SURVIVAL IN THE

DEMOCRATIC REPUBLIC OF CONGO

A HUMANITARIAN DIAGNOSIS

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CONTENT

SUMMARY

Médecins Sans Frontières (MSF) has been working in the Democratic Republic of Congo (formerly known as Zaire) since 1985, and has witnessed the country's continuing decline into a major humanitarian catastrophe. The purpose of this analysis is not only to outline this decline and to show the worsening living conditions for the people in Congo, but also to demand urgent action to stop the downward spiral of violence and human suffering.

This dossier shows the extent to which economic, humanitarian and medical indicators are causing alarm bells to ring. The legacy of the Mobutu regime, the political impasse and the military conflict have had disastrous effects on the economy and the social sectors, which barely continue to function, and on the cities, many of which are on the brink of famine. Hundreds of thousands of internally displaced persons and refugees are seeking refuge among local communities that are already unable to sustain themselves, while orphaned children are abandoned to their fate. AIDS and sleeping sickness are spreading unchecked and are important reasons why international indifference must be overcome.

The challenge for humanitarian organisations lies in continuing to provide aid to those in need and to guarantee the right to health in the midst of the political turmoil. The attitude of the international community with regard to development co-operation with Congo is now characterised by a cautious and conditional wait-and-see approach, watching the changing economic situation and waiting to see how the political and military power struggle will turn out. In the wake of this lethargy, we are not only witnessing the collapse of the social fabric – the state, civil society, family solidarity – we are also watching a humanitarian mega-catastrophe.

MSF believes that it is of vital importance that this "wait-and-see policy" would now come to an end. Irrespective of the political and military changes, immediate action must be taken. In a first phase, initiatives must be launched to meet the urgent needs of the Congolese people and to provide direct support to those social programmes still operating. In a second phase, once the political situation has stabilised, it will be possible to move on to a more comprehensive reconstruction programme.

Finding reliable data for Congo today is very difficult. This analysis is restricted to pointing out trends or statistics that are indicative of the situation in the country.

I. SOCIO-ECONOMIC INDICATORS

"The already declining pre-war economy, legacy of three decades of mismanagement, is currently on the verge of collapse. Eroded by negligence and aggravated by war, the economy fails to sustain the livelihood of increasingly larger masses of urban populations. Millions, in rebel-held just as in Government controlled areas, are increasingly less able to operate through traditional ways which had allowed them earlier to support a meagre existence." OCHA, UN Consolidated Appeal 1999.

The last census in Congo dates back to 1985, and recent demographic figures can only be regarded as an estimate. The total population for 1998 was calculated at 49.2 million, while the forecast for 2015 is 80.9 million (UNDP 1998). Population growth is reckoned to be 2.5% per year. Kinshasa is thought to have a population of 5 to 5.2 million with forecasts for 2015 rising to 9.430,000. Indicative figures for a few large cities are: Lubumbashi: 900,000; Mbuji Mayi: 850,000; Kisangani: 600,000; Kananga: 800,000 and Bukavu: 400,000. Half of the Congolese population is younger than 20. This rapid demographic growth is weighing heavily on the economy, in terms of both the state and individual families. The average number of people living under one roof and dependent on the same budget is 6.3 for Congo overall and rises to 7 in the cities. The average number of children per woman is about 6.4.

Education has become far less accessible for the average Congolese. As teachers' salaries are low and only paid irregularly, parents have to contribute to the operating costs of schools. Many families even have to choose which of their children may attend school. The quality of university education has fallen off sharply since the early 1990s. Due to falling enrolments and the overall decline in the quality of education, the percentage of illiterate young people is now estimated to be as high as 50%.

Another major problem is the collapse of the economic infrastructure itself. The main reasons for this are: the increase in unemployment, which has contributed to the decline in purchasing power, the illegal export of natural resources through neighbouring countries, the burden of the war effort and the influence of the conflict on the economy along the frontline areas. Other major problems are the difficulties in collecting revenue to fund the state budget, the impossibility of keeping public services up to standard and paying civil servants an acceptable salary on a regular basis, and the consequences of recent monetary policy.

The pattern of retail price inflation is no longer as dramatic as at the end of the Mobutu era, but is still far from promising (IMF International Financial Statistics):

1995: 542% yearly variation
1996: 659%
1997: 176 %
1998: 147 %
1999: 221% (April 99 – figures from the US Embassy).

The economic legacy of the Mobutu regime is still a heavy burden. The change in Gross National Product per capita, listed below in US dollars (1987 value) speaks volumes:

1960: 288
1970: 309
1980: 241
1990: 197
1992: 153
1995: 120
1997: 117
1998: 120

The GNP per capita fell by an average 3.4% over the period 1965-95, which made the Congolese – in statistical terms – 53% poorer in 1995 than 30 years ago. (EIU Country Profile 1998-99.) In 1985 the average tax bill still amounted to US$24 per capita, while in 1997 it was only US$7.5, or 7.5% of GNP, whereas it is reckoned that a state should be collecting at least 20% of GNP in personal taxes (Maton, Van Bauwel, 1998). The total foreign debt in 1999 is estimated at US$14 billion.

In 1991 official development aid (ODA) per inhabitant was still US$12 or about 6% of GNP. In the early 90s international aid largely came to a halt when it became tied to conditions in regard to respect for the democratic process and human rights. Apart from humanitarian initiatives, virtually all aid channels dried up. The total amount of ODA received in 1996 was US$167 million, which represented about US$4 per inhabitant, or 2.8% of GNP (World Bank 1999).

GNP fell from US$14,922 million in 1980 to US$6,904 million in 1997. Whereas the Congolese state requires around US$1 billion to function satisfactorily, in the period 1994-97 income was only US$300-350 million. The state can only spend a limited amount on salaries as the regular payment of civil servants would require US$25 million per month or US$300 million per year. During the second half of 1997, an average US$5.6 million per month was paid in salaries, representing only one-fifth of the requirement (Maton, Van Bauwel, 1998). It is therefore hardly surprising that corruption and extortion have increased since the conflict has flared up again.

The direct and indirect consequences of the war are imposing a heavy burden. The average tax mobilisation per month of income fell from US$35.44 million (January–July 1998) to US$25.49

million (August-December 1998) and even to an average US$20 million in the first 4 months of 1999 (Maton, Van Bauwel 1998). This is a catastrophic pattern, especially as the percentage of public expenditure in the social sectors had already fallen from 22.1% in 1980 to 1.6% in 1996 (World Bank, 1999). As the frontlines cross the whole country, cities are cut off from their traditional regional supply sources and local economic transfers are at a virtual standstill.

The uncertainty about commercial and trade agreements is not encouraging for the investment climate. Private investment has ground to a halt, which has hit the mining sector particularly hard. Major investments that were required to modernise the mining industry after the Mobutu era have still not taken place. There has been a sharp fall in revenue from this source: down to 10% of the level at which it stood at the end of the 80s. Gécamines, a large mining company, had exports worth US$1.3 billion in 1989; in 1997 they were worth only US$253.1 million. Congolese copper production at the end of the 80s amounted to 500,000 tonnes, but declined to 40,000 tonnes in 1997 and virtually dried up in 1999. Furthermore, in 1999 the international price of copper fell to only 51.5% of its 1995 value.

