



EVERYDAY

EMERGENCY

**SILENT SUFFERING
IN DEMOCRATIC
REPUBLIC OF CONGO**



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SUMMARY



For years, Democratic Republic of Congo (DR Congo) has been in the grip of an emergency. Persistent conflict in its eastern provinces and instability in other regions have led to recurrent humanitarian crises and outbreaks of disease.

In areas affected by conflict, members of numerous militias and armed groups do not appear to distinguish between civilians and combatants – and neither do the soldiers of the Congolese national army (FARDC). There is little respect for the neutrality of medical facilities, for humanitarian principles or for medical ethics. MSF has seen armed men enter hospitals and harass patients; clinics abandoned as medical staff flee violence; health facilities looted and health workers threatened; patient records confiscated in violation of patient confidentiality.

Meanwhile, a heavily armed United Nations intervention brigade (MONUSCO, formerly known as MONUC) has been authorised by the UN Security Council to neutralise armed groups that oppose the authority of the state. This seriously compromises the perception of humanitarian and medical aid as a neutral activity, as these offensive operations by the UN are being carried out in vehicles that resemble those of humanitarian organisations.

Millions of people living in conflict areas have been forced from their homes by the fighting. As of December 2013, the UN estimates that 2.96 million¹ people in the country are displaced, with the vast majority (around 90 percent) residing in North Kivu, South Kivu, Orientale and Katanga provinces.² Large numbers of displaced people are beyond the reach of humanitarian organisations, living with host families or hiding in forests or in scrubland. They struggle to obtain food and drinking water and receive little or no medical care and humanitarian assistance.

Aid to displaced people in eastern DR Congo goes largely to the small proportion of people who have managed to reach camps near urban centres. Even then, distributions of food and essential goods in these camps are often carried out in an irregular manner and are generally insufficient to cover the actual needs.

Aid organisations operate within an inflexible humanitarian system that does not allow a rapid and effective response to critical needs. They are heavily concentrated in urban centres, and are conspicuously absent in the remote, rural areas where the majority of the population lives.

Outbreaks of diseases such as malaria, cholera and measles occur year after year in eastern DR Congo. In most cases, however, the health system is unable to prevent them or to respond.

Patients are expected to pay for every aspect of medical care, with the national healthcare system and many health programmes run by non-governmental organisations (NGOs) based on a cost recovery system. At the same time, the vast majority of people live on less than US\$2 per day, and only one in four lives within five kilometres of a health facility.³

Although the national health system theoretically guarantees free healthcare in the case of emergency, the authorities in eastern DR Congo have proven unable to assure this. As a result, a woman in obstructed labour can be expected to pay a minimum of US\$50 for a lifesaving caesarean section, despite living in a conflict zone.

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Much of
this human
suffering
could be
prevented.

”

After violence flared up in Pinga, Vumilia Kisuba fled to Malemo with her husband. When they arrived in Malemo, fighting broke out there too. North Kivu province, DR Congo, September 2013.

In this report, MSF seeks to expose, through its medical data* and the testimonies of patients and staff, the true extent of the medical and humanitarian emergency lived through every day by the people of DR Congo, in particular those who reside in the conflict-affected eastern provinces, one of the areas where we work.

Much of this human suffering could be prevented. There are a number of measures that, if taken, would have a real impact on reducing the number of unnecessary deaths and improving the daily lives of people in eastern DR Congo.

*Though country-wide data for 2013 are still being consolidated and analysed, so far they show no significant change from those of previous years. Trends in the data up to 2012 and discussed in this report persist.

RESPECT FOR CIVILIANS, HUMANITARIANS AND MEDICAL FACILITIES

■ Civilians must not be harmed

In MSF's experience, armed groups and militias appear not to distinguish between civilians and combatants. MSF has seen the consequences and received first-hand accounts of abuse, harassment, targeted attacks, counter-attacks and massacres carried out by a variety of armed groups on civilians. MSF urges respect for civilians and for humanitarian and medical facilities from all armed groups, including MONUSCO and the Congolese army. The neutrality of humanitarian action must be respected



In 2012, we carried out

more than

1,600,000

free medical consultations

treated nearly

500,000

people for malaria

and vaccinated more than

480,000

against measles

provided more than

110,000

pregnant women with
quality antenatal care

treated more than

4,000

survivors of sexual
violence and

admitted more than

90,000

patients into our hospitals
in DR Congo.

© Giulio Di Sturco

by all parties to the conflict, including the UN, by clearly distinguishing all military assets from civilian functions.

■ Medical facilities must be respected

The sick and the injured are not combatants. In order for medical staff to act impartially and prioritise the delivery of care solely on medical grounds, the places where they work – ambulances, mobile clinics, health posts and hospitals – must be safe, neutral spaces. The neutrality of medical facilities must be respected by all armed groups, including MONUSCO, the new UN intervention brigade and the Congolese army.

BETTER HUMANITARIAN AID PROVISION

■ Focus on needs

The provision of humanitarian assistance in DR Congo should be timely, flexible and appropriate, especially in emergencies. Aid should be provided based on people's actual needs, rather than on their location or on any kind of political agenda such as stabilisation or enhancing the authority of the state.

■ Reach out to the 'hidden' displaced

More efforts must be made to reach the large numbers of 'hidden' displaced people. Temporarily living with host families or hiding in forests and fields, they are a highly vulnerable group whose needs are being neglected by humanitarian organisations focused on providing services to people in camp settings and in urban areas.

REMOVE FINANCIAL BARRIERS TO HEALTHCARE AND IMPROVE RESPONSE TO DISEASE EPIDEMICS

■ Stop making vulnerable patients pay for healthcare

Making people pay even a small fee for healthcare in DR Congo is enough to prevent many of the most vulnerable from accessing health services, particularly in areas affected by conflict. Health providers in DR Congo – and particularly those with programmes in conflict-affected regions – must act to reduce financial barriers for patients.

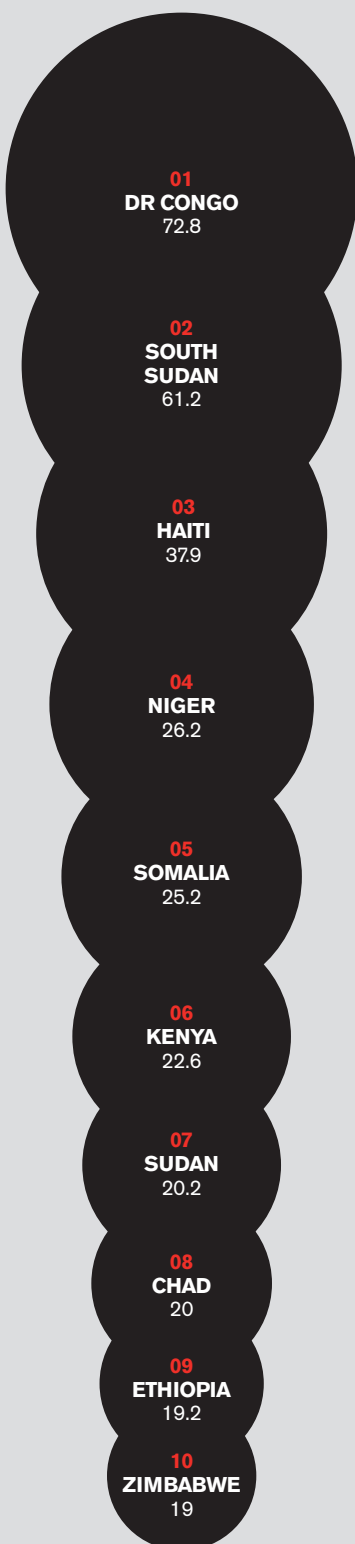
■ Do more to prevent and respond to disease epidemics

In addition to comprehensive routine immunisations and better healthcare infrastructure in DR Congo, there needs to be greater transparency and accountability when reporting coverage rates and better cooperation when faced with a disease outbreak.

MSF IN DR CONGO

MSF provides more emergency medical care in DR Congo than in any other country in the world. In 2012, we carried out more than 1.6 million free medical consultations, treated nearly half a million people for malaria, admitted more than 90,000 patients into our hospitals, and treated more than 4,000 survivors of sexual violence. Since 2008, MSF has vaccinated more than five million children against measles and provided nearly half a million pregnant women with quality antenatal care. But the scale of unmet needs in this vast country is so great that our work seems like a drop in the ocean.

LARGEST COUNTRY PROGRAMMES BASED ON EXPENDITURE



The total budget for our programmes in these 10 countries was

324
MILLION
EUROS
in 2012



OF MSF'S
OPERATIONAL
BUDGET.

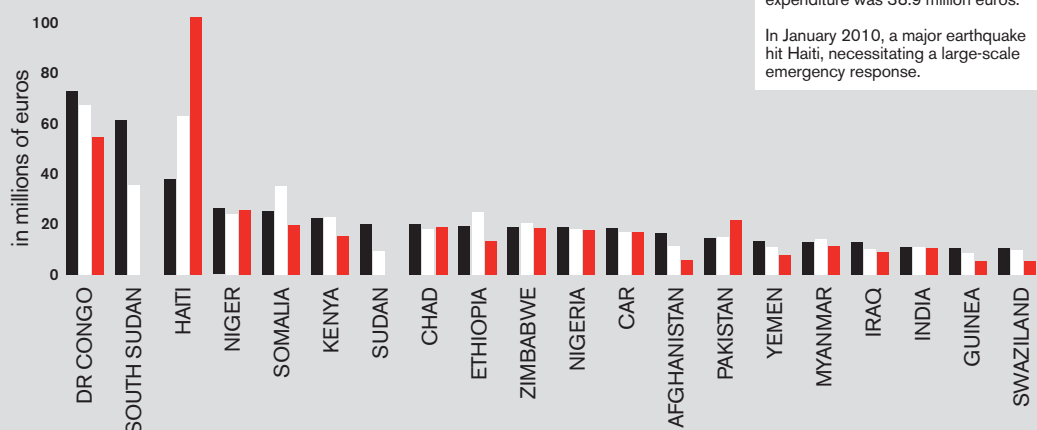


MSF PROGRAMMES IN DR CONGO

MSF runs medical humanitarian programmes in seven provinces: Katanga, Maniema, North Kivu, Orientale, South Kivu, Équateur and Kinshasa city. MSF's emergency pool responds to emergencies in these provinces and others.

COUNTRIES WHERE WE SPENT THE MOST

Countries where MSF expenditure is more than 10 million euros



In 2010, South Sudan and Sudan were one country: total programme expenditure was 38.9 million euros.

In January 2010, a major earthquake hit Haiti, necessitating a large-scale emergency response.



Orientale



North Kivu



Maniema



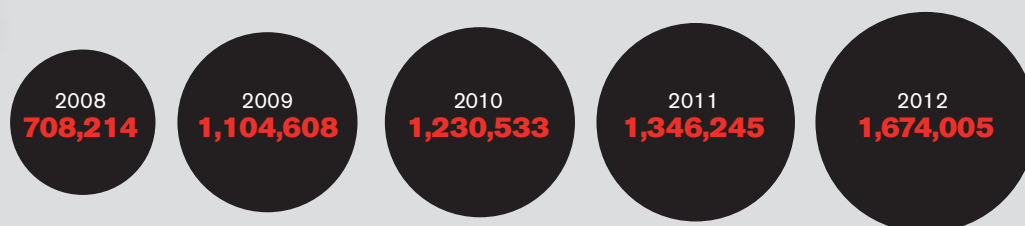
South Kivu



Katanga

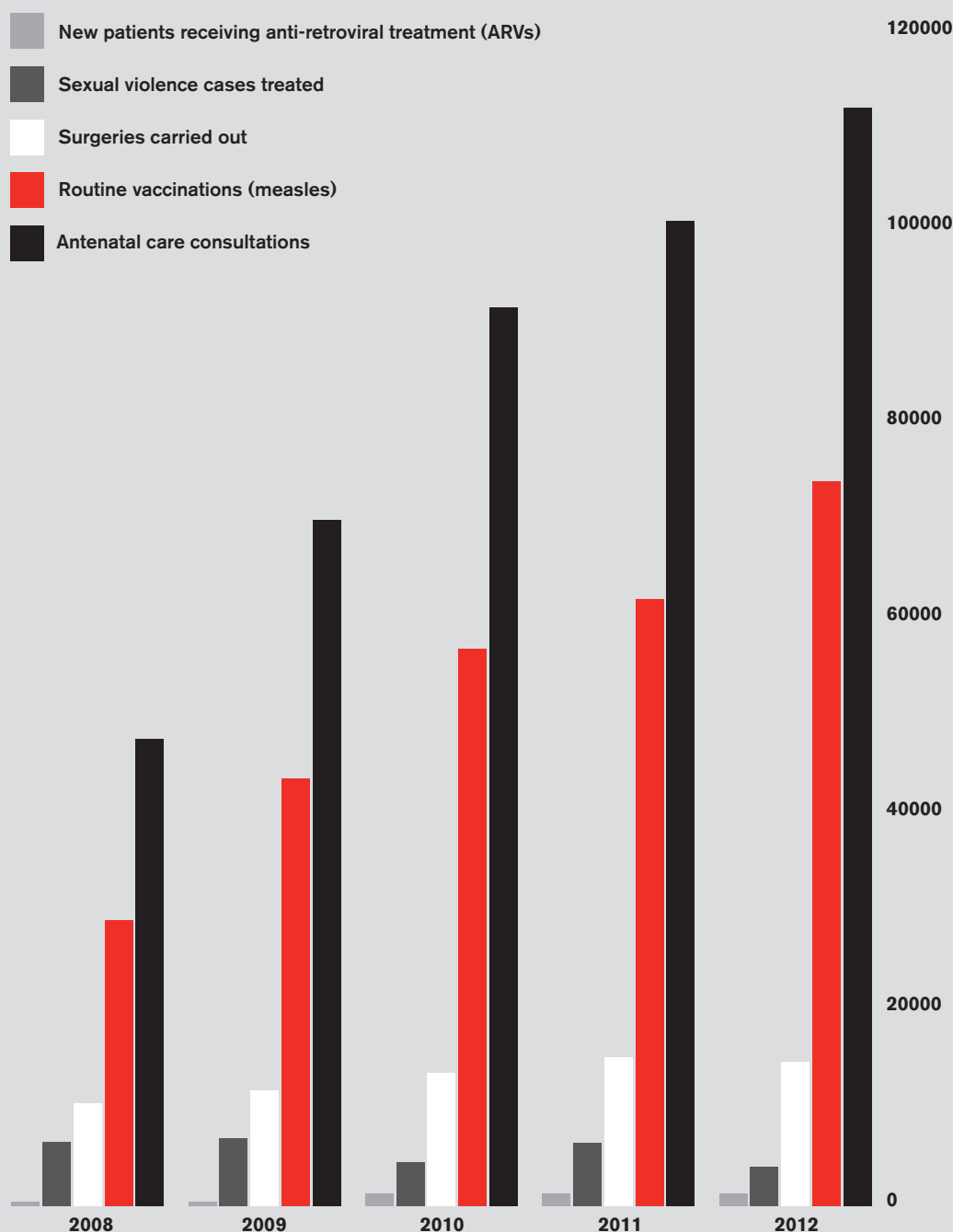
TOTAL OUTPATIENT CONSULTATIONS

Outpatient (OPD) consultations carried out in MSF's projects in DR Congo, 2008 to 2012



