other countries.

The humanitarian consequences of the war in the DRC are horrendous, as shown by the body of evidence now available to the humanitarian community. To date, the humanitarian assistance provided by the international community has been totally inadequate when considered alongside the scale of human suffering, and when compared with the efforts made to address humanitarian crises in other regions of the world. Although the fighting along the frontline has more or less ceased, the human suffering has not. Furthermore, the east of the country continues to experience significant insecurity despite relative quiet on the frontline. A large proportion of humanitarian need in the country is not being met, and thousands of people who require assistance remain inaccessible.

For most Congolese, there is no end in sight – their human tragedy goes on.

## ORGANISATIONS AND THEIR CONTACT DETAILS

Oxfam GB is a member of Oxfam International. It works with others to overcome poverty and suffering through the most effective and enduring solutions. Oxfam was founded in 1942 to bring aid to the starving population of occupied Greece. Since then, it has grown substantially to become a leading international relief, development, and advocacy agency, offering a unique range of skills and experience focusing on the elimination of poverty. By working with people living in poverty, Oxfam helps them to enjoy their basic rights and take effective control over their lives, to build a more just world.

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Save the Children is the UK's leading children's charity. Working in more than 70 countries, it runs emergency relief alongside long-term development and prevention work to help children, their families, and communities to be self-sufficient. Drawing on this practical experience, Save the Children UK also seeks to influence policy and practice to achieve lasting benefits for children within their communities. In all its work, Save the Children UK endeavours to make children's rights a reality.

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Christian Aid is the official relief and development agency of 40 sponsoring churches representing most denominations in the UK and Ireland. It began by helping refugees in Europe after the Second World War, and now works in about 60 countries where the need is greatest, helping people regardless of race or religion. Christian Aid believes local people are best placed to solve local problems. For this reason, it works through 700 local organisations, providing funds for projects. In the UK and Ireland it works with the churches, schools and the public in educating, lobbying and campaigning on world poverty issues.

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## Notes

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- <sup>1</sup> Mission de l'Organisation des Nations Unies en République démocratique du Congo
- <sup>2</sup> Mortality in eastern Democratic Republic of Congo, IRC, May 2001
- <sup>3</sup> The Sphere Project developed a humanitarian charter and associated set of minimum standards. They define levels of service in water supply, sanitation, nutrition, food aid, shelter, site planning and health care in order to meet essential human needs and restore life with dignity.
- <sup>4</sup> Sources given in relevant chapters throughout the text.
- <sup>5</sup> IRIN-CEA Weekly Bulletin 48, December 2000
- <sup>6</sup> Mortality in eastern Democratic Republic of Congo, IRC, May 2001
- <sup>7</sup> Namibia has declared its intention to withdraw all its troops from the DRC by 31 August.
- <sup>8</sup> Mission de l'Organisation des Nations Unies en République démocratique du Congo
- <sup>9</sup> Amnesty International, "Rwandese-controlled East: Devastating Human Toll", 19 June 2001
- <sup>10</sup> The population at the time of the last census (1985) was 34.7 million. Current estimates range from 49 million to 59 million.
- <sup>11</sup> Estimates of the population of Kinshasa range from 5-10 million people.
- <sup>12</sup> Enquête Socio-Economique, Nord Kivu, Decembre 2000, ASRAMES
- <sup>13</sup> USAID exchange rate tracking.
- <sup>14</sup> Severe shortages were reported in November 2000 and May 2001 as the government reneged on the financing agreement that had been negotiated with the oil companies.
- <sup>15</sup> Chronicles of a Humanitarian Crisis, year 2000, Democratic Republic of Congo, OCHA
- <sup>16</sup> Ibid
- <sup>17</sup> In OCHA's report "Chronicles of a Humanitarian Crisis, year 2000, Democratic Republic of Congo" it is estimated that the percentage could be as low as 15%.
- <sup>18</sup> [Norwegian Refugee Council IDP Database, 2001](#)
- <sup>19</sup> Ibid
- <sup>20</sup> Columbite-tantalite
- <sup>21</sup> Source for 1998, 1999 and 2000 is USCR, source for 2001 is UNHCR
- <sup>22</sup> inter alia Article 3 common to the four Geneva Conventions covering both international and non-international conflicts.
- <sup>23</sup> For international armed conflicts, Fourth Geneva Convention Articles 59-61; Protocol 1, Article 70.2 and 70.3.
- <sup>24</sup> For example, 6 ICRC staff were killed in Ituri, northeastern DRC in April 2001.
- <sup>25</sup> 7<sup>th</sup> Report of the Secretary-General on the United Nations Organization Mission in the Democratic Republic of the Congo (S/2001/373) dated 17 April 2001
- <sup>26</sup> Save the Children UK Bukavu Transit Centre statistics.
- <sup>27</sup> Save the Children UK has heard two personal accounts from girls in Kinshasa who reported serving in Mobutu's forces towards the end of the AFDL rebellion.
- <sup>28</sup> President Joseph Kabila has ratified both the Optional Protocol to the CRC and Convention 182, relating to children in armed conflict, and issued orders to respect "conservative measures" as the first steps in the demobilisation process, mandated by *Decret-Loi N° 066 (June 2000)*. A parallel process has been developed by the RCD-Goma.
- <sup>29</sup> Access is defined as both geographical and economic, ie being within a reasonable walking distance of a functioning health service and being able to afford to pay for the consultation and treatment.
- <sup>30</sup> Figure published in the 8<sup>th</sup> Report of the Secretary General on the UN Organisation Mission in DRC (S/2001/572), 8<sup>th</sup> June 2001. However, OCHA estimates that the percentage could be as high as 75%, meaning that over 37 million people would be denied access to health care.
- <sup>31</sup> Etat des Lieux du Secteur de la Santé, Avril-Juin 1998, Ministère de la Santé Publique
- <sup>32</sup> Study commissioned by Oxfam, July 2001.
- <sup>33</sup> REGIDESO is the parastatal body responsible for water production and distribution in urban areas.
- <sup>34</sup> Mortality in eastern Democratic Republic of Congo, IRC, May 2001
- <sup>35</sup> Etat des Lieux du Secteur de la Santé, Avril-Juin 1998, Ministère de la Santé Publique
- <sup>36</sup> Calculated from the 1997 & 1999 "Rapports épidémiologique et rapports des services" from Rethy
- <sup>37</sup> OCHA, preparation for meeting in Geneva, July 2001
- <sup>38</sup> Etude sur les Niveaux et Tendances de la Mortalité à Kinshasa, OCHA, Juin 2001
- <sup>39</sup> Programme National de Santé de la Reproduction (personal reference)
- <sup>40</sup> La carence en sélénium comme co-facteur de la carence en iode dans les grandes endémies goitreuses du Nord-est du Zaïre Dr Ahuka ona Longombe 1993