However, Congo still has a major trading potential. The value of imports from Belgium and Luxembourg in 1998 amounted to approximately BF 6 billion, whereas the value of exports, mostly in diamonds, to the same countries amounted to approximately BF 25 billion. United States exports to Congo in 1997 amounted to about BF 1.5 billion, while imports from Congo – mainly oil and diamonds – amounted to BF 11.2 billion. (EIU 1999).

The outlook is bleak as a result of the recent increases in tax pressure on those businesses that are still paying their taxes and the new monetary regulations. Various companies are either scaling down their activities or have already decided to close down. The ban on the use of foreign currency for business transactions imposed in January 1999 under decree n° 177 could not prevent a devaluation of the new Congolese franc. In September 1999 it was decided to shut down the many currency exchange offices and only permit transactions in Congolese francs, with the exception of transfers via the official banks and a few international hotels. This monetary policy had an immediate impact on economic activity. The actual costs of imported materials, production, transport and salaries tripled. Foreign currency shortages are also causing problems in regard to oil purchases on the international market. The diaspora also appears to be sending home less foreign currency to support family members in Congo.

This economic pattern is also dramatically affecting the sustainability of civil society and local grass-roots organisations. The economic difficulties and the political deadlock are forcing them to concentrate purely on survival, and hopes of being able to implement programmes are fading before their eyes.

Many products are leaving the country via a parallel economy, meaning that customs duties are not being collected for the benefit of the public sector. In some regions this could be described as a pre-colonial economic structure, with businesses functioning as "marketing boards". A strategy aiming only at the extraction and export of the country's mineral wealth is leading to the impoverishment of the population and a further decline in already minimal health care

services, education and infrastructure maintenance. It should be pointed out that the flight of capital from African countries remains very high overall with an estimated 39% of the continent's wealth presently placed "overseas" (ECA, 1999). Crisis situations give criminal circles the opportunity to seize control of the wealth of a region, with or without the knowledge of the authorities there or in neighbouring countries. Political leaders are often unable to resist the temptation to involve themselves in lucrative transfers that undermine the state apparatus.

This development is partly controlled by the political-military leaders in alliance with networks from neighbouring countries involved in the conflict. On the one hand, commercial companies have been set up which are controlled by the national armed forces and their allies; on the other hand, there are also companies which serve as a cover for financing rebel organisations.

In 1996 the export value of coffee was estimated at US$289 million, and in 1997 at US$168 million. Since the coffee plantations are mostly located in the north and east of Congo, a major source of income falls outside the control of the government. Coffee is doubtless being exported via neighbouring countries: Central African Republic, Uganda and Rwanda. It is considered likely that this is being carried out under the control of the rebels or the armies of their allies. The same scenario applies to revenue from the gold mines, which used to produce an average of approximately 4,000 kg per year.

Diamonds

How can the natural wealth of a country in crisis contribute towards improving the living conditions of the local population? The diamond industry has apparently not been too preoccupied with this question. However, given that this is an industry with a product that is highly dependent on its public image, this indifference might prove to be a dangerous attitude in the long run.

Contrasted with Botswana, where the diamond industry is an example of how a sector can drive development, countries such as Sierra Leone, Liberia, Angola and now Congo have fallen victim to the attraction that diamonds hold for armed groups. However, the Congolese government is aware of the importance of diamonds for the treasury and various initiatives have been taken to gain greater control over the industry, although the results have yet to be seen.
The value of official imports of natural uncut diamonds into Belgium has amounted to around BF 20 billion per year in recent years (US$526 million). According to the diamond sector, over 90% of world trade in uncut diamonds passes through Antwerp. (Belgian Diamond Statistics, Hoge raad voor Diamant vzw) (US$ 1 = BF +/-38). The figures for recent years:

1992: 9,373 (billion Belgian francs)
1993: 12,110
1994: 20,812
1995: 19,288
1996: 20,514
1997: 19,600
1998: 22,338
1999: 12,788 (period January-June)

These figures only give the official Belgian statistics and provide no insight into the quantities smuggled via neighbouring countries. At the same time, diamonds from neighbouring countries such as Angola are able to reach Belgium via Congo. As a percentage of total exports, the share of legally exported diamonds rose from 12% in 1987 to 51.5% in 1997. The government challenged the monopoly position of De Beers' Central Selling Organisation CSO in 1998, and called for local production to be sold via a state authority. Two-thirds of mines are in private hands.

In 1999, the government introduced a requirement that purchases and sales of diamonds must be made in local currency, which obviously had a negative influence on the sector. Negative consequences – smuggling via the parallel market – apparently outweigh the anticipated positive consequences, namely increased control and a rise in income. Immediately after the tightening of monetary policy, the Panafrican News Agency (5 October 1999) reported a 30% fall in income from the diamond trade in September 1999 compared with that of August 1999, from US$17 million to US$12 million. The local newspaper, Le Potentiel, of 29/10/1999 reported a sharp fall in the income from diamond trading for the period from 1 to 18 October, compared with the same period in 1998. In 1999 the income from that period is estimated at US$3.233,998 compared with US$18,890,779 in 1998. For the period from January to mid-October, there was a fall of 40.41% in value: US$166,960,655 in 1999 compared with US$280,174,271 for the same period in 1998.

For the first time diamonds are also being mined industrially in the Kisangani region with machinery flown in from South Africa. This output is also escaping the control of the Congolese state.

II. MEDICAL DATA

The economic and political-military situations have direct and indirect consequences for the health of the Congolese population:

- *The basic health care system is collapsing;*
- *Endemic diseases such as AIDS, trypanosomiasis, malaria and onchocerciasis are spreading fast;*
- *There are continual outbreaks of epidemics such as meningitis, cholera, shigellosis, measles and various forms of haemorrhagic fever;*
- *There is a medical and nutritional emergency among the hundreds of thousands of internally displaced persons combined with a limited capacity to react and a limited accessibility when offering aid to this very vulnerable group of the population.*

A. Primary health care

The Congolese State appears to be unable to maintain the quality of the public health sector at an acceptable level. The Ministry of Health is suffering from a distressing lack of resources. The budget is inadequate and really only exists on paper. An eloquent example: of the eleven provincial health inspectors, only two have an official vehicle. Inspections and supervision by national or provincial medical services can virtually no longer take place, and certainly not outside the large cities. The irregular and extremely low salaries offer inadequate motivation to health workers to keep the 306 health districts running. When bilateral aid, mainly from the United States and Belgium, dried up in the early 1990s over 100 health districts were almost totally left to their own devices.

"La santé pour tous dans l'année 2000 – Health for all in the year 2000", the slogan adopted by the World Health Organisation in order to stimulate primary health care, is just an illusion: 79 health districts are more than 100 km from their referral hospital, and only 9% of health districts have a refrigerator for storing medicines. In the provinces of Maniema and South Kivu, there are no longer any lab technicians employed. The number of working health centres fluctuated in 1996 between 30% in Eastern Kasai and 86% in Bandundu.

The ongoing fighting has direct consequences. On November 4, Roberto Garreton, the UN Special Envoy for Human Rights, estimated the number of dead in the present conflict at 6,000, and also reported 500 missing persons (Garreton, R. 1999.) Looting and a "first come, first served" attitude by soldiers, rebels or armed individuals affect many centres along the frontline and in unstable regions. Health personnel run the risk of being taken hostage or prisoner. Imports of medicines via the rivers have come to a standstill for logistic or military reasons. Due to the disappearance and deterioration of equipment, the drying-up of spare parts supplies and the failure to maintain buildings, the quality of medical care provision is declining rapidly.