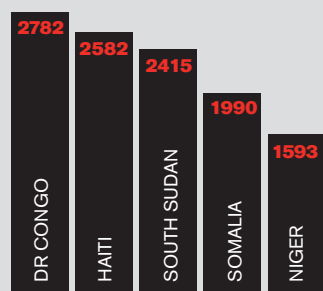
KEY MEDICAL DATA

Key medical data from MSF's projects in DR Congo, 2008 to 2012



STAFF NUMBERS

Largest country programmes based on the number of MSF staff in the field



Staff numbers measured in full-time equivalent units

BACKGROUND:

WAR AND CHAOS IN

DR CONGO 1992-2013

1

An immense country with vast mineral deposits, DR Congo has been plagued by war, especially in its eastern Kivu provinces, for almost two decades. Some of the key causes include the aftermath of the Rwandan genocide and its spillover effects, the armed contestation for state power and the control of valuable natural resources, the influence and interference of DR Congo's neighbours, and the subsequent proliferation of armed groups operating widely and freely.

MSF'S FIRST RESPONSE

MSF began working in DR Congo (known as Zaire under President Mobutu) in 1981,⁴ responding to an influx of refugees in Orientale province who had fled Uganda's civil war. Since then, MSF has been running medical humanitarian programmes in seven provinces, providing free medical care to hundreds of thousands of people each year.

As the Congolese state declined in the 1980s under Mobutu's dictatorship, investment in education, infrastructure and healthcare was neglected.⁵ The 1990s saw an erosion of Mobutu's power and the start of conflicts in the east of the country, as rival militias in North Kivu province fought over land ownership and political control of the region, and ethnic violence increased.⁶ The mass influx of over one million refugees into DR Congo's Kivu provinces in the aftermath of the genocide in neighbouring Rwanda – among them the remnants of armies and militia groups which had perpetrated the atrocities⁷ – fanned the flames of conflict.

AFRICA'S DEADLIEST CONFLICT

Initially limited to the eastern provinces, the First Congo War broke out in 1996 and spread to the rest of the country when a rebel force – under the leadership of Laurent-Désiré Kabila and supported by neighbouring countries Rwanda and Uganda – marched on Kinshasa and drove Mobutu from power in 1997.⁸

The start of the Second Congo War in 1998 plunged the country into violence again. Several African nations sent troops to support the new government, while several others supported rebel groups.⁹ There was widespread plundering of gold, diamonds, timber and coltan¹⁰ – a key element in the production of mobile phones and electronics.

Together, the First and Second Congo Wars are generally considered one of the deadliest conflicts worldwide. The last major mortality survey carried out in DR Congo, released in 2007, estimated that 5.4 million people had died of war-related causes since 1998.¹¹ Millions have been forced to flee their homes.¹²

Peace talks in 2002 helped to end the violence in most of the country, with the retreat of foreign troops and the formation of a coalition government.¹³ An effort was made to reduce outside interference and to integrate the different armed groups into a national army. But in the eastern Kivu provinces, the conflict continues and is sometimes referred to as the Third Congo War.¹⁴

PRESENT DAY

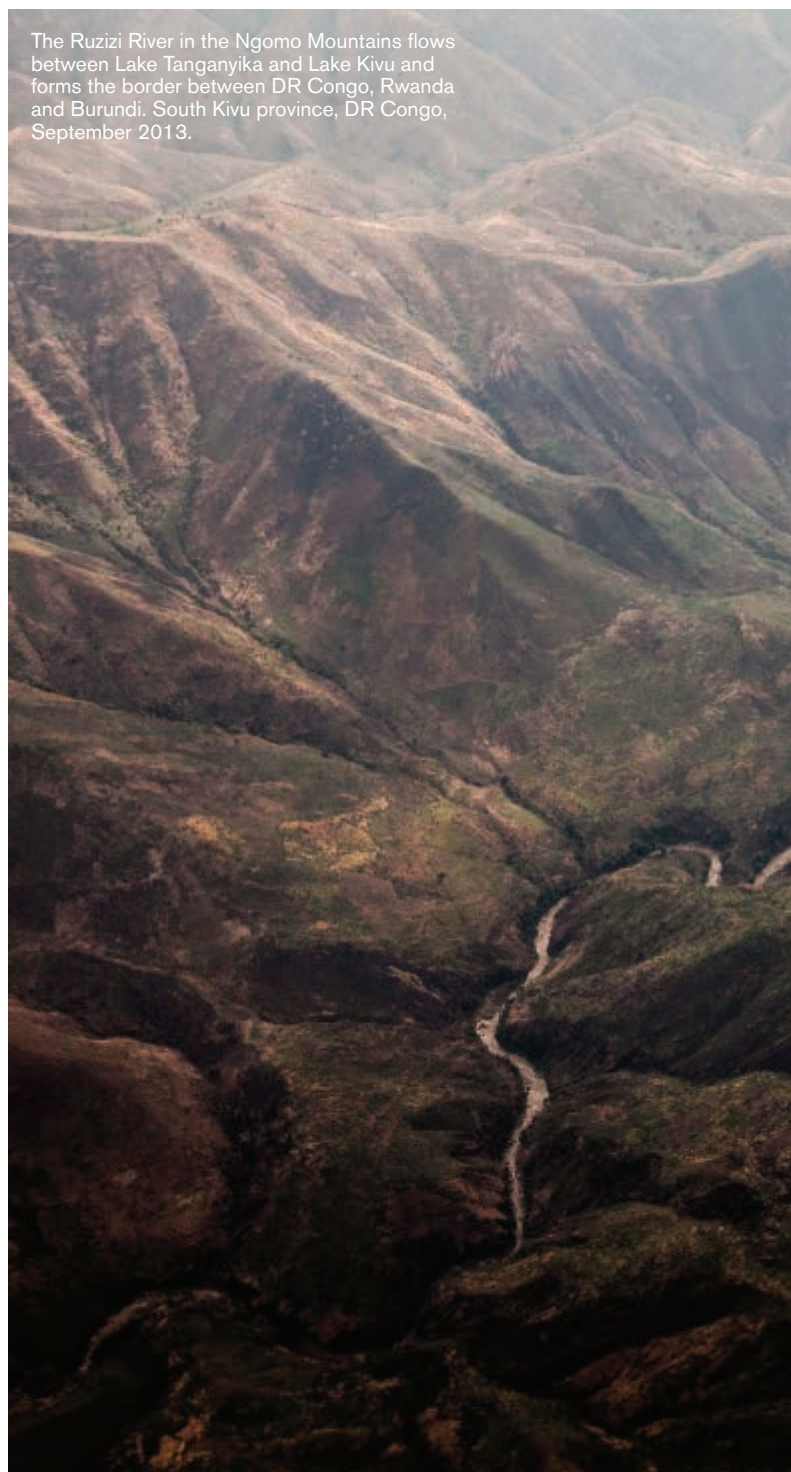
In 2009, the signing of the Ituri Agreement brought hope of an end to the protracted violence in the east of the country.¹⁵ Armed groups were once more brought under the umbrella of the national army. But in early 2012, mass defections and the emergence of the rebel 'March 23 Movement' (M23) led to a rapid deterioration of the already fragile security situation in the east.¹⁶ At the end of 2012, M23 rebels briefly took and held Goma, the largest city in the east.¹⁷

A focus on this new threat by the Congolese national army (FARDC) and MONUSCO resulted in the redeployment of troops and helped to create a power and security vacuum elsewhere in the region.¹⁸ New, opportunistic alliances between pre-existing armed groups and warlords, and the spread of new 'self-defence' movements, have since contributed to intensified fighting in the region, triggering new waves of displacement.

Elsewhere in the country, pockets of insecurity persist. After a period of relative calm in 2010 and 2011, active fighting resumed in Katanga province, causing widespread panic and leading to massive displacement.¹⁹ The situation worsened in early 2013 as the Congolese army prepared for offensive operations against Mai Mai militias, and tens of thousands more were displaced.²⁰ In Orientale province, intensifying clashes between the Congolese army and various militia groups have also caused significant population displacement.²¹

The ongoing conflict in DR Congo is one of the world's most longstanding and complex, and continues to generate huge medical and humanitarian needs. Despite the presence of a large and well-armed UN intervention force and the apparent end of some armed movements like the M23, the conflict looks unlikely to be resolved any time soon.

The Ruzizi River in the Ngomo Mountains flows between Lake Tanganyika and Lake Kivu and forms the border between DR Congo, Rwanda and Burundi. South Kivu province, DR Congo, September 2013.





“

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© Brendan Bannon

ARMED ACTORS IN DR CONGO²²

There are thought to be more than 60 armed groups active in DR Congo – these are just some of them.^{23 24} The proliferation of these groups, their increasing influence over territory and the atrocities many of them carry out against civilians has led to the formation of 'self-defence' militias. As these groups clash, civilians are caught in the crossfire.

Since March 2013, MONUSCO has been authorised through a 'Force Intervention Brigade' to neutralise armed groups that oppose the authority of the state. This seriously compromises the perception of humanitarian and medical aid as a neutral activity, as these offensive operations by the UN are being carried out from white helicopters, vehicles and other transports that resemble those of the UN's humanitarian corps.

In October 2013, the M23 fired at a UN helicopter with a UN humanitarian mission inside because they could not distinguish between UN transport bringing aid, and UN transport bringing artillery. It is unacceptable that an attacking force does so from civilian transports, rather than military vehicles clearly recognisable as such.

This will have major consequences for the delivery of aid, as the people will no longer know if a white vehicle driving into their village brings bullets or blankets. The neutrality of humanitarian action must be respected by all parties to the conflict, including MONUSCO, by clearly distinguishing all their military assets from the civilian functions of the UN.

TROOP STRENGTH

> 100

100-250

250-500

MONUSCO

Raia Mutomboki

Mai-Mai Morgan

MAC

MPA
URDC

500-1.000

1.500

2.000

3.000

4.000

< 100.000

FPD
FDP
NDC
Nyatura/

FDC

FAR

APCLS

ADF/NALU

FRPI

UPCP/FPC
Maï-Mai Simba
FDLR/RUD



**VIOLENCE AGAINST
CIVILIANS, AID WORKERS
AND MEDICAL FACILITIES**

2

Every day, MSF is confronted with the medical consequences of violence in its hospitals, health centres and mobile clinics in DR Congo.

Medical teams treat trauma injuries from guns, machetes, lances, rifle bayonets, knives, hammers, shells, bows and arrows. Every year, thousands of survivors of sexual violence receive specialised medical care to prevent the transmission of HIV/AIDS and treat sexually transmitted infections (STIs). Patients are offered psychosocial support to help them to cope with the stress and trauma of conflict and to resume their daily lives.

As well as the direct consequences of violence, MSF also witnesses the secondary effects of conflict in DR Congo. Teams have found that, during times of active fighting, people put off visiting a healthcare provider for fear getting caught in the crossfire. They arrive in our facilities in the advanced stages of illness – by which time it can be too late to save them. Clashes between armed groups and attacks on the population can cause displacement, which makes people more vulnerable to malnutrition, disease, and further abuse.

Violence, or the threat of it, forces medical staff to flee and health facilities to suspend activities. Often, people in the affected areas have no other healthcare providers to turn to – and it is those people who suffer most.

CAUSES OF VIOLENT INJURIES

Machine
guns



Hand
guns



Machetes



Lances



Rifle
bayonets



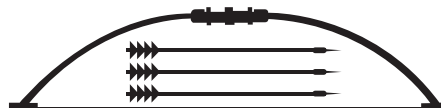
Knives



Hammers



Bows and
arrows



Clubs



Tank
shells



TREATING GUNSHOT WOUNDS

"Among the patients toward the end of the afternoon was a man in his early twenties with a gunshot wound in the arm.

After induction of anaesthesia, I could see he had a two-inch-diameter hole through his mid upper arm. By pulling on his arm I could see straight through to the other side. His humerus was broken, with the two ends staring at each other 180 degrees apart and a visible gap. Without an X-ray it was impossible to tell how much of the bone, if any, was missing. I debrided skin and fat, cut away pieces of bruised and non-viable muscle with attached bone fragments, and washed out the wound. I checked to be sure there wasn't any more bleeding, and placed a dressing followed by a plaster splint.