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- <sup>41</sup> Rapport Epidemiologique Annuel des Maladies à Potentialite Epidemique sous Surveillance en RDC, 2000, published May 2001.
- <sup>42</sup> The other 11 are measles, cholera, meningitis, polio, typhoid, monkey pox, bloody diarrhoea, neonatal tetanus, yellow fever, bubonic plague and haemorrhagic fever.
- <sup>43</sup> WHO/UNICEF Joint Mission, Democratic Republic of Congo, 18-29 June, 2001
- <sup>44</sup> Programme d'Appui Transitoire au Secteur de la Santé
- <sup>45</sup> Economist Intelligence Unit.
- <sup>46</sup> The World Bank Data profile for 2000 estimates the percentage of people with access to clean water was only 27%.
- <sup>47</sup> Aires de Santé are subdivisions of Health Zones.
- <sup>48</sup> La Société Minière de Bakwanga
- <sup>49</sup> Joint survey conducted by Oxfam GB, the Public Health University of Kinshasa and the Urban Health Inspection, 1999.
- <sup>50</sup> Rapports du Centre de Santé de Kitshanga (1999 – 2001) et Rapport de la Mission d'Evaluation des Besoins, Oxfam, December 2000.
- <sup>51</sup> Cassava is the staple for 70% of the Congolese population. Over the past 7 years, cassava crops across the country have suffered from viral and bacterial diseases that have totally wiped out production in some areas such as Bandundu. The war has hindered the application of measures to control the diseases and provide healthy disease-resistant varieties to farmers.
- <sup>52</sup> Final report on rehabilitation activities in Walungu/ Kaziba and Masisi, Save the Children UK, 2000
- <sup>53</sup> A type of malnutrition associated with diets that are poor in animal protein and other micro-nutrients.
- <sup>54</sup> Condensé d'informations statistiques, Banque Centrale du Congo, 11/2001, April 2001, Kinshasa
- <sup>55</sup> Global malnutrition rate registered by SC UK during a vaccination campaign in Bunyakiri, South Kivu. The methodology used was a first screening using MUAC and oedema detection. No anthropometric measurements were taken.
- <sup>56</sup> Rapport de l'enquête nutritionnelle dans la ville de Kiambi, Nuova Frontiera, March 2001
- <sup>57</sup> Nutrition Survey in Tshimungu, Mapela, Kimbanseke and Lobiko Aires de Santé, Save the Children UK, 28 April 2001
- <sup>58</sup> Kinshasa, Enquetes Nutritionnelles, Communes de Kimbanseke, Selembao, Bumbu et Kisenso ACF-USA/Ceplanut, 31 January – 23 February 2001
- <sup>59</sup> "No Excuses", Christian Aid, 2001
- <sup>60</sup> Economist, 2 January 2000, quoted in "No Excuses", Christian Aid, 2001
- <sup>61</sup> Programme National de Lutte contre le SIDA, quoted in "No Excuses", Christian Aid, 2001.
- <sup>62</sup> Education pour tous, Bilan à l'An 2000, Ministère de l'Education Nationale, November 1999. Figures also supported by UNICEF – State of the World's Children 2001.
- <sup>63</sup> Personal reference
- <sup>64</sup> Rapport circonstiel des écoles de la collectivité des Walendu-Pitsi, M. Belo Lonema, Conseiller de l'enseignement primaire, 6 April 2000
- <sup>65</sup> Mission effectuée par le PAM et Nuova Frontiera, au Nord Katanga (Kalemie, Nyunzu), 10-11 Avril 2001
- <sup>66</sup> DRC Consolidated Appeal, UN-OCHA Financial Tracking System, Relief Web, July 2001.

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