The life expectancy at birth of the average Congolese is decreasing. In 1996 the life expectancy for men was still 51 years and 54 for women. In 1999 it was estimated to be 47 years, partly as a result of AIDS. The number of people not living beyond the age of 40 amounted to 30% of the total population in 1995. According to WHO, the number of women dying in childbirth rose from 870/100,000 in 1995 to almost twice as much in 1999 (OCHA 1999). The poor quality of mother-and-child care also has consequences for infant mortality, which rose from 131/1,000 live-born children in 1972 to 111/1,000 in 1980 and to 141/1,000 in 1995 (UNICEF). Between 65% and 84% of deliveries take place outside health care institutions or without the help of qualified midwives.

Preventive work such as vaccination campaigns can no longer be carried out in a structured way. Overall vaccination statistics are difficult to obtain because of the inaccessibility of many areas and the massive migrations of internally displaced persons. The efficiency of one-shot actions such as national vaccination days still has to be analysed. Although these one-shot initiatives receive a massive response, the disastrous everyday reality of primary health care is pushed into the background. Epidemics are no longer detected in time, and are left to spread unchecked. In 1999 alone, a polio epidemic broke out in Equator province claiming over 200 victims.

Due to the wretched working and living conditions, some medical staff are leaving the country, and those who remain are concentrating in the cities. For the whole country, it is estimated that there are 2,000 doctors and around one hundred surgeons, plus some dentists. Fifty per cent of doctors live and work in Kinshasa, as do seven out of ten surgeons. In 1999 there was one doctor per 4,237 inhabitants in Kinshasa and one doctor per 73,261 inhabitants in Equator province. And these doctors are having to work with ever scarcer resources. A number of experienced doctors have now left the country and settled in other countries, including South Africa, Benin and Rwanda.

The economic situation can also be felt in the private medical sector, which exists mainly in the cities. Imported medicines cannot be bought, or only in far too small quantities. The recent monetary reforms, requiring medicines to be paid for in local currency, can only further undermine health services. A growing number of patients can no longer afford treatment and medication, leading to a fall in the number of consultations. A blood transfusion in Eastern Kasaï costs between US$4-18 if no blood needs to be bought, and US$40-70 if blood has to be provided by the patient. In rural districts, the percentage of income spent on health care is very high: 17% in Bandundu (May 1999) and 22.4% in Bas-Congo (June 1999). For education, the figures are 19% and 9% respectively. (FAO 1999) Programmes aimed at self-financing have stopped as patients are only able to make limited contributions. Treatment periods are being curtailed due to "excessive cost". In the public sector, patients opt not to attend health centres because they often suspect – with good reason – that there will no longer be any medicines available, and they cannot afford to buy them in the private sector.

Non-commercial private initiatives (NGOs, missions, etc.) also have to contend with the difficult working conditions and the low purchasing power of the population. Various programmes ac-

quired a certain degree of built-in sustainability through insisting on patients making financial contributions for the provision of care. These now have to choose between lowering prices to maintain accessibility for the average patient, or continuing with the same level of contribution and only providing services to families that can pay for them. In the present crisis situation, maintaining the criteria of financial sustainability is clearly leading to the exclusion of a proportion of sick people, which means that care providers are faced with enormous dilemmas every day. In some provinces, the few hospital beds available are not even occupied. In Maniema and North and South Kivu, where only 53 beds are available per 100.000 inhabitants, the occupancy rate is restricted to 32% (ISA). This figure could indicate either that people are shying away from modern health care, or experiencing financial inaccessibility and/or a limited quality of care; in any case, it is a symbol of the erosion of the basic right to health care.

B. AIDS

Although attention is currently focused mainly on the political and military turmoil and the general economic decline, the Congolese people are also fighting a hidden battle against the AIDS epidemic. As in other areas, exact statistics are lacking, but there are nevertheless sufficient indications to assume that the AIDS epidemic will also reach enormous proportions in Congo.

In 1991 the number of people in Kinshasa infected with the HIV virus was estimated at 6% of the population, which would amount to approximately 240,000 people. In the high-risk group, which comprises prostitutes, that percentage has already risen to 35%. At the end of 1997 the total number of people who have died from AIDS was estimated at 470,000, and the annual number of deaths at 100,000 (WHO, 1998).

In 1995 it was estimated that 125,000 people (or 0.25% of the population) were actually suffering from AIDS. It is true that there are large regional differences. In 1996, in North and South Kivu, the HIV infection rate was estimated at 18% of the population, or 1.8 million people. In Eastern Kasaï, on the basis of the information from the MIBA company hospitals, seroprevalence was estimated at 5.9%, with peaks in some urban centres. In 1998, in one of the health structures in Mwené Ditu, a seroprevalence of 16.8% was recorded among blood donors. (175 HIV+ out of 1,043 donors.) In Lubumbashi, the capital of Katanga, a study in one hospital in 1999 revealed a prevalence of 8.5% (BCC SIDA RDC statistics). At the end of 1997 the World Health Organisation gave a national infection level of 4.35% or approximately two million HIV seropositive people.

The risk of a rapid spread of the disease far into the interior of the country is increased by the population movements and lack of family ties, the spiral of violence and rape, and the presence of soldiers from countries where the HIV+ infection levels for adults are among the highest in the world (Zimbabwe 25.84%; Rwanda 12.75%; Uganda 9.51%).

The "Bureau Central de Coordination Sida – AIDS Central Co-ordination Bureau" is seriously under-resourced. In 1996 the World Health Organisation estimated that only 3%

of the population had access to condoms. The reluctance to encourage the use of condoms, and sometimes even resistance to them from religious organisations working in the medical sector, has serious consequences for the further spread of AIDS. Various prevention campaigns have been launched, such as an information brochure for schoolchildren produced by Médecins Sans Frontières. However, the crisis situation is pushing the battle against AIDS out of the spotlights.

The consequences of this epidemic on the social fabric are already clearly visible.

A growing number of infected and seropositive children. According to UNAIDS, the number of HIV+ children between 0 and 14 years of age in 1997 was 49,000. The World Health Organisation estimated the total number infected with AIDS at 410,000 in 1997.

An increasing number of children are rejected by their families, with AIDS given as one of the reasons to explain this stigmatisation. The child is accused of being the carrier that brought the disease into the family. Blame for the disease is attributed to the "witch child" acting as a medium for the forces of evil. Faith healers hold ceremonies to drive out "the evil", but many children still end up on the street. The number of children thrown out onto the streets of Kinshasa has been estimated at several thousands.

A growing economic cost for society. The economically active population is seriously affected, and the cost of treating AIDS patients is a heavy burden on the health-care sector. Few patients can afford prompt treatment of the opportunistic illnesses and the cost of this is a heavy burden on the family budget. Many patients develop tuberculosis.