Like all of our patients with gunshot wounds, he will come back to the operating room in four or five days for re-evaluation. For smaller wounds without bone injuries or secondary infections, we close the skin at the time of the second operation. For larger wounds, we wait until they are ready for a skin graft. For patients with open fractures who need an external fixator (our patient will definitely need one to salvage his arm), it is placed at the time of the second surgery.

There's a significant difference between wounds from a handgun and a military rifle. Compared to gunshot wounds in the United States, the ones in Rutshuru come with bigger holes and more tissue destruction. Bigger guns make bigger holes."

MSF surgeon, Rutshuru, North Kivu province, April 2013



VIOLENCE AND ABUSE AGAINST CIVILIANS

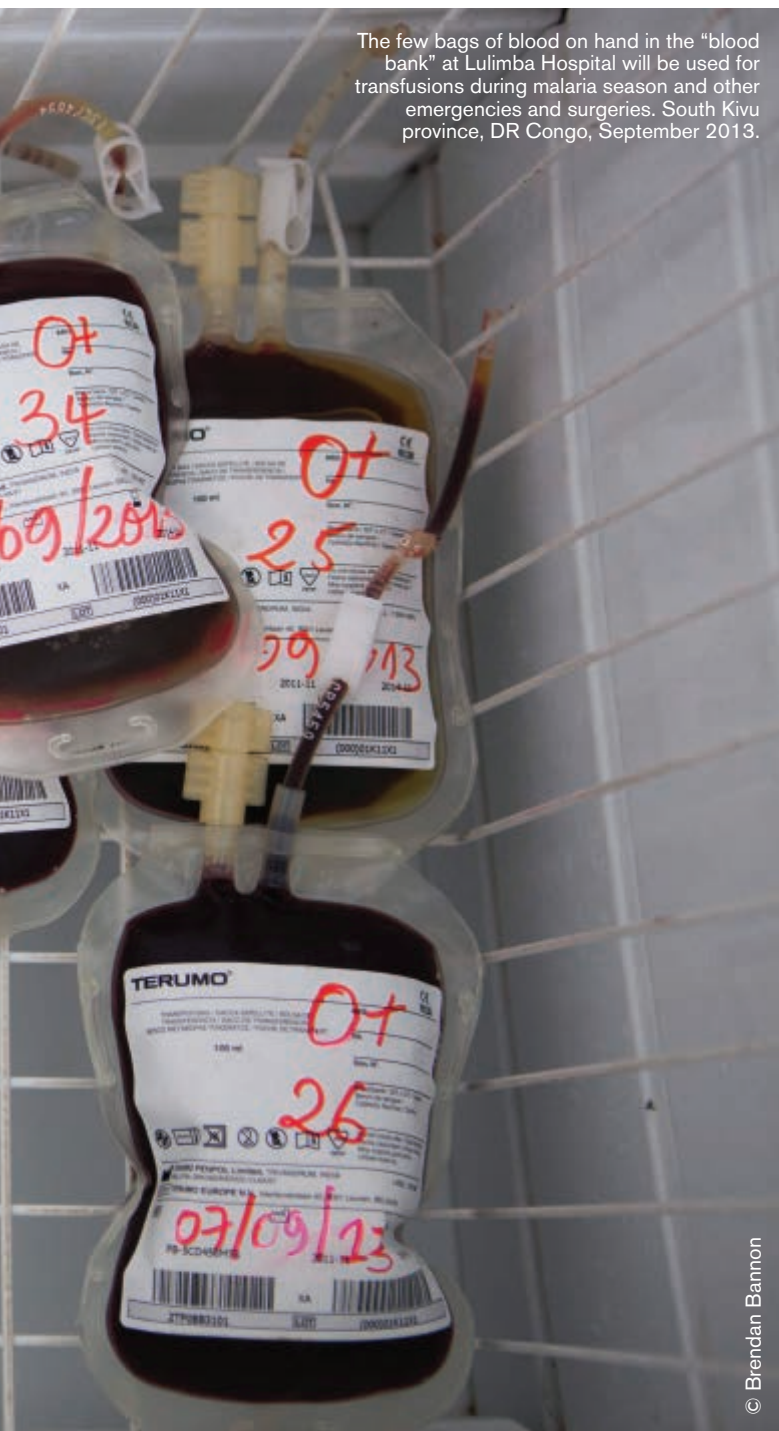
In eastern DR Congo, MSF has seen the consequences and received first-hand accounts of targeted attacks, counter-attacks and massacres carried out by a variety of armed groups.

MSF teams tend to see large influxes of patients with violent injuries during periods of intense fighting. In late 2012, clashes broke out in Masisi and the surrounding areas, and in November of that year, the team working at Masisi general hospital saw nearly twice the number of patients treated for trauma, injury and burns caused by violence than in each of the two previous months.*²⁵

* The team saw 77 cases in November 2012, as opposed to 43 cases in October 2012 and 36 cases in September 2012.

"We waited until we could no longer hear gunfire before leaving the room. We then realised that not all of us had been fortunate. A woman collapsed on the ground, screaming. The baby she carried on her back had been hit by a stray bullet. The bullet had entered under the baby's nose and exited through the back of the head. The little girl had died immediately. She looked as if she was asleep. But her body was already cold."

Aid worker, Pinga, North Kivu province, August 2013



The few bags of blood on hand in the “blood bank” at Lulimba Hospital will be used for transfusions during malaria season and other emergencies and surgeries. South Kivu province, DR Congo, September 2013.

© Brendan Bannon

“I found the dead bodies of a woman and a child. The lady was my neighbour and the child was mine. They were tied up and there were machete or knife wounds and a lot of blood. My child was a one-year-old boy.”

Father of child killed in attack, Mpeti, North Kivu province, May 2013

INSECURITY AND VIOLENCE

Insecurity and violence mean a higher risk of epidemics, maternal deaths, respiratory tract infections, malaria, diarrhoea, malnutrition, sexually transmitted infections, HIV/AIDS and chronic illnesses becoming acute or drug resistant.

Epidemics



Maternal deaths



Respiratory tract infections



Malaria



Diarrhoea



Malnutrition



Sexually transmitted diseases



HIV/AIDS



Chronic illnesses becoming acute or drug resistant



Lightning strikes from a distance as a storm approaches at dusk in the village of Shamwana. Katanga province, DR Congo, September 2013.



A dark, stormy sky with heavy clouds dominates the upper two-thirds of the image. Below the sky, a dark silhouette of a landscape with rolling hills and a small, simple building is visible. The overall mood is somber and ominous.

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Civilians report that they are regularly subjected to abuse, harassment and taxation for transit or protection. People are forced to carry supplies; items are extorted; women are kidnapped and held as slaves.

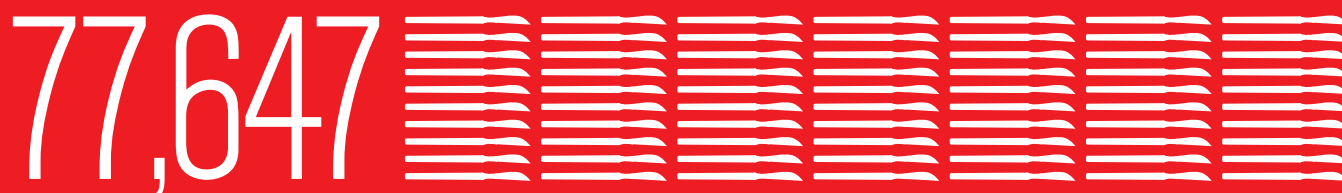
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NUMBER OF SURGERIES PERFORMED

2007	2008	2009	2010	2011	2012
11,772	10,479	11,817	13,596	15,215	14,768

TOTAL





Nyirambabazi, 30, lives in Kahe camp and is pregnant for the first time. Neighbours transported her from Kazuba to the hospital St. Benoit of Kitchanga. It took them six hours of walking. North Kivu province, DR Congo, September 2013.

© Giulio Di Sturco

Patients admitted to MSF hospitals include wounded soldiers and militia members as well as civilians. MSF teams often treat the injuries of civilians who have been either directly targeted or caught up in the crossfire.

Civilians also report that they are regularly subjected to abuse and harassment. Taxation of the population in exchange for protection or transit is common practice. People are forced to carry supplies for armed men; items such as food, cooking equipment, money and mobile phones are extorted; sometimes women are kidnapped and held as slaves.

"My wife was allowed to pass without having to pay because she was pregnant and needed to go to the hospital to deliver our child. I still had to pay. On the way back, the militia would not let us pass. We had to pay for three, my wife, the baby and myself."

Man, Kivuye, North Kivu province, December 2012

“

Armed groups and militias appear not to distinguish between civilians and combatants.

”

SEXUAL VIOLENCE

MSF treats more survivors of sexual violence in DR Congo than it does in any other country worldwide.²⁶ In 2012, MSF teams provided medical care to a total of 4,037 women, men and children after incidents of sexual violence in different project locations. The annual number of cases treated has not dropped below this number in the past five years.²⁷

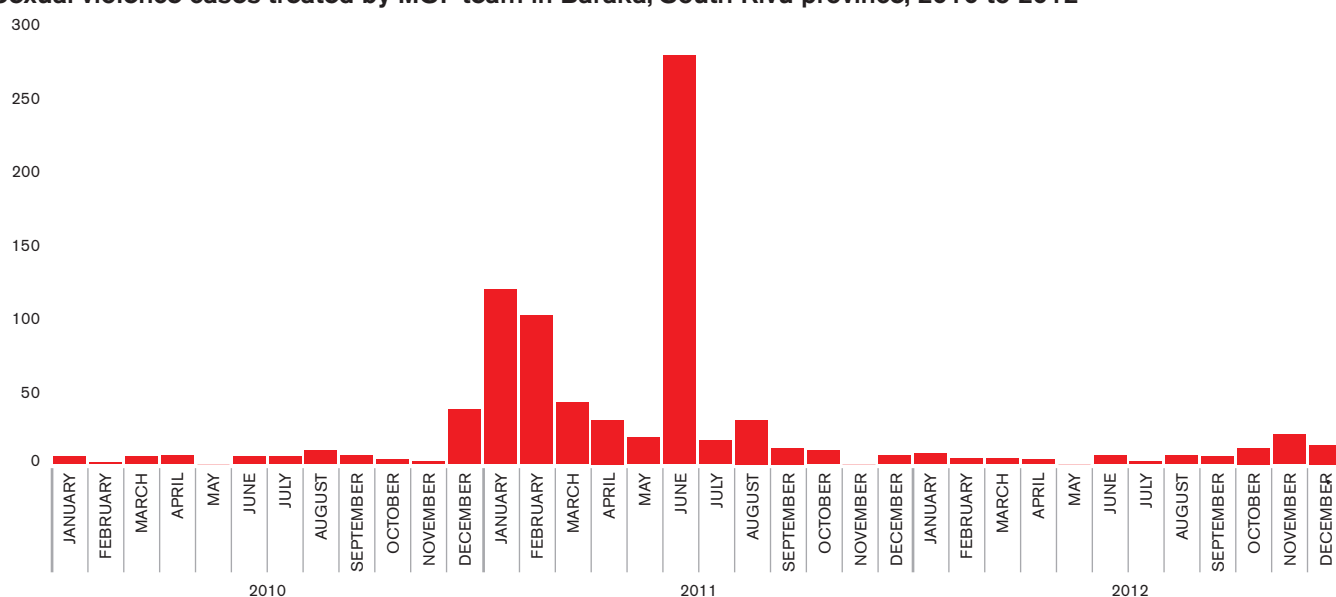
In addition to the physical trauma suffered by victims of sexual violence, there are a large number of medical consequences, including the risk of HIV/AIDS, STIs and serious complications for reproductive health. Women may fall pregnant from the attack, and women who are pregnant at the time of the attack risk losing the foetus.

Survivors of sexual violence must also live with the psychosocial consequences of the attack. They may experience fear, nightmares and psychosomatic body pain after the fact. The stigma of rape sometimes means rejection by their families and the community, resulting in shame, social isolation, and economic hardship.

MSF medical teams have observed that the incidence of sexual violence tends to increase when more soldiers and armed groups move into an area. In late 2012, MSF found that the heightened presence of soldiers and armed groups around the Mugunga internally displaced persons (IDP) camps in Goma created a chronic state of insecurity in which rape became commonplace.²⁸ Over five weeks in December 2012 and January 2013, MSF treated 95 victims of sexual violence in one camp, Mugunga III.²⁹ In mid-January 2013, the MSF team saw 27 cases in just one day.³⁰

Some project locations have recorded peaks in the number of reported cases of sexual violence, indicating mass rape incidents. For example, the number of cases reported to MSF's team in Baraka, South Kivu province each month generally ranges between one and 20. In January 2011, some 119 cases of sexual violence were reported and treated.³¹ Following a mass rape incident on 1 January 2011 in Fizi town, about 90 minutes by road from Baraka, the team treated 33 cases in two days.³² That same year, they treated 278 cases in June alone.³³

Sexual violence cases treated by MSF team in Baraka, South Kivu province, 2010 to 2012



Source: MSF collated data for sexual violence cases treated monthly by team based at Baraka project, South Kivu province, 2010 to 2012.

