



**A Rapid Assessment of the  
Prevalence and Impact of Disabilities among Children  
On the High Plateau in South Kivu, DRC**



**December 2018**

## List of Acronyms Used

<b>CRPD</b>	Convention for the Rights of People with Disabilities
<b>CWD</b>	Children with Disabilities
<b>DHS</b>	Demographic and Health Survey
<b>DRC</b>	Democratic Republic of Congo
<b>EMI</b>	Ebenezer Ministry International
<b>NGO</b>	Non-Governmental Organisation
<b>OOSC</b>	Out of School Children
<b>PWD</b>	People with Disabilities
<b>UN</b>	United Nations
<b>WHO</b>	World Health Organisation

**Cover photo:** (Left to right) Jean-Claude (13) contracted polio as a baby and has lower limb deformities that make it difficult to walk. He is not attending school. Jolie (16) suffers from hearing loss and lower limb impairments which have excluded her from school. Pierre (12) has a learning disability that prevents him from attending school.\*

\*All names have been changed.

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## Key Findings

- ❖ At least **90%** of children with disabilities (CWDs) on the high plateau are not in school, compared to a national average of **54%** of CWDs who are out of school.
- ❖ The challenge of **physical access** is the primary obstacle to school attendance on the high plateau. Following that, in order of significance, are **lack of specialist support** offered to CWDs by schools, a **lack of assistive devices**, unsupportive **parental attitudes** and **stigma**.
- ❖ Overall prevalence of disability among children on the high plateau is estimated to be at least **10%** and may be significantly higher.
- ❖ **Physical disabilities** of the lower or upper limbs are the most common impairment affecting **40%** of CWDs. **30%** of CWDs have a **cognitive or learning disability**, **17%** a **hearing impairment** and **11%** a **visual impairment**.
- ❖ Only **25%** of CWDs living on the high plateau have ever received medical support or treatment and only **12%** have been treated on the plateau.
- ❖ **1 in 3** children who have received treatment have not experienced any improvement in their condition.

## Executive Summary

Street Child works to enable children to go to school even in the toughest situations. Around the world, children with disabilities (CWDs) are among the most likely to be out of school as a result of multiple, overlapping barriers to both access and learning<sup>1</sup>. The disadvantages faced by CWDs are more pronounced in the poorest contexts, where poverty and inadequate health provision increases the risk of children being born with or developing a disability, and where health and education services are ill equipped to meet CWDs' specialist needs.<sup>2</sup>

For over a decade, Street Child has been working in the Democratic Republic of Congo (DRC) through its subsidiary Children in Crisis to improve the quality of primary education and increase access for the most marginalised children. Over that period we have trained over 1,700 teachers in 314 schools, rebuilt 25 schools and helped 4,000 families to send and keep their children in school. While we have worked with CWDs and their families as part of our programming, we have not to date implemented programmes directly addressing the needs of CWDs.

This assessment was carried out to help inform future Street Child programming in DRC by increasing our understanding of the needs of CWDs and their families in our primary operational area, the high plateau in South Kivu. By shedding light on the circumstances of CWDs living in this location, the findings will enable us to develop targeted interventions while also contributing more broadly to sector understanding of the impact of disability among children in a remote and conflict-affected part of eastern DRC.

Although relatively small in scope and relying on simple survey methodologies, the study has brought to light the extremely challenging circumstances faced by children with disabilities on the high plateau. Childhood disability prevalence rates are at least **10%** and likely higher, yet only **1%** of the school population is a CWD. In a context where **35%** of children do not attend school, this implies that at least **90%** of CWDs of school age are not enrolled. Since upper or lower limb disabilities are most common and affect 40% of CWDs, the lack of roads and significant distances between villages are a major factor behind non-attendance. This was cited by **39%** of parents as the primary reason their children weren't in school. In addition, schools and teachers are poorly equipped to cater for the special needs of CWDs. Only **25%** of parents surveyed said schools made efforts to cater for their disabled children's needs. While **38%** of parents said that school's inability to support their children was the main reason for non-attendance. Meanwhile health and other support services on the plateau are minimal. Only **25%** of parents surveyed said their child had received any kind of treatment and only **half of those** from a clinic on the plateau. Although stigma/active discrimination and non-supportive parental attitudes exist as barriers to education, this survey found their significance to be dwarfed by structural and resource issues such as access, school capacity and health provision.