C. Trypanosomiasis

The spread of trypanosomiasis or sleeping sickness has assumed grave proportions. The rise of this serious disease in the capital Kinshasa is particularly alarming. In the 1980s this deadly disease appeared to be spreading again. Through large-scale bilateral aid programmes, including some funded by Belgium, and through indirect support from NGOs such as Fometro, *the damage was limited. When some of these programmes were stopped in the early 1990s, there was another rise in sleeping sickness. In 1994 there were 19,000 new cases recorded among the 20% of the high-risk population that could be examined. The total number of cases diagnosed among the accessible part of the population at risk amounted to 35,089 in 1997, and 27,044 in 1998. In some communities in the provinces of Equator and Bandundu,, a prevalence of more than 30% was observed, with peaks of up to 70%.*

The cases in Kinshasa are mainly found along the rivers Ndjili and Nsele and in the Massina district. The high population density will inevitably accelerate the further spread of this epidemic. Along the Ndjili river alone, the population is estimated to be 400,000. The disease was only present in the capital sporadically until the mid-90s, after which a considerable increase in new cases was recorded: 1996: 254; 1997: 226; 1998: 433; 1999: 735 new cases up to 30 June, of which 30% were children under 15 years of age. In the context of vector control, 42,231 tsetse flies were caught in a four-month period during one community-based programme.

There are various reasons for this development:

- *No systematic vector control campaigns.*
- *Reduced possibilities for tracing potentially infected people.*
- *Lack of drugs and adequate treatment.*
- *Decline in the quality and availability of primary health care.*
- *Limited effectiveness of the Bureau Central de Trypanosomiase (BCT), which has inadequate resources.*

In June 1999, Belgium signed a specific agreement to provide BF 300 million over three years to support the battle against sleeping sickness. Whether a vertical approach to this disease will prove adequate to curb the epidemic is not yet clear. The more health districts get into difficulties, the more difficult will be the task of the services that are supposed to fight a specific disease. In this regard, it is important to note that finding new medicines for trypansomiasis is not high on the list of priorities for the pharmaceutical industry. The medicines presently used have many side effects, but research into new, less harmful treatments has not advanced much. Apparently, it is not sufficiently economically attractive for the pharmaceutical industry to invest in fighting this disease.

Because of the neurological symptoms, this deadly disease imposes a heavy burden on communities. The treatment of the mentally ill is always greatly dependent on assistance from third parties and the cost of treatment is relatively high, approximately BF 2.000 per patient. The

more people are infected, the greater the chance of the disease spreading, so rapid detection and treatment are crucial in controlling it.

The problem of sleeping sickness goes beyond the country's borders, and civil wars in Angola, Sudan and Congo-Brazzaville mean that the disease strikes with impunity there too.

D. Measles

Although a simple vaccination is all it takes to prevent this illness, MSF has noticed a revival of measles epidemics in the interior of the country. This disease remains a major cause of death amongst children in Congo, with the risk of death rising to 33% among malnourished children. The risks are very high especially where there are concentrations of internally displaced persons. The inadequacy of vaccination campaigns as a result of the successive conflicts and the deterioration of the medical infrastructure and service provision increases the chance of epidemics. According to OCHA, fewer than 33% of Congolese children are vaccinated (OCHA , 1999)

In the first eight months of 1999, 7,693 cases were notified in Katanga, of which 293 were fatal. The Rethy health district, in Orientale province, was hit by an epidemic in June-August 1999 that resulted in 2,381 cases with 394 deaths.

E. Tuberculosis

The limited scale of TBC programmes and the uncertainty of diagnosis make it impossible to draw a complete picture of the TBC situation in Congo. The increase in the number of AIDS victims and the chronic lack of medical monitoring lead to the most serious concern about the further spread of this contagious disease. The total number of cases is estimated at certainly 250,000 for the whole country.

The following statistics provide an indication of the number of new cases in 1996 (ISA):

Katanga : 9,000
Eastern Kasai : 2,000 (based on information from 7 health districts out of 27)
Equator : TBC (main reason for consultations in Bangobola health district)
Bas Congo : 3,500
Bandundu : 8,000
Orientale : 3,500

F. Cholera

Cholera is endemic in many areas, but new outbreaks occur regularly. In Kinshasa, there were 673 cases recorded at health centres between March and August 1999, which gives an indication of the poor hygienic conditions in some parts of the city. The failure of electricity supplies often causes problems with the water supply in urban areas. The poor quality of the drinking water used also entails risks. In Bandundu city, an epidemic raged from May to July 1999 causing 217 cases, including 89 among prisoners-of-war. Of the 20 deaths, 10 occurred among the latter group. The detention centres are breeding-grounds for epidemics due to the precarious living conditions.

G. Malaria

Malaria remains the number one disease in Congo, and is responsible for many deaths, especially among children. The deterioration of basic health care and increasing resistance to the standard drugs are allowing this disease free rein. A rise in cases is also perceptible in higher-altitude regions, where there was previously no malaria. Information and prevention campaigns have more or less ended. Even in Kinshasa, malaria is the principal cause of death recorded in health centres. On the basis of the recorded death figures for the months of May and June 1999, 140 children under five years of age, and 105 people aged five and over died of malaria. (Bulletin Epidémiologique de Kinshasa no.11/99).

H. Haemorrhagic fever

Extremely infectious epidemics of haemorrhagic fever occur regularly, and cannot be identified or isolated promptly. In Kikwit, between May and August 1995, there were 315 cases of Ebola, of which 244 died. In Watsa-Durba, between 16 November 1998 and 18 May 1999, 73 cases of van Marburg virus were notified. A doctor, Dr. Bonzali, died after giving a sample of his own blood so that the disease could be identified. The working conditions in the medical institutions make this disease a real threat for personnel, patients and visitors: there are still no isolation wards, little or no protective equipment, and no analysis facilities to discover the nature of the disease at an early stage.

III. HUMANITARIAN DATA

A. Cities on the verge of famine

Malnutrition in the cities has increased as the result of a combination of economic crisis, transport problems, tight monetary policy and the influence of the war. A study carried out by the "Centre National de Planification de Nutrition Humaine" (CEPLANUT) in April 1999 on 1,648 children aged between 6 and 59 months shows the seriousness of the situation in Kinshasa, and proposes urgent measures. Overall malnutrition (<-2ET and/or oedema) amounts to 10.5%, from which we can extrapolate that a total of 125,000 children are affected in the city. Throughout the period since nutritional surveys started, only the month of April 1994 yielded worse results. In a one-year period, an increase of 3% has been observed (from 7% in 1998 to 10.5% in 1999). Serious malnutrition (<-3ET and/or oedema) amounted to 2.1%, and affected 25,000 children for the city as a whole. The figure for chronic malnutrition was 31%, which is also a bleak record compared with previous years. Only 17% of households had a small reserve of food to feed the family for three days, 13.6% of families eats only one meal per day and only 10% of families spends less than half their daily budget on food (CLEPANUT 1999).

Recent research by the "Système d'Information sur la Sécurité Alimentaire et la Nutrition" (SISAN) shows that an average family in Kinshasa spends up to 62% of its monthly budget on food. The average income is estimated at 112 US$. Other cost items are housing, 6%; clothes, 2%; transport, 2.2%; education, 10%; health, 4.7%; water and electricity 3.4% (FAO 1999).

The availability of imported products that have to be paid for in foreign currency is falling as a result of the new monetary policy. Supplies of imported fish in particular fell sharply in Kinshasa. The consumption of cereals and vegetables has gone down sharply. Meat and fish are only eaten occasionally, and are always of the cheapest quality. The quantity of "expensive" foods per meal is falling, as is the number of meals per day. Wherever possible, people attempt to work a piece of land near their home to produce as much as possible for their own consumption.

The various programmes supported by the international community need to be intensified and extended as part of the battle against malnutrition in Kinshasa. Furthermore, the situation has worsened considerably since the tightening of monetary policy. Cassava (manioc) has become by far the most important food but only has low nutritional value. Due to price freeze on basic products, there is also less food sold on the official market by producers as the cost of transport is often already higher than the permitted selling price allowed. Various products available on the black market, but at a higher price.