SEXUAL VIOLENCE SURVIVORS

From 2007 to 2012, MSF treated

34,372



CASES OF SEXUAL VIOLENCE IN DR CONGO



Survivors report being attacked:

- Returning from the market
- Looking for food in the fields
- Gathering firewood
- In and around displaced persons camps
- In villages

MEDICAL CONSEQUENCES



HIV/AIDS



Unwanted pregnancy



Sexually transmitted infections



Serious complications for reproductive health



Miscarriage

PSYCHOSOCIAL CONSEQUENCES



Fear



Nightmares



Psychosomatic body pain



Isolation



Shame



Stigma



Socioeconomic hardship

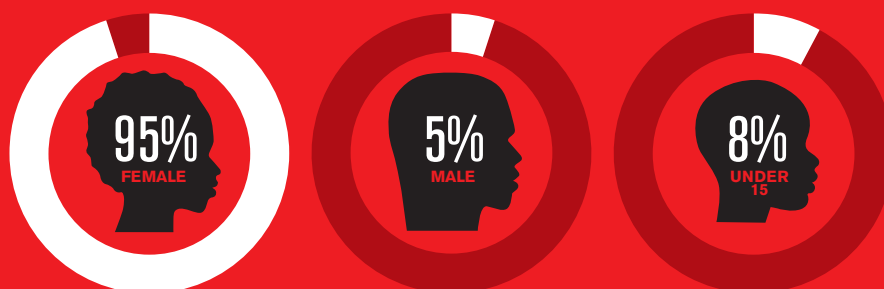
MSF treats more survivors of sexual violence in DR Congo

than it does in any other country worldwide.



Other cases likely go unreported.

In North Kivu province in 2012, one in 20 rape survivors treated by MSF were male, and about one in ten were under the age of 15.



MSF PROVIDES

- Physical exam
- Treatment for wounds and injuries
- Emergency contraceptives
- Treatment for sexually transmitted infections
- Antiretroviral treatment to prevent transmission of HIV/AIDS
- Hepatitis B and tetanus vaccinations
- Psychosocial support
- HIV testing

Time is of the essence

- Prevention of HIV must begin within three days of a rape
- Emergency contraception within five days

MSF urges everyone treating sexual violence in DR Congo to work towards providing timely, high-quality, appropriate medical care to survivors.

TREATING SURVIVORS OF SEXUAL VIOLENCE

MSF provides immediate, specialised medical assistance for those who seek treatment. Providing care shortly after sexual violence is critical to mitigate some of the health risks.

Prevention of HIV must begin within three days, emergency contraception within five. The minimum package of care that should be available for a survivor of sexual violence includes a physical exam, treatment for wounds and injuries, emergency contraceptives, treatment for STIs, antiretroviral treatment to prevent transmission of HIV/AIDS, and hepatitis B and tetanus vaccinations. Psychosocial support and voluntary counselling and testing for HIV are also recommended.

MSF provides survivors of sexual violence with a medical certificate detailing their treatment. If a patient wishes to press charges against a perpetrator, the certificate can contribute as evidence in court – and is sometimes the only evidence beyond the victim's own words.

In the fight for justice for sexual violence survivors in DR Congo, respect for patient confidentiality should be upheld. On several occasions over the past years, medical staff working in MSF-supported facilities have been put under pressure by investigators to hand over medical files, violating patient confidentiality both as an important principle of medical ethics as well as contained in Congolese law.

MSF urges everyone involved in the issue of sexual violence in DR Congo to work towards providing timely, quality medical care to survivors, and – for those concerned with combating sexual violence – to integrate the respect of patient confidentiality into their strategies, procedures and trainings.

MENTAL HEALTH EFFECTS OF VIOLENCE

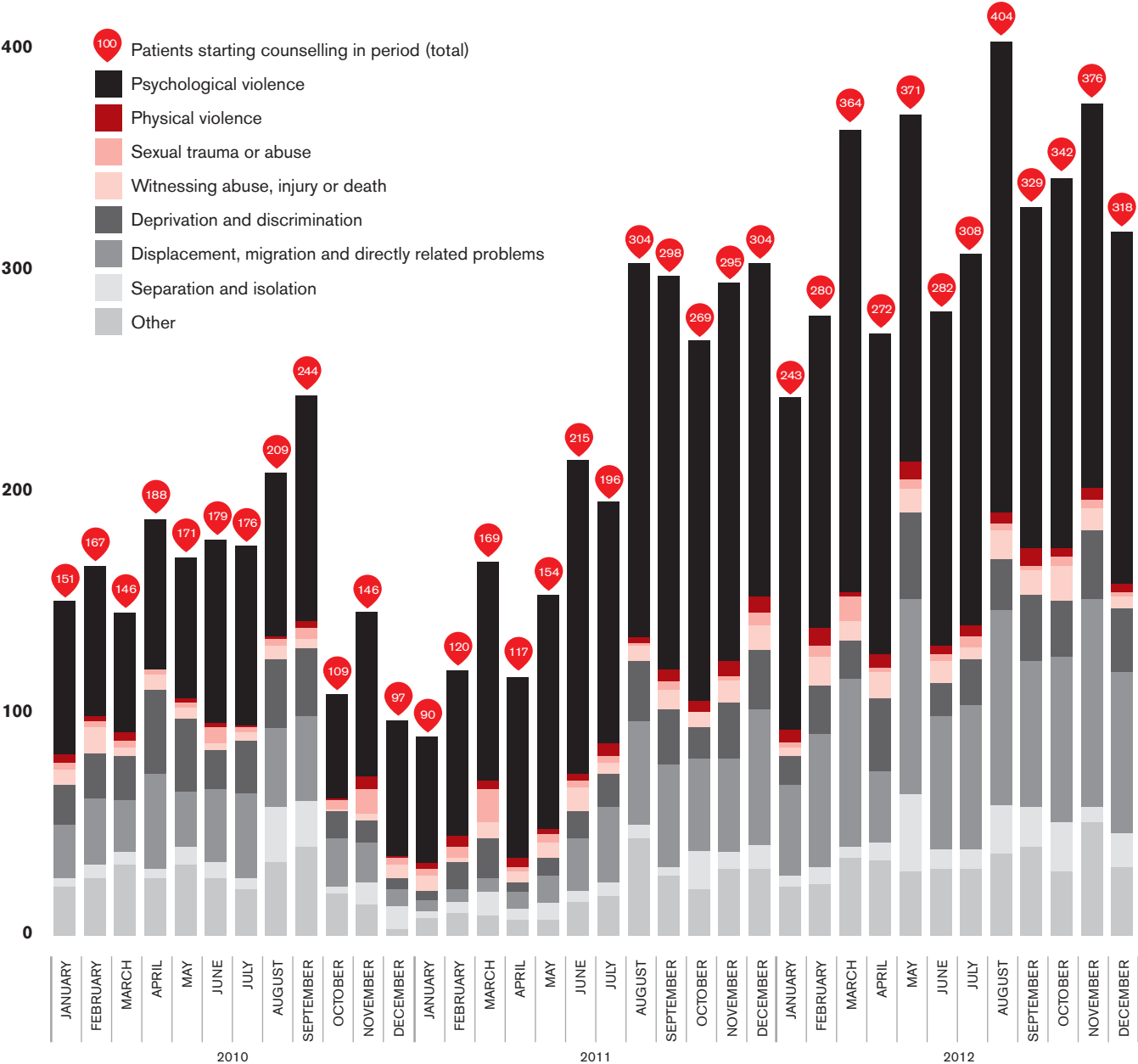
Mental health needs run high in the conflict-affected areas of DR Congo. Many of the patients MSF treats display post-traumatic symptoms that include constant fear, flashbacks, insomnia, suicidal thoughts, feelings of despair, heart palpitations and breathing difficulties.

On three projects in North Kivu province, MSF has seen increasing numbers of new patients for mental health consultations. Teams have also seen growing numbers of patients who seek mental healthcare following violent precipitating events, such as sexual trauma or abuse; psychological violence; or witnessing abuse, injury or death (see graph opposite).

A recent mental health needs assessment carried out mostly among internally displaced people (IDPs) in Bibwe, North Kivu province, revealed the extent of violence to which respondents had been subjected, and the consequences on their psychosocial well-being. Of 600 respondents, more than 80 percent reported being the victim of violence³⁴ and nearly 90 percent reported having witnessed an act of violence.³⁵ Seventy-one percent of respondents said that they had nightmares,³⁶ and 74 percent said they had flashbacks of violent events at least some of the time.³⁷ People interviewed during the assessment commonly used the word “massacre” to describe the violence taking place.³⁸



Patients starting counselling, and precipitating events, on three projects in North Kivu province, 2010 to 2012



Source: MSF collated data for patients starting counselling monthly and reported precipitating events on projects in Pinga, Mweso and Kitchanga, North Kivu province, 2010 to 2012. Part of the drop in consultations between autumn 2010 and spring 2011 can be explained by the temporary suspension of Kitchanga project between January and April 2011.

A LONGLASTING LEGACY

"It is unsurprising that, in these dire circumstances, so many suffer from serious mental health problems, problems so debilitating that they are no longer able to care for themselves or their loved ones. Some spend the days alone, sitting in front of their shacks; others never leave their beds. For many people in the camps, social events such as weddings and celebrations have stopped. Some have even stopped seeking healthcare for themselves and their loved ones. A woman with severe burns is left alone in her shack by her family: "She will die anyway," they say.

All of this is of no surprise when angry outbursts and acts of revenge towards innocent bystanders have become an accepted part of daily life.

Counsellors are trained by MSF to provide psychosocial support to their own communities. They help those in psychological distress to regain control over their lives, reducing the severity of their symptoms so they are able to function again – to cultivate crops, care for their children, trade goods and participate in community activities. Through a series of individual or group counselling sessions, the counsellors work to address psychosomatic symptoms, practical problems, family disputes, grief, loss and overwhelming emotions such as sadness or anger.

Helping their clients understand that their symptoms are normal, considering what they have lived through, is often the first step towards managing or resolving their problem.

Like the rest of the medical care that MSF provides in DR Congo, the mental health service preserves lives. It helps the most traumatised and desperate patients accept their challenges and decide against suicide. It helps those desiring revenge, such as attacks and killings, choose a less aggressive way of dealing with their anger. Psychosocial care also restores dignity by helping patients grapple with their traumatic experiences in order to avoid chronic health problems and to heal.

Some clients walk over 15 kilometres to attend their follow-up sessions. The majority of the people who seek help do get better."

MSF mental health counsellor, Mweso, North Kivu province, 2011

Street scene in Mweso. North Kivu province, DR Congo, September 2013.



“

Psychosocial care also restores dignity by helping patients grapple with their traumatic experiences in order to avoid chronic health problems and to heal.

”



POSTPONING ESSENTIAL MEDICAL TREATMENT

In MSF's experience, when active fighting breaks out in an area, people will put off a trip to a health facility to avoid being caught up in the violence. Patients arrive at MSF facilities in the very latest stages of illness, often in need of emergency care.

"A woman began miscarrying late at night. The bleeding was severe. But with all of the military and armed groups on the roads, her family was too scared to travel during the night, so they waited until the morning to walk the few hours to our hospital. She arrived at noon. By then she had lost too much blood and there was very little we could do. She died within minutes of arriving."

MSF midwife, Mweso, North Kivu province, April 2012

During these periods, MSF often sees a drop in outpatient consultations. In February 2012, an attack on Shamwana, Katanga province, by a militia group caused large numbers of people to flee. The number of consultations carried out in the MSF-run Shamwana health facility dropped dramatically for two months before they reached normal levels again in May. After a second round of fighting in June 2012, consultation numbers dropped again only to reach above average levels in November 2012 following months of problematic access.

During a period of intense fighting in Masisi, North Kivu province, in November and December 2012, an MSF team working in Masisi general hospital observed a drop in the number of sexual violence cases treated. In January 2013, once the situation had calmed somewhat, the team saw more than two times the number of cases they treated in December. Nearly a third of those patients reported being assaulted more than one month prior – in other words, during the period of active fighting.³⁹

LACK OF PROTECTION

In MSF's experience, abuses by armed groups and growing popular anger about the lack of protection for civilians have contributed to an environment in which people settle their own scores with violence. Violence between civilians as a way to restore order has become the norm in places where MSF has worked. Incidents of suspected bandits being burned alive or lynched by an angry crowd are not unheard of.

"I just saw a man being dismembered. I thought [it was] an ordinary accident this morning when gunmen opened fire on a motorcyclist and his passenger a few kilometres from the city The crowd joined the scene of the accident, and took the suspected bandits. They killed them on the spot with stones and sticks. The whole town came down on the road, more than 50,000 people who sang and marched in triumph. Soon after, the limbs of the bandits arrived in town. Heads, arms, internal organs, all brought to parade on the main road of the city. The children ran after the bikers, and were excited to carry the fingers [of the] bandits as if [they] were their new toys. It was the event of the day. Only rain in the afternoon ended the celebrations."

Aid worker, Kitchanga, North Kivu province, September 2012

The lack of protection has also led to a dynamic in some parts of DR Congo whereby groups who control territory organise protection for local residents in exchange for remuneration.

"The FDDH [Force for the Defence of Human Rights] group organises security in Mweso. It functions like a quasi-authority. It's a deal between the armed group and the local population: in exchange for a monthly instalment of 1,200 Congolese Francs per household, the group protects the population – this happens along tribal lines. In the adjacent area, they are not safe to go unless they pay. They gain protection, but lose freedom of movement. On the stretch of road leading to Kashuga, people run the risk of being 'taxed' by three different actors. Surely this complicates access to healthcare too."

MSF project coordinator, North Kivu province, May 2013

When active fighting flares up, people leave their homes and villages in panic and seek refuge in the surrounding forests, or in churches, schools or hospitals. Many MSF hospital compounds in DR Congo happen to be surrounded by bamboo or reed fences. These can be trampled by crowds of people desperate for protection.

In April 2012, a few thousand people spent the night in an MSF hospital compound in North Kivu after fighting between the Congolese army and rebel groups broke out in the town of Mweso.

"After an hour and a bit of sustained gunfire in the hills, we heard loud gunshots much, much closer, definitely in town. We knew that the whole town would converge on the hospital, but none of us were ready for how fast people arrived. The population was banging on the gate, being crushed up against it, while others were climbing over the back fence."

Our team could not control the massive crowd. Within minutes we had 2,000 to 3,000 people in the back of our hospital compound where the warehouses, the generators and everything else non-patient related is. We started blocking the doorways to the hospital wards so they would not mix with our sick patients.

There was no way that anyone would leave the hospital compound, and we prepared for them to spend the night. We couldn't offer food or shelter, but luckily most had brought food with them. Importantly, the latrines were accessible and we got a drinking water storage tank set up."

MSF project coordinator, Mweso, North Kivu province, April 2012

In February 2013, fighting between government forces and Mai Mai militias in Katanga province caused thousands to flee their homes. Around 500 people sought refuge at the MSF hospital in Shamwana, where they lived in the grounds for several weeks. After it proved difficult to maintain a satisfactory level of hygiene, and fearing a disease outbreak, the medical team managed to convince people to move to just outside the compound walls where they stayed until they felt safe enough to return home.

ETHNIC DIMENSIONS OF VIOLENCE IN EASTERN CONGO

MSF does not routinely collect data related to its patients' ethnic or linguistic backgrounds, as this information is not considered medically relevant. But in the provinces of North and South Kivu, our patients' accounts of the nature of the attacks they have suffered indicate a fierce ethnic undertone to some of the violence.

“

We don't know where they [the attackers] came from. They appeared in front of us, yelling, 'We are the Raia Mutomboki. We are going to kill everyone who speaks Kinyarwanda.' It was a very large crowd of people, all men. They had guns and lances and machetes. They started to cut people with the machetes and to shoot. They were cutting and shooting everyone they came across. We all fled.

”

“

They were singing 'We are Kifuafua'. They had guns, spears and machetes. After the attack they burned all of the houses. We fled towards the forest. I had my son, who was shot, with me. Later we went back to bury the dead and look for wounded. I found nine of my children dead; they had been killed with machetes and spears. I counted 49 dead. I knew some of the people who attacked us; they were BaHunde and BaTembo who were neighbours to us (on nearby hills/in nearby villages). We have been walking through the forest since the attack. My son has not received any care yet for his bullet wound, and my wife has diabetes and is sick.

”

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From Mutongo to Pinga, we had been in the forest for two months. We did not have access to healthcare. The children could not play, they used stones to grind cassava [so as] not to make noise to avoid attracting the attention of bandits.

”

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We are refugees from Rwanda ... For over 18 years now we have lived like hunted animals in the bush, without shelter or protection.

”

“

I fled because of the war. In Kato, the Mai Mai were taxing us, while the FARDC were stealing our goats. We had to leave. Some of us escaped into the bush.

”

“

There are about 3,000 households that are nearly starving to death. Since the attacks resumed there has been a huge problem with food in our families. We have nothing to eat but leaves. In the rush to flee the violence, armed groups stole our kitchen utensils. Now we have only one kitchen set for every 15 families. It is impossible to prepare food for all of us. To find water to drink is also a great problem for us. We have a good relationship with the local population here, but those families are also [victims] of our presence. There is not enough food for all of us. Old people cannot reach the health centre - it is too far. It is very difficult to transport the sick in the bush. For pregnant women there is nothing. Nothing before, during or after delivery. A lot of people suffer from anxiety – they have experienced a lot of horrible things.

”

“

There have been many incidents the last six months, including sexual violence committed by different armed groups. So many people here are suffering from mental health problems because of the violence and insecurity. Militiamen pillaged the health centre and the school. The roads here are really bad. Insecurity is high here and the militiamen are frequently forcibly recruiting kids. They come and take them, then they return and pillage the family and the neighbours. It is a big problem for the entire community.

”

“

We feel very unsafe. If people in town are not safe, how can we be safe? We trust God will save us, we have no faith in men. Men with arms can – and will – take what they can.

”

Teams have observed that the ethnic dimension to the violence has affected displacement patterns. Displaced populations seek refuge in a place where they feel safe, with their own or a friendly community, and away from groups by whom they feel threatened. While this provides them with the relative safety of a group, being grouped together can make them more vulnerable to targeted attacks.

"Three months ago we did not sleep, we stayed in the forest, unprotected, in the open air. [Here] it is safer for us. For now FDLR protects us, but I am afraid that Janvier and Cheka will come after us also here.

Displaced person, Bibwe, North Kivu province, December 2012

Numerous accounts heard by MSF suggest that ethnic or linguistic violence, or the threat of it, is a major rationale for much of the displacement.

"They were speaking a 'sophisticated' language and we didn't understand what they were saying. They came into the village and the men of the village asked 'Who are you?' and then they responded by saying, 'We are the Raia Mutomboki. We are going to kill all those who speak Kinyarwanda.' They came from everywhere, from every corner; we didn't know where to run. The only choice left was to run into the bullets. I took my child [a baby, nine months old], who was not even dressed yet, and my daughter and ran. Everyone ran however they could."

Displaced person, Masisi, North Kivu province, January 2012

"I left my village Remeka, in Masisi territory, on 18 April [2012]. I had to flee; the FDLR attacked our village in the night, raping the women and burning houses, some with people in it. They attacked us because we are Tembo. When we arrived in Ngungu, [Mai Mai] Nyatura told us to leave. They

ETHNIC DIMENSIONS OF VIOLENCE

Budidi Baritome, 14, comes from Kivuye. The war in his village began at three in the morning. "I was accompanying my sister to the toilets, when a man suddenly appeared and shot at me saying I was from a Tutsi tribe. I fell down and I don't know who brought me here to the hospital. Now my legs are paralysed. Our house has been burnt and all our belongings taken. I don't think I will ever go back there again...."

said like FDLR they are Hutu and also targeting Tembo people. It took five days to reach Mugunga; we were on foot having to carry the kids and some items to cook and basic shelter. During the day we walked and at night, we slept with host [families] and in the forest."

Displaced person, Mugunga I, near Goma, North Kivu province, December 2012

VIOLENCE AGAINST HUMANITARIANS AND HEALTH WORKERS

Despite a general acceptance of MSF health services by the population and armed groups, respect for humanitarian workers, transport, goods and health facilities is not a given.

At times, armed men have entered our hospitals in search of enemy fighters, patients have been harassed, health posts looted and clinics abandoned as health workers flee threats and violence.



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A recent internal analysis of security incidents connected to 12 project locations in North Kivu, South Kivu and Katanga provinces highlighted a wide range of incidents, including assaults, shooting episodes where humanitarian staff were caught in crossfire, armed robberies, attempted kidnapping, armed intrusion, arrest, theft and vehicle incidents.

"Patients who had just had surgery, sick people, elderly people, children and hospital staff were all seated together in a room far too small for the number of people in it

I heard the shooting coming closer and closer. We realised the men were just outside. People were shaking and crying but everyone remained silent I whispered a frantic call to base to tell them the men were in the hospital. Suddenly we heard the men enter the room next door. We heard people on the other side of the wall crying out that they were civilians. I held my breath,

utterly terrified, waiting to hear their executions. After about 40 minutes, a Congolese doctor entered and told us that the attackers had retreated. The people in the room next to us had been spared. A man with a machete had burst in but turned back when he saw that there were only civilians there."

MSF doctor, Pinga, North Kivu province, August 2013

In conflict-affected areas, Congolese staff working for MSF are often aid workers and victims at the same time. Many fear for their safety, and when active fighting broke out in 2012 in Pinga, North Kivu province, the majority of MSF's Congolese staff fled together with thousands of the town's residents in search of safety.

Health workers from the Congolese Ministry of Health also work in extremely challenging conditions, with those in conflict areas exposed to violence and disease.

"We used to talk openly. We would share information in the team. But then accusations from the armed groups started about collaborating with the enemy. We became very afraid. We were afraid to speak. Three MSF staff had to leave. They would be killed if they stayed. We all thought we would be next, that our turn would come."

MSF Congolese staff member, Pinga, North Kivu province, November 2013

Over the past few years, violence and threats against MSF staff have resulted in the temporary suspension, and on occasion permanent closure, of medical programmes. When a medical programme is suspended, people in the affected area often have no other healthcare providers to turn to.

As a direct result of a serious security incident, MSF's Kitchanga project in North Kivu province was completely suspended during part of 2011. The project saw around 6,000 to 8,000 patients per month, and the suspension affected thousands of people.

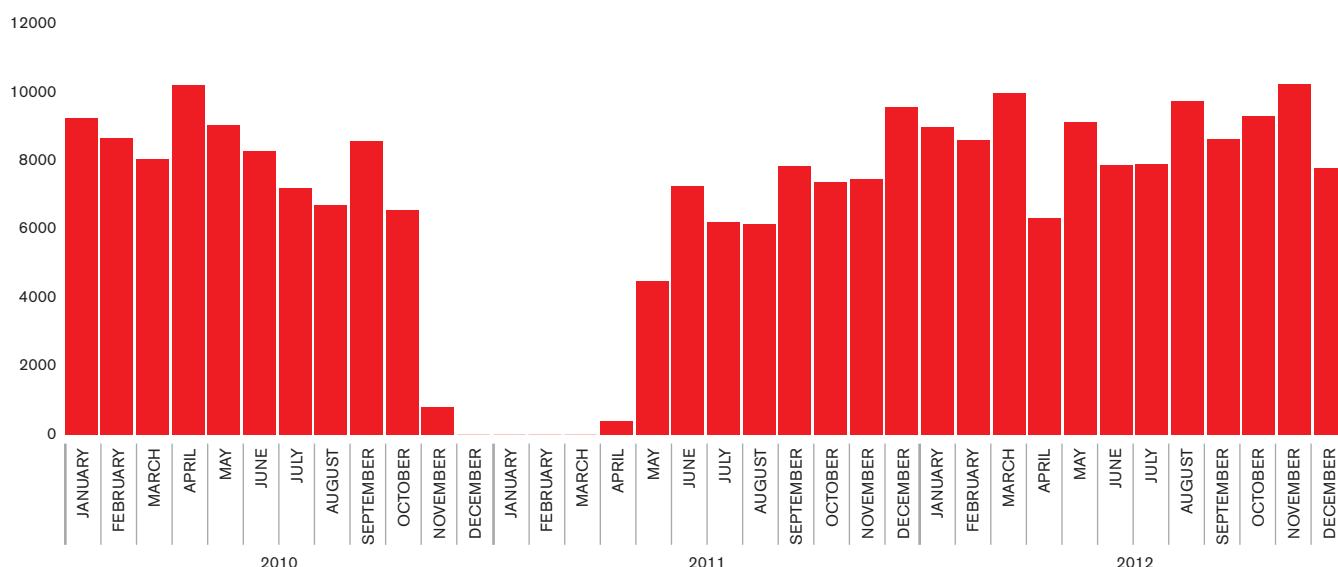
Early in 2013 in Mweso, North Kivu province, medical outreach activities to thousands of patients were suspended for two and a half months following a serious security incident.

"Suspension of our outreach activities to Kalembe and Kashuga severely hampered access to healthcare. In an average week we saw 750 patients. During the time that our outreach activities were suspended, Ministry of Health staff recorded only 30 consultations a week. We heard of at least 30 people who died during that period."

"During the period when activities were suspended, we were touched by the support we got from the communities. Twenty women from the towns where our health centres were located walked over five hours to pay their respect, chanting, dancing and begging us to resume activities. This is how desperate they were."

MSF project coordinator, Mweso, North Kivu province, May 2013

Outpatient department (OPD) consultations carried out by MSF team in Kitchanga, North Kivu province, 2010 to 2012



Source: MSF collated data for OPD consultations carried out monthly by team at Kitchanga project, North Kivu province, 2010 to 2012.

Staff carry out consultations in the malnutrition ward at the MSF hospital in Mweso. North Kivu province, DR Congo, September 2013.



© Giulio Di Sturco

“

Twenty women from the towns where our health centres were located walked over five hours to pay their respect, chanting, dancing and begging us to resume activities.

”

MEDICAL CARE UNDER FIRE

Medical care benefits everyone and anyone in need should be able to access it, unconditionally. The sick and the injured are not combatants. Medical ethics oblige all health workers to care for all patients and to keep medical care free from interference. In order for medical staff to act impartially and prioritise the delivery of care solely on medical grounds, the places where they work – ambulances, mobile clinics, health posts and hospitals – must be safe, neutral spaces.



An MSF office that burned down during recent fighting in Kitchanga. North Kivu province, DR Congo, September 2013.



INTERNAL

DISPLACEMENT

– NO SAFE

PLACE TO GO

3

In December 2013, the estimated number of Internally Displaced People (IDPs) in DR Congo was 2.96 million.⁴⁰ The year before, the country was home to nine percent of the world's IDPs^{41 42} – and more than 25 percent of those internally displaced on the African continent.^{43 44}

Around 90 percent of them live in the eastern provinces of North Kivu, South Kivu, Orientale and Katanga.⁴⁵ North and South Kivu alone are thought to host about 1.7 million, or nearly 60 percent of DR Congo's displaced.⁴⁶

Displaced people are a particularly vulnerable group, often surviving in the open or with limited protection from the elements. Many have been forced to leave their homes multiple times in relation to violence and leave behind their possessions when they flee.

'HIDDEN' DISPLACEMENT - OUT OF SIGHT AND OUT OF REACH

In MSF's experience working in remote areas of conflict-affected eastern DR Congo, many displaced people stay close to home.⁴⁷ They tend to settle in a relatively nearby place of refuge,⁴⁸ in the forest or with host families for example, hoping to return home once it is safe to do so.

As a result, they are often out of sight and out of reach to humanitarian agencies, which tend to operate near urban centres. They struggle to find food and clean water, and receive little or no humanitarian assistance.

"The most urgent need here is food, for the old and newly displaced. They live with host families and in a camp, which is not registered, and they receive no assistance whatsoever. There are tensions between the community and the displaced because there is so little food."

Community health worker, Bibwe camp, North Kivu province, December 2012

With inadequate shelter, sanitation and limited to no medical care, these people are particularly prone to malaria, malnutrition, respiratory tract infections and diarrhoea. Young children, the elderly and pregnant women are particularly at risk.