In the provincial capital of Lubumbashi, serious problems are menacing the city as it is mainly supplied by areas in the north of the province, which are now cut off by the front line. The reforms in the Gécamines mining company, with 6,000 job losses and the discontinuation of the "food for work" programmes to supplement wages, are imposing a heavy burden on the economies of local households.

A nutritional survey in Kisangani in November 1999, carried out by Médecins Sans Frontières on 941 children aged between 6 and 59 months revealed alarming figures in regard to the food situation in the city, with an indication of 9.2% overall malnutrition, and 5.2% serious malnutrition (Z-score). An extrapolation to the 400,000 actual inhabitants of the town gives us a figure of 7,360 malnourished children and 4,000 children who would need therapeutic support. The figures for chronic malnutrition are very high: 42.7% global and 19.7% severe. The mortality figures for the population concerned – households households with children under 5 – are up to 1.65/10,000/day (in January 1999 this figure was 0.95/10,000/day). The mortality rate amongst children under five is now 2.95/10,000/day (in January 1999 it was 2/10,000/day). From January 1999 onwards more than 3,000 children received nutritional support in the town.

In the same month, it was reported that food prices had quadrupled since the war has flared up again in Kalemie, a town in Katanga province. In fact, the problems in the towns are not only related to the limited purchasing power, but also to transport difficulties: the poor quality of the roads and the vehicle fleet make it extremely difficult to bring food in from the outskirts at reasonable prices. "The global food deficit in major urban markets is estimated at 40-60 % of what is considered as a minimal level to meet the most basic needs." *(OCHA 1999)*

For the province of South Kivu, the number of families that cannot farm normally is estimated at 125,000 for the period from September 1999 to January 2000. This situation has serious consequences for the quantity of food produced and food supplies to surrounding towns. A disruption to the food supply is forecast for the year 2000. At the same time, there is a trend towards higher transport costs – wherever transport is still possible at all. It is estimated that there will be a shortfall in available food of 30,000 tonnes for February 2000 (FAO), with a potential impact on 30% of the population of the province. An FAO study indicates that the number of cattle in the east of Congo (Orientale province, North Kivu and South Kivu) has fallen from 950,000 in 1991 to 486,500 for the period 1998-99, which represents a fall of 48%.

According to UNDP (1998), the change in the daily intake of kilocalories per person in Congo is as follows: 1970: 2,158; 1995: 1,870. The index of food production per person has fallen from 100 (1980) to 84 (1996). FAO estimates that 17% of the population is living in a situation of food uncertainty. For 4.3% of the total population, or 2,150,000 people, the situation is said to be serious (FAO 1999). The World Food Programme has started an action to support vulnerable groups and the displaced. The total number of beneficiaries is thought to be 350,000 and provision has been made to supply 37,000 tonnes for a six-month period. Due to high transport costs, the cost of this operation is estimated at 30 million US$. Given the context of food uncertainty over the whole country, this programme should certainly be continued, and increased to reflect the number of beneficiaries.

B. Increase in the number of displaced persons

There have been large-scale migrations of civilians due to insecurity or out of economic necessity, and the numbers of displaced persons are rising continuously. In October 1999, OCHA estimated the number of internally displaced persons, including Kinshasa, at 830,000 (OCHA 1999).

South Kivu	*195,000*
North Kivu	*160,000*
Katanga	*185,.000*
Equator	*120,000*
Orientale	*80,000*
Eastern Kasai	*60,000*
Maniema	*20,000*

On 17 November 1999, the number was already 910,000 due to an increase in Haut Uele (Orientale), in Walikale (North Kivu) and Mongola (Equator) (Irin News Online 17/11/1999).

In addition to the growing vulnerability to disease, malnutrition and sexual violence among the displaced persons themselves, these migratory flows put enormous pressure on the living conditions of host communities as the limited resources have to be shared among more people. Mortality and morbidity among the displaced, especially the children, is well above that of the average population. In August 1999, 28,000 displaced persons were registered in Lubumbashi, but only 3,300 were receiving aid.

Fewer than half the number of displaced persons live in areas that are accessible to humanitarian organisations. Logistical restrictions, especially in regard to transport, and difficulties in obtaining authorisation to go to where they are, often on security grounds, restrict access to isolated groups of displaced persons. And there are other consequences for the displaced as a result of their confused situation: traditional ties of solidarity break down, and agricultural cycles are seriously disrupted, which increases the risks of famine.

C. Conflicts behind the frontline

In addition to the military confrontation between rebels and the authorities, both supported by their respective allies, fighting is still going on to flush out suspected Interhamwe militias in the Kivu provinces. Both in South and North Kivu there are also armed confrontations with local "Mai Mai" fighters who may or may not be organised into defence groups to protect their villages, but spread terror along the roads or attack military units in the vicinity.

As a result of the diversity and fragmentation of warring factions, the conflict in the East of Congo has taken on a very complex character. Ethnic tensions, such as those between the Hema and Lendu, seriously disrupt the humanitarian situation. In the Ituri district, a conflict broke out between the Hema (livestock breeders) and Lendu (a farming community) on 19 June 1999, after a dispute over land in the Djugu region. A number of villages were razed to the ground and between 100,000 and 150,000 people were driven from their houses. The exact number of fatalities is difficult to estimate, but must be between 2,000 and 5,000. Fleeing Hema mainly sought protection in the small towns in the region where Ugandan soldiers are stationed. Many Lendu scattered into the surrounding forests. The local economy was disrupted and epidemics of cholera, measles and even bubonic plague are spreading unchecked. In the Rethy health district in September/October 1999, 24 cases of bubonic plague were recorded, and a measles epidemic produced a death rate as high as 15% among those infected. To the north of Bunia, over 200 cases of cholera were diagnosed in the same period.

Despite the difficult situation, there are an estimated 270,000 refugees from neighbouring countries living in Congo to escape from civil wars in their homeland: 147,000 Angolans, 20,000 Burundians and 35,000 Rwandans. And many thousands of Congolese have also fled into neighbouring countries. According to the UN High Commissioner for Refugees, they number 130,000, living mainly in camps in Tanzania and Zambia.

D. Anxiety and impunity

"The social and economic development of the Democratic Republic of Congo requires peace and security. To establish such conditions, it is necessary to end the cycle of impunity which stimulates and encourages every form of violence and violation." *(First recommendation listed in the report of the UN Secretary-General's inquiry team into serious violations of human rights and international humanitarian law in the DRC, June 1998).*

"With the disintegration of the rule of law in Congo and elsewhere in the region, Congo has become the battle ground for the interests of its neighbours and a political and military elite – all at the expense of Congolese civilians. In this context, neither the Congolese government and its allies, the RCD and its backers, nor the myriad of militia and rebel groups in Congo have made respect for human rights a priority. Without firm action from international players in the region and elsewhere, the results for the Congolese are likely to be more abuses and a further degradation of the situation."*(Human Rights Watch report on the Democratic Republic*

of Congo, Feb. 1999).

The rule of law remains an illusion in Congo, both as it affects the investment climate and the individual citizen. Reports by human rights organisations and by the UN particularly emphasize the repression of the civilian population during military operations by the rebels and their allies. On the government side, criticism focuses mainly on the shelling of civilian targets and the growing lack of discipline among the troops.