EXPOSED TO THE ELEMENTS

Cecile (name changed), from Kashuga, has five children and lives in Bulengo makeshift displaced persons camp, North Kivu province. Three of her children are sick. They have no sheeting to shelter them from the rain as the last distribution of plastic sheeting to the displaced was in December 2012. Exposed to the elements, her children are constantly falling ill. Food distributions are also infrequent. Women often have to leave the site to look for sticks to sell. This makes women less than US\$0.50 per day, and it exposes them to violence along the way.



INSECURITY AND INADEQUATE HUMANITARIAN AID IN CAMPS

Of the people MSF treats in numerous IDP camps throughout eastern DR Congo, some have just arrived, whereas some have lived in camps for years; others were born in a camp setting and know nothing else.

In general, living conditions in camps are deplorable. Temporary shelters, barely able to withstand seasonal changes, are bunched together on soil depleted of vegetation. In some cases, entire families share a space a few square metres in size.⁴⁹ Insecurity is rife and people living in camps must guard constantly against lootings, harassment and sexual violence.

"It's very insecure here. A lot of theft and pillaging takes place by armed groups. It happens every day. The rebels live outside the camp, but they come every day to abuse us and for forced labour."

Displaced person, Kivuye camp, North Kivu province, December 2012

Although residents of some camps and settlements may have some access to basic services organised by humanitarian agencies, people in others receive very little humanitarian assistance or none at all.



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MSF provides assistance in Bulengo, a makeshift site hosting around 50,000 displaced people a few kilometres from Goma in North Kivu province. In December 2012, a partial distribution of plastic sheeting was carried out at the site. Some people did not receive this assistance, and continued to live without protection from the wind and rain. From January to August 2013, nearly 30 percent of consultations carried out by MSF in Bulengo camp were for respiratory infections,⁵⁰ which can be caused or exacerbated by exposure to the elements.

"When we returned after the frontline moved on, everything was gone: blankets, jerrycans, tarpaulins. The same thing happened in Kanyarucina camp, people said. Living here is not easy. We got a little bit of food from Oxfam and ICRC, and medical assistance from MSF..."

Displaced person, Mugunga I, near Goma, North Kivu province, December 2012

DISPLACEMENT AFFECTS HEALTH

Often lacking food, water and basic supplies, displaced people are particularly vulnerable to illness and disease. Among populations who have been displaced, MSF teams treat large numbers of patients for conditions linked to poor living conditions, food insecurity, lack of clean water and proper sanitation.

For example, MSF runs mobile clinics in Katale, Masisi territory, where approximately 6,000 people have settled on a makeshift site. The site is located about 2,000 metres above sea level, and temperatures fall to as low as 15°C at night. Some families received some plastic sheeting upon arrival, but most families live in shelters that barely protect them from the rain and cold. In the first six months of 2013, more than one quarter of 5,190 consultations carried out in Katale by the MSF team were for acute respiratory infections.

The medical consequences of displacement are severe, as medical care is interrupted or cannot be accessed.

"In November 2012, a 35-year-old woman in obstructed labour was carried on a bamboo stretcher to the hospital in Pinga. Doctors performed an emergency caesarean, saving the lives of both mother and baby. However, the next day fighting broke out between armed groups in the town and the patient fled from the hospital with her baby in panic."

A few days later, when the town was quiet again, the patient returned to the hospital with an infection, having spent several nights hiding in unsanitary conditions in the forest. She was immediately treated with intravenous antibiotics but, after a few days, the fighting restarted and she pulled out her IV drip and fled the hospital again. When she returned a week later she was in a very bad condition, with blood poisoning. The MSF midwife and the doctor soon realised that she needed surgery to remove her uterus, which was heavily infected. With the amount of infection, the tissue would have been very fragile and she would run a high risk of bleeding. She needed a specialised gynaecologist to perform the surgery.

They tried to arrange a patient transfer by plane to a specialist hospital in the provincial capital, Goma. But, that day, M23 rebels had taken over the city and the airport was closed. After three days of fighting for her life, a transfer by plane to Bukavu, capital of the neighbouring province, was possible. When the patient left, she was in a life-threatening condition, but she returned to Pinga some weeks later after a successful operation and rejoined her family."

MSF nurse, Pinga, North Kivu province, 2012

The effect of displacement on the treatment of chronic illnesses is a particular concern. The condition of patients with HIV/AIDS or tuberculosis (TB) can easily deteriorate or become acute if treatment is interrupted, while patients living with TB may develop drug resistance – for which treatment is not a given. The knock-on effects go beyond the individual patient and may involve significant public health risks, by exposing more people to disease.

In January 2013, fighting between the Congolese army and Mai Mai militias in Katanga province caused mass displacement around MSF's project in Shamwana. People fled the area in their thousands. MSF's hospital was emptied, with the majority of HIV/AIDS patients, TB patients and malnourished children in nutrition programmes halting their treatment.

"The recent violence between FARDC and Mai Mai displaced thousands towards Mpianga The women who fled could not access their fields. They were completely cut off from their livelihoods and had nothing to sell on the market, so they were left to sell themselves. Some of those women were on antiretroviral treatment and had unprotected sex and came back pregnant."

MSF doctor, Shamwana, Katanga province, July 2013

While a few patients returned to Shamwana hospital at a later date, the majority did not. The MSF team is still trying to locate those patients whose treatment has been interrupted.

At the time of the upsurge in fighting, MSF had been treating an average of 1,000 patients a week for malaria in Shamwana. These patients – most of whom were children under five – could no longer access medical care as they were hiding in the surrounding bush.

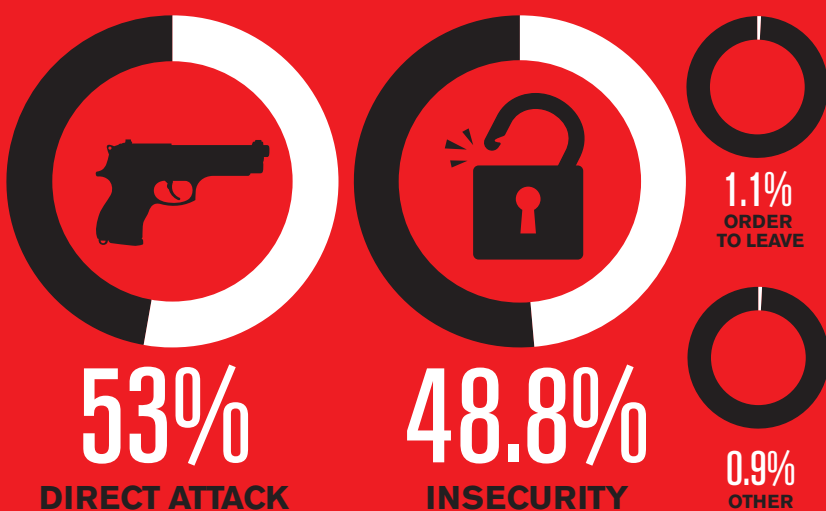
Fighting and subsequent displacement also resulted in the interruption of a measles vaccination campaign by MSF in Katanga province in September 2012, leaving thousands of children susceptible to the disease.⁵¹

INTERNALLY DISPLACED PEOPLE (IDPS) IN DR CONGO

REASONS FOR DISPLACEMENT

MSF mortality survey, Walikale, North Kivu province, June 2013

In 2013, an MSF study looked into the reasons for displacement in one area of North Kivu province. Some 42 percent of the more than 4,000 respondents reported they had been displaced in the past year and 28 percent were currently displaced. Of those who had been displaced, the majority (53 percent) reported that they had fled due to a direct attack on their village. Forty-nine percent of respondents indicated that general insecurity was the reason for their displacement during the past year. Some households reported that they had fled due to both a direct attack and insecurity.⁵²

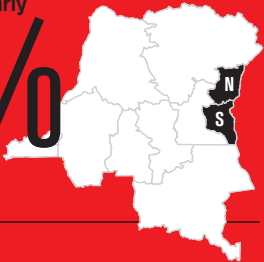


NORTH AND SOUTH KIVU

account for nearly

60%

of the IDPs in DR Congo.



With more than

1 MILLION

in North Kivu alone.



CLOSE TO HOME



People tend to stay close to home. Field research carried out by MSF in North Kivu province in 2009 showed that people travelled roughly half a day to one and a half days in search of a safe place.⁵³

BASIC NEEDS

Whether sheltering in makeshift sites or in official camps, displaced people require:



Medical care



Food



Shelter



Healthcare



Water & sanitation



Safety



Essential household goods

Humanitarian assistance must focus on responding to the urgent needs of all of DR Congo's displaced people in a timely, flexible and appropriate manner.

As of December 2013, there were an estimated

2.96 MILLION



displaced people in DR Congo



DRC hosts 9% of the world's IDPs.

And 25% of the total number of IDPs in Africa.



ABOUT 90%

of DR Congo's displaced people are in the eastern provinces (North Kivu, South Kivu, Orientale and Katanga).

In camps, entire families live in temporary shelters on spaces of a few square metres in size or less.



People living in camps are particularly vulnerable to:



HARASSMENT



LOOTING



SEXUAL VIOLENCE

OVER 5 WEEKS IN LATE 2012

MSF TREATED 95 VICTIMS OF SEXUAL VIOLENCE

IN JUST 1 CAMP NEAR GOMA, NORTH KIVU⁵⁴



Displaced persons camp in the forest around Kirchanga. People fled here after the fighting in the city started. North Kivu province, DR Congo, September 2013.



DEATH AND BIRTH IN THE FOREST

"That night, there were rumours that a rebel group had surrounded the village and would attack the next day. At 5 am, a gun battle broke out, and people ran in all directions. Some ran to the hospital, hoping that they would be safe there, but most ran into the surrounding forests.

A Congolese midwife working at an MSF clinic fled with her family and joined a group of about 40 people who ran together across rivers and through dense, mountainous jungle. A stray bullet grazed the head of a woman running with her 10-month-old baby on her back, and killed her baby.

A 13-year-old boy in the group was also hit by a stray bullet and died instantly. His family stopped to bury his body and the rest of the group continued to run, stopping when they came to a clearing, where they stayed for two days until the attack in the village was over.

While there, the midwife examined a young pregnant woman whose baby was ready to be born. The midwife had taken a childbirth kit with her that she received from MSF, and safely delivered a baby girl. She tied and cut the umbilical cord and put the baby on her mother to keep her warm. They had no clothing for the baby as they had fled empty-handed."

*As told to an MSF doctor, Pinga,
North Kivu province, June 2013*

**DISEASE
OUTBREAKS**

4

In late 2011, MSF launched an emergency intervention in the lakeside town of Kikondja, Katanga province, in response to a high number of measles cases. The team vaccinated more than 65,000 children, but stayed on during 2012 after cholera broke out, treating more than 1,000 patients. During the response, the team became aware of large numbers of children dying from malaria after hearing funeral processions weave through town night after night. The team then mounted a malaria response and went on to treat over 35,000 malaria patients over the next four months.

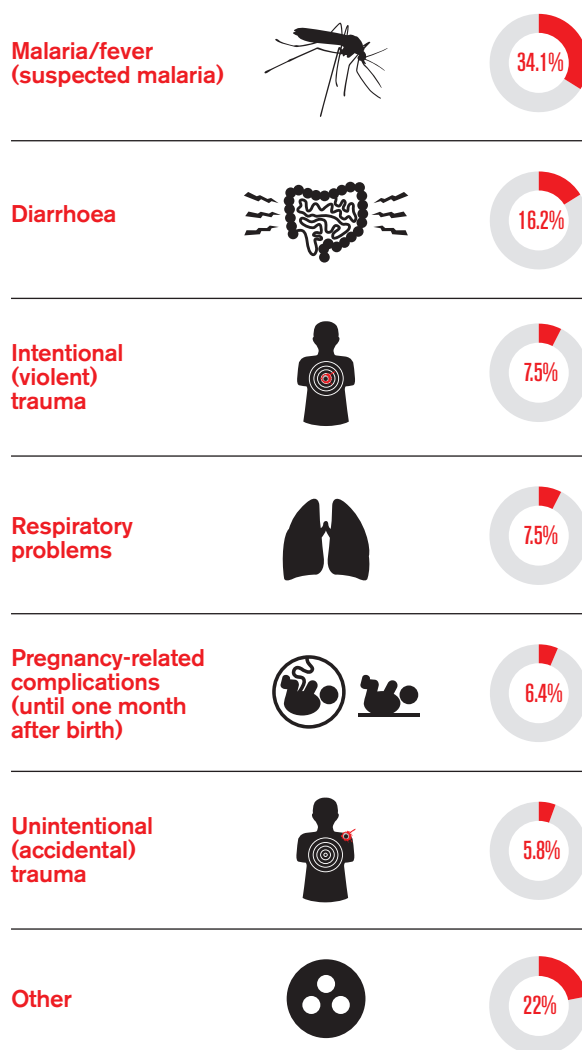
Disease outbreaks occur year after year in DR Congo; but the health system is, in most cases, unable to prevent them or to respond.⁵⁵ As a result, many suffer and die from preventable illnesses. Diarrhoea, acute lower respiratory infections and malaria account for more than 50 percent of the deaths of children under five in the country.⁵⁶

Year after year, MSF treats hundreds and thousands of patients for diseases like malaria, cholera, and HIV in DR Congo. Tackling recurrent outbreaks in the long term, however, demands firm commitment from DR Congo's health authorities, international donors and aid organisations.

CAUSES OF DEATH

A retrospective mortality survey carried out by MSF in Walikale, North Kivu province, in 2013 revealed that malaria or fever (which is suspected malaria) were the most common reported cause of death in the surveyed population – nearly five times greater than violence-related injuries.

Reported causes of death in study population, MSF mortality survey, Walikale, North Kivu province, June 2013



TREATING MALARIA IN DR CONGO

Malaria is an illness caused by a mosquito-transmitted parasite.



Common symptoms are



If left untreated, malaria can develop into its severe form within

DAYS

or even

HOURS

and become

FATAL

In 2012, we treated

434,300

patients for malaria in our projects in DR Congo.

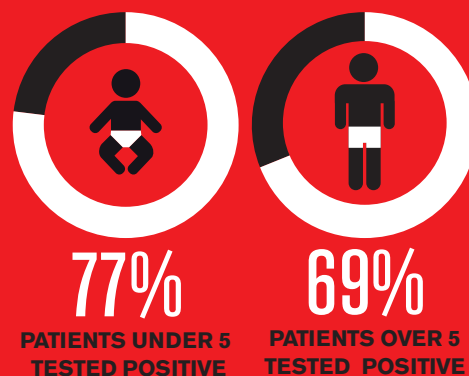


That's about 1/4 of all the malaria cases we treated worldwide.

In DR Congo, the number of cases MSF has treated has increased year after year.



MSF medical teams continue to test and treat large numbers of patients. In Orientale province in 2013, MSF teams in Bili tested pregnant women and children under five for malaria and provided treatment at a local hospital. In total, MSF tested 4,309 people for malaria. The majority of patients were found to be carrying the disease.⁵⁷



Fear of violence can prevent people from seeking treatment for malaria.

The cost of health services in DR Congo prevents many people from accessing the treatment they need. In emergency situations such as a malaria outbreak, the national health system theoretically guarantees free healthcare. Sometimes people are made to pay anyway.



PER CONSULTATION



Under the cost-recovery scheme exercised by the Ministry of Health, an outpatient consultation costs US\$3 for a child.

PER DAY



Many people can't afford this. In DR Congo, the majority of the population lives on less than US\$2 per day.⁵⁸

IMPORTANCE OF TIMELY TREATMENT

Delays in treatment can cause malaria to become severe, and even deadly.



Teams treat large numbers of patients with the severe form of the disease.



In 2011, nearly half of all severe cases of malaria treated globally by MSF (10,503) were treated at Baraka hospital in DR Congo's South Kivu province (5,026).

MALARIA



Malaria is endemic in DR Congo and outbreaks occur almost year-round. The country's tropical climate and its many rivers and lakes contribute to the proliferation of the mosquitoes that spread the disease.

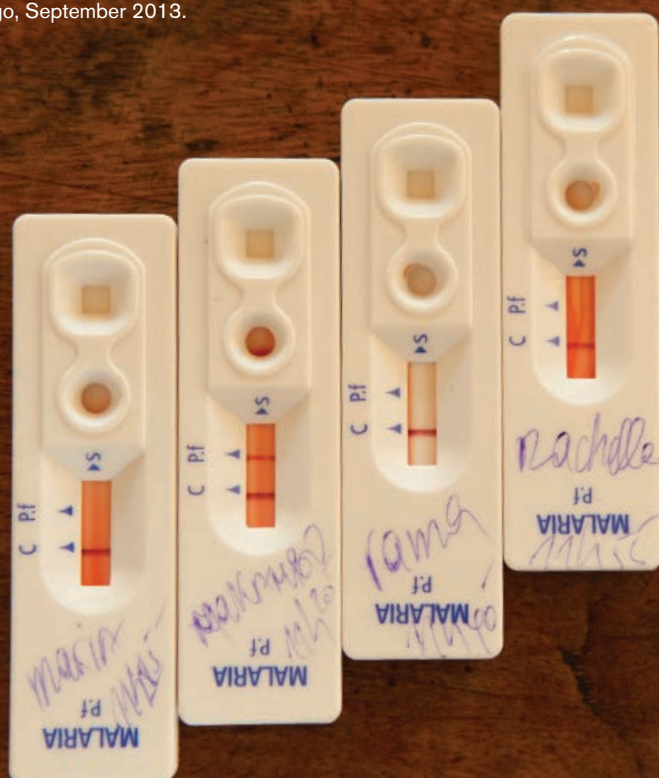
While malaria mortality rates have been decreasing in the WHO African region,⁵⁹ in DR Congo they have increased,⁶⁰ and the disease accounts for 40 percent of deaths among of children under five in the country.⁶¹

MSF medical teams treat vast numbers of patients for malaria – around half a million people in 2012.⁶²

Malaria cases account for a large percentage of all diseases treated in many 'regular' MSF projects. At Baraka hospital in South Kivu province, more than a quarter of the approximately 160,000 patients the MSF team saw in 2012 were treated for malaria.⁶³ In the same year, 43 percent of in-patient admissions at Baraka hospital were for severe malaria.⁶⁴

MSF regularly carries out emergency interventions in response to outbreaks of the deadly disease. In 2012, MSF took emergency action to respond to a dramatic increase in severe malaria cases near Kisangani in Orientale province. In the Ganga-Dingila, Buta, and Aketi areas, MSF provided outpatient malaria treatment to almost 60,000 people and inpatient treatment to more than 3,500 people.⁶⁵

Malaria tests, Katanga Health Centre, South Kivu province, DR Congo, September 2013.



SIMPLE AND SEVERE MALARIA

If simple malaria is left untreated it can become severe. Severe malaria causes organ damage to the brain, lungs, kidneys and blood vessels. Sufferers are more likely to experience convulsions and coma, with the chance of long-term neurological damage. If it is not diagnosed early and effective drugs are not available to treat it, the infection can rapidly become life-threatening. The majority of deaths from malaria are due to severe complicated malaria, and children are most at risk.⁶⁶

A variety of factors contribute to the severity of malaria outbreaks in DR Congo. Mosquito nets are not sent to vulnerable areas and if they are, they can be misused. Many health centres lack the necessary supplies to test and treat patients, such as rapid diagnostic tests and blood transfusions. Frequent drug ruptures mean that medicines are perpetually in short supply. The cost of health services in DR Congo can also be prohibitive to patients (see Chapter 5, Lack of Healthcare).

Displacement further increases a population's vulnerability to malaria. In July 2012, MSF suspended an emergency programme in Walikale, North Kivu province, after heavy fighting between the Congolese army and the Raia Mutomboki armed group. MSF teams had been treating over a thousand cases of malaria each week. Medical activities resumed in mid-August 2012, and MSF treated over four thousand patients for malaria in the remainder of that month. Patients reported having been bitten by mosquitoes while sheltering in the forest.⁶⁷

MEASLES



Measles is a highly contagious disease caused by a virus and transmitted through droplets from the nose, mouth or throat of infected people by coughing, sneezing and breathing.⁶⁸ It can be fatal, and is particularly deadly for children under the age of five.⁶⁹

Measles infections are preventable: to vaccinate a child for the virus costs only about US\$0.25,⁷⁰ and only a single dose is required for protection.⁷¹ Yet DR Congo has been in the grip of an ongoing measles epidemic since 2010.⁷²

Year after year, MSF vaccinates hundreds of thousands of children against measles, and responds to outbreaks across the country. The challenges of doing so are manifold.

For many people, prevention and treatment for measles remain out of reach. In the Yahuma health zone in Orientale province, for example, the health centre has two refrigerators and one broken motorcycle to serve an area half the size of Switzerland. Most people live in remote villages and under

CHALLENGES OF CARRYING OUT MEASLES VACCINATIONS IN DR CONGO

The cold chain: To ensure that the measles vaccine is effective, it needs to be kept cold. In DR Congo, the cold chain is often broken in the most remote areas because of a lack of equipment or electricity.

Official vaccination rates: While official coverage rates suggest that a large proportion of the country is protected from measles, recurring outbreaks suggest otherwise. The claim of coverage complicates humanitarian assistance, as negotiations for authorisation can delay outbreak response.

Infrastructure: Roads are poor in many areas of DR Congo, and most people lack the means of transportation to get to a health centre. Health facilities in the country often function poorly, frequently run out of drugs and struggle to find qualified staff.

the poverty threshold, meaning they cannot travel to access treatment. MSF vaccinated 76,000 children in this area during an emergency response in 2012.⁷³

CHOLERA



In early 2013, MSF started a cholera response in the capital of Katanga province, Lubumbashi, the second biggest city in DR Congo and home to more than one million people. The emergency response lasted for five months with MSF teams treating a total of more than 6,000 people.

Cholera, a diarrhoeal disease caused by an infection of the intestine with the bacterium *Vibrio cholera*, tends to break out when there is overcrowding and inadequate access to clean water, refuse collection and sanitation.⁷⁴ Cholera is endemic in five provinces of DR Congo.⁷⁵

Water and sanitation provision is inadequate in many of the country's towns and cities.⁷⁶ It is especially poor in camps for displaced people.⁷⁷

MSF vehicle making its way on the muddy roads in Mweso, North Kivu province, DR Congo, September 2013.

© Giulio Di Sturo

In late 2012, MSF responded to a deadly cholera epidemic that swept through Kishusha camp, Rubaya, North Kivu province, treating 830 people between November 2012 and July 2013. The outbreak was directly related to poor living conditions and lack of access to drinking water.

Aid organisations specialising in water, hygiene and sanitation were slow to act in Rubaya, facilitating the outbreak and spread of the cholera epidemic. In late July 2013, just 54 latrine blocks were serving a population of 14,000, and nearly half of the latrine blocks were full.⁷⁸

HIV/AIDS



There are an estimated half a million HIV-positive people in DR Congo.⁷⁹ Approximately 243,000 of them are eligible for antiretroviral (ARV) treatment; and even by the most optimistic estimates, only about 30 percent of those people can access it.⁸⁰

Though DR Congo is considered to have a low HIV prevalence, timely screening and treatment is still out of reach for the majority of those who urgently need it. At the Centre

Hospitalier de Kabinda in Kinshasa, MSF has seen large numbers of patients with serious complications resulting from a lack of care that could be prevented if patients received early ARV treatment.⁸¹ In Kinshasa, MSF is treating 5,000 patients on ARVs – or about 10 percent of the total number of HIV/AIDS patients receiving treatment in DR Congo.⁸²

“We often see people arrive at our hospital when they are already critically ill with full blown AIDS. For many people, it's too late and they are literally dying on our doorstep. Twenty-five percent do not survive and 39 percent of deaths occur within 48 hours.”

MSF doctor, Kinshasa, November 2013

There is an urgent need in DR Congo for health providers to expand ARV coverage, and for the Congolese authorities to meet their commitment to provide free prevention services and free treatment for people living with HIV. Decision makers at the international level must also mobilise the resources necessary to ensure that people with HIV have access to free ARVs.

**LACK OF
HEALTHCARE**

5

DR Congo has long featured in the bottom ranks of the Human Development Index; year on year, the country scores very low on all health indicators, which include life expectancy at birth, under-five mortality,⁸³ and proportional public expenditure on health.⁸⁴ The harsh reality is that in many areas, people have little or no access to quality medical assistance.

"The patient was 23 years old, pregnant, and came from a small village called Kilenge, which has no healthcare facilities at all. The village is 25 kilometres from Kafumbe, where there is a small health post. There hasn't been anybody working at the health post for a long time – because of the fighting, and because there is a lack of health staff and medicines in this region.

The patient had started getting abdominal pains at home, and got worried as she was already late in her pregnancy. She went over to her mother's house, and a traditional birthing attendant and a traditional healer were called for. For three days this woman drank concoctions of different herbs and the traditional healer gave her some physical exercises to do to get the baby out.

On the fourth day, the baby still hadn't been born. Her family was very worried as she had developed fever, smelled very bad, and the pain was worse than ever. At 3 am the family set out for Shamwana, where MSF runs a hospital offering free medical care.

It took the family 48 hours to reach MSF's hospital on foot. The patient was transported on a bicycle, and ten men and four women came along as protection, since the roads are not safe and they were worried about an ambush.

On arrival at the hospital in Shamwana, the patient immediately went into emergency surgery. A serious infection had already spread though her body and her baby had died. There is no doubt that without the surgery provided by MSF, the woman would not have survived."

MSF doctor, Shamwana, Katanga province, February 2013

In remote areas, health centres and hospitals are frequently non-functional.⁸⁵ A wide variety of non-state actors, privatised, faith-based, national and international health actors have stepped in to deliver medical services that are traditionally in the purview of the state.⁸⁶ In a country where getting medical care is difficult to begin with, there are considerable obstacles for anyone who wants to obtain medical care in the country's conflict-affected rural areas. The majority of health NGOs operate primarily in and around urban centres.

The pervasive cost-recovery system operated by state-run health facilities and private health providers requires patients to pay for medical care, which is a major financial barrier for vulnerable patients trying to access the few facilities available – especially in an emergency.

In areas in chronic crisis, reaching those in need and impartial delivery of aid in an acute emergency remain a huge challenge, as became clear during the emergency that took place in 2012 and 2013.

OBSTETRIC FISTULA

As well as significant numbers of maternal deaths in DR Congo, the lack of timely access to quality medical care has resulted in the incidence of an entirely preventable condition called obstetric fistula. This is a permanent hole in the birth canal caused by a prolonged and obstructed labour without medical intervention. The woman is left with chronic incontinence and, in most cases, a stillborn baby. Sufferers often live with severe social stigma due to the odour and to people's perceptions of uncleanness.

Said one fistula patient, who received treatment on MSF's Shamwana project:

"After I found out I had a fistula, my husband left me. I used to work in the fields and I had friends. But now I've distanced myself from my community. I don't work; I just wait for my parents to provide for me. I'm weak, I can't do much. When I get better, I will be able to go back to work. I will feel stronger."

The condition exists because of the failure of healthcare systems to provide accessible, quality maternal healthcare. In DR Congo, MSF holds camps on a yearly basis offering a surgical procedure to repair women's internal injuries and provide a cure for their incontinence.



LOW AVAILABILITY OF HEALTHCARE IN RURAL AND CONFLICT-AFFECTED AREAS

Although 80 percent of DR Congo's population live in rural areas, 80 percent of medical services are concentrated in urban locations.⁸⁷ For many people in remote parts of the country, the nearest health post will be miles away.