By systematically denying the basic principles of international humanitarian law and human rights, the region has been forced into a cycle of mistrust and the desire for revenge. Impunity both for criminals and political leaders who allow or encourage these inhumane practices means that citizens no longer trust in the rule of law in the country, which leads to some of them taking the law into their own hands. Apart from the lack of resources, the summary dispensation of justice and ever-present insecurity not only harm the relationship between the citizens and their leaders, but make individuals wary of taking initiatives and are also disastrous for the development of "civil society".

Displaced persons not only need food, shelter and medical care, but also protection against enforced displacements, extortion, theft or revenge by armed elements. The situation in the detention centres, prisons, solitary confinement units and internment camps is often so bad that just being there is a sentence in itself, a sentence to lifelong trauma, to infectious disease or to death through privation.

E. Abandoned children

According to Médecins du Monde there are between 8,000 and 15,000 street-children living in Kinshasa, mainly originating from the city itself. Their main problems are malnutrition, disease, unemployment, poverty, mistreatment, lack of shelter or hygiene facilities and naturally, a total lack of schooling. Many mothers find themselves alone, and it is increasingly difficult to maintain the traditional family solidarity. The stigmatisation and rejection of children by the family is a practice that is becoming more and more common, particularly in the cities. A new phenomenon that is arising is that of the "witch child", resulting from a contemporary interpretation of traditional magic and the active role played by the many faith healers.

Abandoned children make up a substantial proportion of the displaced. In September, in the city of Kabina alone, there were 3,000 malnourished children out of a total population of 150,000, of which 15,000 were displaced persons (Hôpital Catholique Sainte-Camille). In Lubumbashi too, the number of street children is growing fast. Estimates for this relatively new phenomenon are as high as 3,000 children. Perhaps this is an indication that essential family ties are no longer able to withstand the pressure of the circumstances.

For children who find themselves alone, joining one of the military groupings is one of the few remaining alternatives if they are to survive. There is no time to lose in setting up large-scale

programmes to offer these vulnerable children an alternative option, so that they are not drawn into a violent environment and forced to contribute themselves towards the spiral of violence.

IV. ATTITUDE OF THE INTERNATIONAL COMMUNITY

In the early 1990s, when the tension in East-West relations eased, the unconditional flow of money to Mobutu's former Zaire dried up. Large sums were required in Eastern Europe and improving education and health in the satellite states of both blocks ceased to be a priority. Multilateral and bilateral funds dried up in the name of a policy directed towards defending human rights and stimulating the democratisation process.

After decades of generous support to the Mobutu regime, the United States suspended economic aid in 1991 on the basis of legislation banning aid to countries that were no longer able to repay their loans.

In 1993 various indirect aid channels were opened up again, but never really reached a substantial volume. From 1996 on, the international community appeared to adopt a wait-and-see attitude, but also began scaling down existing programmes. Some local partners relying on aid via international channels had to close down because their funding dried up. The little remaining aid since then can only be described as symbolic crumbs in relation to the real needs: it was as if sanctions had been introduced.

A. Belgium

Bilateral aid to Congo came to a complete halt in 1991, after which only indirect and humanitarian aid was offered. In 1995 a change took place and an overall budget amounting to BF two billion over five years was made available for structural aid via indirect channels targeting the food situation and health care. As from 1997, we have seen a gradual recovery in development aid to Congo: in 1997 the total amount was BF 1.064 million, of which 256 million represented bilateral funding; in 1998 the total amount was BF 905 million, of which 249 million were bilateral funds. Co-financing provided support for NGO projects to the extent of BF 264 million in 1997, and 322 million in 1998 (ABOS annual report, 1998). This budget is of enormous importance as a response to the day-to-day problems in these sectors, but needs to be adapted to the reality in the field in order to be more effective.

The current mechanisms for financing health districts are not flexible enough to meet the actual needs of these districts. Each district receives the same budget, while the costs may vary enormously for logistical reasons. Transport costs are very different for health districts in Equator and those in Katanga.

This indirect budget line is not open to non-Belgian NGOs, which does nothing to stimulate competent operational partners to become involved. Yet, this shortage of operational partners is just one of the great problems in devising indirect aid measures, especially now that the possibilities for local partners or local administrations have been sharply reduced due to the collapse of the economy. Belgian NGOs do not have sufficient capacity to meet all the needs alone.

The concept of "sustainability" has unfortunately become illusory in regard to the implementation of programmes nowadays, especially in terms of "self-financing". Given the working conditions and the general socio-economic climate, if existing services can be kept in operation, then that in itself can be regarded as a success.

B. European Union

The European Union decided in 1992 to suspend development co-operation with Zaire on the basis of Article 5 of the Fourth Lomé Convention dating from 1989, which emphasises the importance of respect for human rights and democratic principles. A humanitarian budget of 309.81 million US$ was made available for non-governmental organisations and grass-roots movements in the period 1992-96.

Shortly after the present conflict broke out, the current president of the European Commission stated that aid programmes needed to be adapted to avoid them being used for purposes related to war. In a statement issued in December 1998 during a meeting of the consultative group of the Club de Paris in Kampala, the EU called for an urgent political solution to the conflict and said that without it, it would no longer be possible to give the same level of budgetary aid to countries involved militarily.

Non-structural aid was provided indirectly for health care, water supplies and sanitation through the PATS programme (Transitional Health Support Programme), NGOs and religious charities. This programme has a budget of approximately Euro 40 million, but it has only been possible to spend approximately 25 million so far because of the war situation and a lack of operational partners to implement the programme in the field.

The PAR programme (Programme of Aid for Rehabilitation) has been temporarily suspended. This is intended for rebuilding infrastructure, repairing roads and urban water supplies, and support for manufacturing and sales, and theoretically has Euro 84 million available for a period of three years.

In the field of humanitarian aid provision, ECHO invested Euro 15.4 million in Congo in 1998 and the spending forecasts for 1999 are around Euro 16.4 million. Like other donors, the European Union is cautiously watching how the situation evolves in the country. Financial aid for the implementation of the Lusaka Agreement was slow to arrive and is clearly inadequate. The chances of success for this agreement are waning due the lack of genuine support.
The various member states of the European Union are still hanging back. Although there have been occasional statements about restarting aid – from France, for example – we have not yet seen any genuine commitment. Germany also seems to be gradually scaling down bilateral aid.

C. United Nations

On 24 November 1999, the United Nations launched its Consolidated Appeal 2000, for a total amount of US$71.3 million. Although the various UN agencies have often worked individually in the past, at the instigation of OCHA efforts now are being made to achieve greater co-ordination.

As the UN also has a political and military mandate under the Lusaka Agreement, it is extremely important to separate the military/political and humanitarian agendas. Past experience in Somalia, Rwanda, Afghanistan, etc. has taught us how this dual agenda can lead to problems in a complex crisis situation. Security Council Resolution 1279 of 30 November 1999 provided the United Nations Observer Mission for DRC (MONUC) with a dual mandate under which humanitarian programmes – and access to populations in need – could become highly dependent on the results of the UN's political achievements.

D. World Bank and International Monetary Fund

The International Monetary Fund struck Zaire off its list of possible beneficiaries for special funds in September 1991. We have noted a sharp fall in the level of international financial aid to what is now the DRC since that time. The number of donations and loans (with a gift component of at least 25%) fell from US$457.4 million in 1991 to US$183.3 million in 1996. As a result of the failure to pay debt instalments, the burden of foreign debt continues to rise to US$14 billion or BF 545 billion.

In December 1997, the "Friends of Congo" held a conference in Brussels, at which it was decided to set up a trust fund, managed jointly by the Congolese government and the World Bank, to which donors could pay contributions. It is taking a long time to fill this fund: by mid-1999, only three donors had contributed a total of US$17 million. The fund was intended to support small-scale initiatives of up to US$500,000 in education, health care, transport, urban development and water supplies.

The cutback in World Bank and International Monetary Fund programmes means that Congo is now caught in a spiral of financial exclusion. An exploratory mission from 3-14 November 1999 by the World Bank, the IMF and representatives of the UN and donors spoke only in vague terms of contacts for "post conflict relief" and a timetable for restarting co-operation with Congo. Few immediate results should be expected.

V. RECOMMENDATIONS TO THE INTERNATIONAL COMMUNITY

The present situation in the Democratic Republic of Congo has all the characteristics of a complex emergency.

Characteristics of complex emergencies:

- *administrative, economic, and socio-political decay and collapse;*
- *high levels of violence;*
- *cultures, ethnic groups and religious groups at risk of extinction;*
- *catastrophic public health emergencies;*
- *vulnerable populations at great risk;*
- *internal wars resulting in major violations of the Geneva Conventions and the Universal Declaration of Human Rights;*
- *increased competition for resources between conflicting groups;*
- *long lasting and widespread.*

Frederick M Burkle, Jr. Lessons learnt and future expectations of complex emergencies. BMJ vol. 319, 14 August 1999.

MSF, therefore, urges the international community to adopt a proactive attitude with regard to the current situation in the Democratic Republic of Congo.

All efforts should now focus on ***ending the ongoing armed conflict as soon as possible,*** *in order to allow the DRC to launch real development efforts. Genuine pressure should be brought to bear on the international players in this conflict to gain free and unhindered access to the population in need, as well as to guarantee a safe working environment for humanitarians aid workers. Weapons sales to the region should be strictly controlled, while arms smuggling should be addressed in a serious manner. Budget aid to the countries involved in the conflict should be strictly controlled, to avoid the siphoning off of aid into the war effort.*

In the meantime, a two-phase approach should be envisaged ***to break the deadlock situation over aid*** *to the Democratic Republic of Congo.*

A. A Two Phase Approach

A.1. The first phase: humanitarian assistance for stabilisation

Before a large-scale development programme can be devised and implemented, a first phase needs to focus on the most immediate humanitarian needs. These needs must be addressed irrespective of the evolution of the conflict.

These needs are not just for aid and assistance to the many vulnerable groups, (internally displaced persons, refugees, abandoned or orphaned children), but also maintain existing services.

It is not possible to determine the duration of such a first phase. This will be determined by the political and military evolution in Congo and the reaction to it by the international community and by the economic sector. The increased proliferation of weapons, the complexity of the domestic and regional situations, and the apparently limited will to actually enforce the Lusaka Agreement leave little hope today for a quick solution.

Even on the assumption that genuine peace would become a reality tomorrow, a minimum period of five years would be required during which humanitarian emergency aid and reconstruction activities would be the central focus.

A.2. The second phase: a development phase

A second phase which must focus on long-term development, and is dependent on peace and stability in the country. Nevertheless this second phase should already be under preparation and may be expected to partially overlap the first phase time-wise.

This second phase should consist of a thorough rebuilding of services and infrastructure.

As far as capacity-building is concerned, specific attention should be paid to the legal sector. In particular, many complex legal questions will have to be resolved with regard to land ownership. Uncertainty about "property law" was one of the causes of instability in the Kivu province, and has remained a stumbling block. "Pour nous aider, il faut calmer nos morts. Il faut redonner nos terres a nos ancêtres (To help us, our dead need to be pacified. Our lands must be returned to our ancestors)" *(Congolese, anon.)*

Confidence will be restored only when there is a political system that functions in a manner acceptable to the population at large, while putting an end to injustice and impunity. The tension that currently exists in the relationship between the citizen and the State must be addressed in such a way that the citizen no longer needs to fear repressive authority and the government authorities no longer need to fear an emancipated citizenry expressing its democratic voice.

B. Recommendations for the first phase

At present, the situation is so dramatic that even the last remnants of local structures are in jeopardy. Due to the seriousness of the present situation, it is necessary to respond as quickly as possible.

MSF emphasises that, especially during the emergency phase, humanitarian support must be unconditional. "A policy of critical longer-term engagement is likely to be more effective than negative political conditionality" *(Baaré, A OECD 1999). The right to life, health and education are unconditional human rights.*

The following objectives could be aimed for in this phase
Humanitarian aid reflecting the needs, both with regard to the direct consequences of the present conflict and within the context of the general decline of social service provision in Congo. An urgent reaction is already required in order to reduce the likelihood of a large-scale food crisis in the cities and in isolated regions along the front line during the first months of 2000.
Direct support for services in the social sector, which are still achieving an acceptable degree of operation (schools, health districts, AIDS prevention programmes, the judiciary and so on). The objective of this support should be to provide services with direct benefit to the population, not to assist systems as such.
Diplomatic support to the operational partners should be provided in this phase to safeguard respect for international humanitarian law, and limit the negative impact of present monetary policy and local administrative regulations. Obtaining access to vulnerable population groups close to the front line is often problematic.

MSF therefore wishes to put forward following recommendations for immediate action.

B.1. To the Donor Community

1. *MSF asks for an **immediate increase in humanitarian assistance**, including direct support for services in the social sector, which are still achieving an acceptable degree of operation (schools, health districts, AIDS prevention programmes, the judiciary and so on).*

2. *An **urgent and consistent reaction is required in order to reduce the likelihood of a large-scale food crisis** in the cities and in isolated regions along the frontline in the early months of 2000.*
3. *Since the aid is being provided within the context of an armed conflict**, particular attention should be focussed on guaranteeing that the aid actually reaches the population in need**. MSF asks that aid should be closely monitored to check how it is ultimately used. The distribution of aid needs to be checked on the spot, to avoid the parties to the conflict making improper use of it.*

4. *Administrative obstacles put forward by donors themselves should be avoided as much as*

possible in the first phase. ***Flexibility and creativity in response to a sometimes rapidly changing reality*** *are characteristics of aid policy in complex emergencies. Slowing down the implementation of decisions on the basis of bureaucratic arguments regularly leads - intentionally or unintentionally - to unacceptable delays.*

MSF wishes to draw the attention of donors to the necessity of flexibility with regard to funding: working in complex emergencies requires continuous adaptation to changing circumstances. The number of beneficiaries can change quickly, regions can fall under different control and new needs can arise. Programmes implemented in the first transitional phase will need to be managed in a flexible and transparent manner.

The rapidly evolving nature of aid needs calls for an approach that does not slow down the implementation of initiatives. The quality of international assistance does not lie in the intention, but in the reality of the aid actually provided to the population. The establishment of budgets is only a first step, while the actual implementation of these decisions is the essence of a policy, above all in a phase in which the absence of decisions can be a matter of life or death.

The crucial point is that the humanitarian agencies willing to bring qualitative support to Congo during the emergency phase should quickly be able to call on a "humanitarian stabilisation fund", and provide support to all the inhabitants of Congo - no matter on which side of the frontline they live.

In the transitional phase, sustainability criteria are difficult - if not impossible - to achieve under the prevailing conditions (low purchasing power of the population; isolation of projects; limited possibility for supervision).