In these areas, health centres and hospitals are often completely non-functional, lacking properly trained medical staff and medical supplies.⁸⁸ Government salaries are low and payments are infrequent and unreliable, with health workers reportedly receiving no salary for months at a time.⁸⁹ Drug management systems are weak and lack accountability, with multiple parallel systems in place and frequent ruptures.⁹⁰ Drug prices are also not fixed and vary across health facilities.⁹¹

The situation is made worse by instability and violence and DR Congo's notoriously poor infrastructure. The roads are inadequate and many health facilities lack electricity and water.⁹²

POOR EXCLUDED FROM HEALTHCARE

It is estimated that the vast majority of DR Congo's population lives on less than US\$2 per day.^{93 94} For many people in remote, conflict-affected areas of the country, cost acts as a major barrier in seeking healthcare.

Research carried out by MSF in Walikale, North Kivu province in 2013 found that nine out of ten households had had at least one person fall ill in the previous two weeks. More than 35 percent reported not seeking care, with the majority of those reporting lack of money as the reason.⁹⁵

As a medical humanitarian organisation, MSF is concerned with ensuring medical treatment is available to those who need it most and the aim is to provide healthcare to the most

A woman works in fields near Shamwana, Katanga province, DR Congo, September 2013.

© Sam Phelps

vulnerable people, regardless of their ability to pay. State-run health facilities in DR Congo, by contrast, operate a cost-recovery system, in which patients must pay for every component of medical care. Many NGOs running health facilities do the same.







In emergency situations such as conflict, epidemic or natural disaster, the national health system theoretically guarantees free healthcare in its facilities.⁹⁶ However, the authorities have proven unable to assure this.^{97 98}

MSF research carried out in DR Congo spanning more than a decade demonstrates that user fees compromise people's access to health services. They are often forced to resort to alternative providers of care, and end in further impoverishment.⁹⁹

However, MSF's experience shows that when free medical services are introduced in an area, people are more likely to seek healthcare.

UPTAKE OF MEDICAL SERVICES, COST RECOVERY VERSUS FREE OF CHARGE¹⁰⁰

In 2011, Lulimba hospital in South Kivu switched from using a cost-recovery system to operating free of charge. The number of patients soared. This increase in the uptake of medical services can be attributed in large part to the introduction of free quality healthcare in the area.

Services		2010 (cost recovery)	2012 (free of charge)
Admissions to Inpatient Department (IPD)		1,000	4,925
Deliveries		182	1,663
Surgeries		90	225
HIV/AIDS		0	62
TB treatment started		0	90
Vaccinations (measles)		0	2,055

MSF started supporting the local hospital in Lulimba, a remote gold mining town in Fizi territory in South Kivu, in October 2011. Before then, Lulimba hospital had been operated by the Ministry of Health under a cost recovery system, in which an outpatient department consultation cost US\$3 for a child; a delivery cost US\$5; and an operation cost US\$50. In the previous year, some 1,000 people were admitted as inpatients to Lulimba hospital.

As soon as the hospital started operating free of charge, there was a fivefold increase in patient numbers, with 4,925 inpatients in 2012. Deliveries also soared, from 182 in 2010 to 1,663 in 2012 – a ninefold increase. Even when taking into account an increase in hospital beds from 30 to 70, this sudden surge in the uptake of services can be attributed in large part to the introduction of free quality healthcare in the area.

INEFFECTIVE AID

The humanitarian community in DR Congo is large and well-established, and includes UN agencies and programmes, the International Red Cross and Red Crescent Movement, hundreds of international and national NGOs and ten donor government agencies. But the current aid system is not addressing the population's most urgent needs.

Humanitarian assistance is patchy across eastern DR Congo, and many organisations have no presence outside urban centres. Where organisations are present, their capacities to ensure base-level services vary widely.¹⁰¹

In MSF's experience, humanitarian actors struggle to respond quickly, flexibly and appropriately to people's urgent needs in crisis. Findings of a review of the emergency response in North Kivu in 2012 and 2013 show that the ability of humanitarian agencies to respond quickly to emergencies is hampered by overly bureaucratic structures, inflexible funding and risk-aversion. Most humanitarian agencies are simply not present in the field, unwilling or unable to go far from the main towns because of logistical constraints or security concerns.¹⁰²

In July 2013, nearly 5,000 people fleeing fighting between the M23 movement and the Congolese national army sought refuge in Majengo, in Goma, North Kivu. In spite of desperate living conditions in Majengo, it took three weeks for NGOs to coordinate and mount a response. Throughout this period, MSF was the only humanitarian organisation offering assistance to the population.

Whether or not people receive assistance in conflict-affected eastern DR Congo is also increasingly dependent on political agendas. Donor agencies linked to national governments are increasingly exerting pressure on aid providers to channel assistance to 'liberated' zones with a view to stabilising conflict-affected areas and strengthening the authority of the state.

THE ABUJA DECLARATION

The Abuja Declaration, signed by African heads of state in 2001, committed its signatories (of which DR Congo is one) to allocate at least 15% of government revenues to health.¹⁰³



However, in DR Congo, expenditure on health was just 2.9% of the national budget in 2010



a decline from 5.4% in 2009.¹⁰⁴



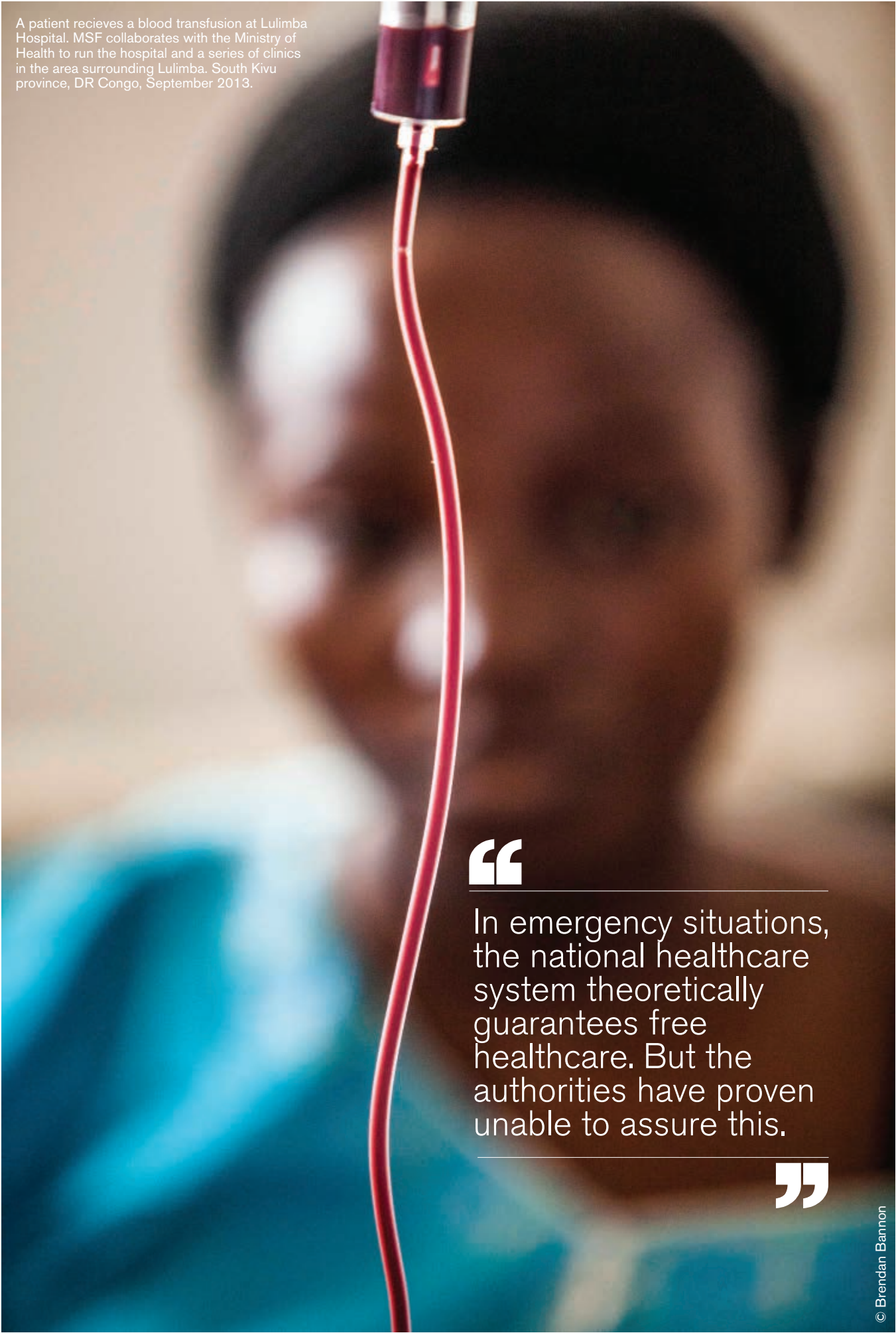
The total expenditure on health per capita is

US\$16

Far below the estimated minimum spend of

US\$44

per person per year needed to provide basic, lifesaving services for low income countries.¹⁰⁵

A close-up photograph of a patient's face, blurred in the background, looking upwards. A red blood transfusion tube hangs vertically in the foreground, with a drip chamber at the top. The patient is wearing a blue hospital gown.

A patient receives a blood transfusion at Lulimba Hospital. MSF collaborates with the Ministry of Health to run the hospital and a series of clinics in the area surrounding Lulimba, South Kivu province, DR Congo, September 2013.

“


In emergency situations, the national healthcare system theoretically guarantees free healthcare. But the authorities have proven unable to assure this.

”

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CONCLUSION

6



DR Congo is living through a medical and humanitarian crisis. People face a daily struggle for survival in what can only be described as an everyday emergency. The country has been embroiled in conflict and political crisis for years. Violence against civilians and displacement are a part of life for many people in DR Congo's conflict-affected eastern provinces, and continue to cause great suffering to individuals, families, and communities.

Every day, MSF is confronted with the medical consequences of violence in its hospitals, health centres and mobile clinics in DR Congo. Conflict causes people to put off visiting health posts or to flee their homes, impeding access to health services. Medical personnel and hospitals are regularly attacked. This is unacceptable and makes provision of lifesaving care a difficult, if not impossible, task. Suspensions of services due to attacks leave many people without care on a regular basis.

The government has not met its obligation to provide basic services and healthcare for the country, and thousands die each year of preventable and treatable diseases as a result. Low immunisation rates and an ineffectual national vaccination programme mean that outbreaks of infectious diseases are frequent and widespread. Aside from shortcomings in the country's infrastructure and public services, a pervasive cost recovery system in place in DR Congo means that many people cannot afford any medical assistance at all.

Though the international aid effort in DR Congo is substantial, it is not serving those who are most in need. Humanitarian aid is disproportionately allocated to people located in camps and in urban areas. As a result, many people fall through the cracks, receiving little or no humanitarian assistance at all.

MSF calls for immediate action to end this suffering. The lives of those in desperate need of medical assistance cannot be sacrificed while we wait for much-needed longer-term solutions, including economic development, the regeneration of the health system and a political or military resolution to long-running conflicts.

While recognising the difficulties of working in a protracted crisis in a seemingly constant state of flux, **MSF calls on international and national aid agencies working in DR Congo to urgently revise their operational priorities to ensure aid serves those most in need.** The delivery of humanitarian assistance should take impartiality as its leading principle, and should not be directed by any kind of political or stabilisation agenda. It should focus on increasing the availability and quality of services to people living outside urban areas, and to displaced people living outside camps.

MSF calls on all armed actors to refrain from harming civilians and targeting health personnel and facilities. Violence against civilians should not be accepted as an inevitable aspect of war. These actors must respect civilians, humanitarians and medical facilities so that those most in need can access medical care. The neutrality of humanitarian action must be respected by all parties to the conflict, including MONUSCO, by clearly distinguishing all their military assets from civilian functions.

Finally, addressing the alarming levels of morbidity and mortality in DR Congo must be a priority. All involved in the provision of healthcare must **stop making the most vulnerable people pay to access health services, especially in conflict-affected areas**, so that people have genuine access to medical assistance. More must be done to prevent and respond to the disease epidemics that claim so many lives every year. **MSF calls on the government to increase its efforts to fulfil its responsibility to provide adequate health services, and remove the barriers for accessing healthcare that exclude the most vulnerable.**

Mother Feza Maliyabo travelled 300 kilometres to seek treatment for her son who had malaria. They travelled from Kongolo to Kalemie to Lulimba. They came that distance to seek treatment because they knew MSF provides free treatment at the clinics in Lulimba and Misisi. Dr Patient, a Ministry of Health attending doctor, on the night shift examined the child. South Kivu province, DR Congo, September 2013.

METHODOLOGY

This report concerns the health and humanitarian situation endured by people living in conflict affected provinces in Democratic Republic of Congo: North Kivu, South Kivu, Orientale and Katanga.

It is based on medical data collated in 2013, 2012 and 2011 from MSF projects responding to violence and neglect in these provinces and is complemented by information from internal reports relating to operating medical programmes in DR Congo.

Routinely collected medical data from all MSF projects in DR Congo from 2007 to 2012 has been used to give an insight into the scale and nature of MSF's response to the medical humanitarian emergencies in DR Congo.

Though country-wide data for 2013 are still being consolidated and analysed, so far they show no significant change from those of previous years. It is fair to say that the trends evident from data up to 2012 and discussed in this report persist.

The multiple testimonies collected from MSF staff and patients, and from the wider population, were aimed at understanding the health and humanitarian impact of violence and lack of healthcare on the population.

DR Congo conducted its last official population census in 1984, which explains why humanitarian actors, including MSF, have had to rely on estimates and extrapolations.



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