5. ***Indirect aid should be targeted via competent voluntary partners****, irrespective of their nationality (NGOs, universities and so on). In Congo there is a tremendous shortage of operational organisations, especially in the interior of the country. The political climate and chronic levels of insecurity have fundamentally undermined civil society. Aid from abroad would not be perceived by the population as substitution, but would be accepted as part of the joint struggle for survival.*

B.2. To the international community and political decision makers

1. *MSF emphasises the importance of* ***guaranteeing an effective and continuous presence of the UN agencies with a representation on both sides of the frontline*** *in order to improve access to humanitarian aid for all beneficiaries.*

2. *MSF pleads for an* ***immediate increase in humanitarian assistance according to assessed needs****, which should be provided on an impartial basis without discrimination and on both sides of the frontline.*

3. *MSF demands that the* ***humanitarian and political-military agendas should be totally independent of each other****.*

   In the context of the UN initiatives, it is extremely important not to link humanitarian and military/political priorities. The mandate for humanitarian intervention should clearly remain the responsibility of humanitarian agencies. The distinction from peacekeeping activities by military personnel of MONUC and the Joint Military Commission (JMC) should not be blurred by overlapping mandates. This could lead to the obstruction of humanitarian activities because of difficulties with the political agenda and/or the peace process. A linkage or overlap between both mandates could also increase the risks for aid workers.

   Independent humanitarian organisations should preferably be supported outside the funding framework of UN programmes such as the consolidated appeal. Otherwise non-governmental agencies risk being confused with the United Nations agencies which combine the mandate of peacekeeping and humanitarian actions.

4. *MSF urges the international community to provide support to the operational partners in order to* ***safeguard respect for international humanitarian law, and guarantee access to the populations in need****. Real pressure should be brought to bear on the international players in this conflict to gain unhindered access to the population in need, as well as a safe working environment for the humanitarian aid workers.*

5. *MSF requests that diplomatic pressure on the local authorities in Congo be strengthened to* ***limit the negative impact of present monetary policy and local administrative regulations on effective aid.***

6. *MSF urges the international community to* ***take into account the potential role of transnational and economic actors****. Initiatives related to this stabilisation phase are interconnected with the economic environment in which they are carried out. Apart from subsistence farming, international companies dominate economic life. Since the State is so weak, multi-national companies - whether controlled by political and military interests or not- , fight for control of raw materials. The social sector does not share in the profits of the economic transfers that are generated.*

   Political circles must make it clear to private companies and other economic players that they have social responsibilities, otherwise we shall drift back to the "marketing boards" system prevalent during the colonial period.

   The institution of an international requirement that official certificates of origin must be issued for diamonds could be a first step towards regaining control over a trade that has obviously been blossoming in war zones.

B.3. Non Governmental Organisations

1. *MSF expresses the hope that more humanitarian agencies could be mobilised to intervene in Congo. Humanitarian aid should reflect the needs, both with regard to the direct consequences of the present conflict and within the context of the general decline of social service provision in Congo.*

2. *A concerted effort should be made by the different medical agencies to combat the alarming re-emergence or increase of endemic diseases, such as Trypanosomiasis and AIDS.*

B.4. Local authorities

1. *Local authorities in the different regions of DRC should facilitate the work of the humanitarian agencies on the ground. They should guarantee the unhindered access to the populations in need and waive administrative obstacles with regard to internal travelling for humanitarian aid programmes.*

2. *Authorities should facilitate access to the population in need, irrespective of which side of the frontline they live. Therefore the recognition of impartiality of humanitarian agencies is crucial.*

3. *Local authorities should be aware of the negative impact of the present monetary policy on humanitarian action and seek appropriate solutions.*

Médecins Sans Frontières is urgently appealing for a genuine international commitment not to abandon the Congolese people to their fate.

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ANNEX: MEDECINS SANS FRONTIERES IN THE DEMOCRATIC REPUBLIC OF CONGO

MSF started activities in the DRC/former Zaïre in 1985 in support of Angolan refugees. Between 1986 and 1990, structural long-term programmes were developed and health zones supported. During the political crisis in the period from 1990 to 1993, assistance was provided to internally displaced persons, especially in the Kasai provinces. Long-term programmes continued, but suffered as a result of the shrinking international support. Local NGOs were supported in order to develop a sustainable dynamic, but the successive crises forced MSF to focus on the direct consequences of the political and military events: refugees, internally displaced persons and nutritional support.

The following overview summarises MSF's current activities in the DRC.

Kinshasa

MSF set up and continues to supervise an emergency pool of Congolese doctors who monitor and intervene in epidemics and other health emergencies within the whole country. MSF runs an Sexually Transmitted Diseases (STD)/AIDS clinic in Matonge, Kinshasa, providing training, treatment and drugs. Assistance and STD drugs are also being provided to seven health centres around Kinshasa with a view to expanding this to 22 health centres in February. MSF is distributing a STD/AIDS prevention leaflet in schools in all the provinces in which we are working in the DRC.

Equateur

Equateur is a vast, sparsely populated province crossed by many rivers. The geography poses huge logistical problems for any relief effort. All the programmes have to be reached by canoe from the regional office in Mbandaka. The closest health zone takes five hours to reach by boat and the furthest can take up to two days' travel. MSF is supporting 11 health districts from Mbandaka with supervision, drugs, training and logistical help, and provides financial back-up for staff salaries. Each health district consists of approximately 100-150,000 people with one hospital and up to ten health centres. MSF also provides support to a sleeping sickness programme that is an integral part of the Bomongo, Lukolela and Befale health zones. A three-year training programme provides ongoing training for doctors and nurses in the health zones. An emergency pool of Congolese doctors monitors and intervene in epidemics and other health emergencies in the province

Katanga

From its regional base in Lubumbashi, MSF supports eight health zones in the Katanga Province with supervision, drugs, training, logistics and salary support. MSF recently conducted polio vaccinations in all the health zones as part of the National Vaccination Campaign. The team also provides medicines and surgical equipment to help the hospital cope with the war wounded.

MSF gives medical help and assistance in providing shelter for 40,000 people displaced by war. An emergency pool of Congolese doctors monitors and intervenes in epidemics and other health emergencies in the province

Bas Congo

MSF is supporting two health zones in this province, assisting with drugs and medical supplies. The sleeping sickness programme has been suspended due to insecurity. Health activities are continued in two refugee camps (coming from Congo-Brazzaville and Angola, 10,000 people)

Kivu

A full-scale programme is not possible in Kivu province because of the continuous state of insecurity. However, four expatriates based in Goma are assessing the needs of Kivu's population. MSF has provided drugs to some health centres in South Kivu as well as carrying out water and sanitation activities. In Uvira, MSF is assisting a local NGO with drugs and medical equipment for the local health centres. A nutritional survey has been carried out in Kisangani and a nutritional programme is under assessment.

Orientale

MSF distributes medical drugs in 13 health zones to relaunch the medical activities interrupted at the beginning of the present war. An emergency pool of one expatriate doctor and one expatriate logistician monitor and intervene in epidemics and other health emergencies in the province. MSF manages five therapeutic feeding centres to cope with the high malnutrition observed in Kisangani. Medical assistance is provided through the local health infrastructure in the Ituri region after the ethnic clashes there.

MSF's Belgian, French and Dutch sections employ a total of 27 international staff and over 350 local staff in the Democratic Republic of Congo.