Being born with a disability or developing one in infancy or childhood not only presents a gloomy future for any child on the plateau, but often has negative implications for the rest of the family. Disability can present a major economic burden to the household, particularly if the child requires full or part time care, thereby reducing the family's capacity for productive work and income generation. This lost income may mean that other children in the family miss out on an education. For children with disabilities themselves, the lack of educational opportunities in addition to very poor health and support services hugely limits their life prospects and condemns them, in many cases, to a life of poverty and dependency.

# 1. Context

## 1.1 Disability in DRC

Little data exists around the prevalence of disability in DRC, and what does exist is inconsistent. One estimate places the number of People with Disabilities (PWDs) in DRC at 11%.<sup>3</sup> Another places it at 10,500,000 or 15% of the population.<sup>4</sup> This latter figure aligns with the WHO estimate for the prevalence of disability among the world's population.<sup>5</sup> However, the 2013 Demographic and Health Survey (DHS) indicates that as many as 35% of 2 – 9 year olds in DRC have at least one form of physical or learning disability.<sup>6</sup> Given the elevated risk factors for disability in DRC, as described below, there is a strong possibility that the true prevalence rate is above the global average.

Children with Disabilities (CWDs) are disproportionately represented among out-of-school children (OOSC) in DRC. A 2012 study found that 54.5% of CWDs are not attending school, representing 300,000 6 – 17 year olds.<sup>7</sup> Of these, the majority (62%) have physical disabilities of the upper or lower body, 31% have a learning/cognitive disability and just under a quarter (24%) are hearing impaired. Children who are blind represent 4% of this group, and partially-sighted 11%. As these figures indicate, while upper and lower body disabilities are by far the most common impairment among children, many children have more than one physical or learning disability and a significant number have multiple disabilities.

A range of factors increase the risk of a child either being born with or developing a disability in early childhood in DRC. Extreme poverty increases the risk that a pregnant woman will be in poor health, have a restricted diet and poor sanitation and hygiene facilities, all of which may impact negatively on foetal development<sup>8</sup>. Women giving birth in DRC are at elevated risk of birth complications caused by inability to access and/ or inadequate medical intervention and high rates of early teenage pregnancy among other things, which may lead to cognitive or physical disabilities in the child.<sup>9</sup> The rate of sexual violence is high in DRC, particularly in the east of the country, and women who conceive as a result of rape may be less likely to seek medical help during pregnancy and childbirth because of the shame and fear of stigma/ social ostracising experienced by many rape victims.<sup>10</sup>

If born in to poverty, a child may be exposed to inadequate nutrition, poor sanitation and hygiene and inadequate childcare in the first years of its life which puts it at higher risk of developmental delays.<sup>11</sup> Epidemics of childhood diseases such as polio and meningitis which can cause physical and cognitive disabilities are relatively common in DRC as a result of inadequate vaccination programmes and the poor quality and coverage of medical facilities.<sup>12</sup> Isolated rural areas like the high plateau tend to have elevated rates of consanguinity (intra-family marriage) which have been shown in other contexts to increase the risk of congenital illness such as club foot, spina bifida and muscular dystrophy.<sup>13</sup>

## 1.2 Government Services and Support for PWDs

After a long period of neglect, the Congolese government has in the last few years begun to increase the attention paid to disability issues. A National Disability Policy was adopted in 2010 and disability rights fall within the remit of the National Human Rights Commission established in 2013. In 2015 the government voted in favour of ratifying the UN Convention on the Rights of Persons with Disabilities (CRPD) but is not yet a signatory.<sup>14</sup>

Despite these promising developments, governmental dysfunctionality and corruption means that very little of this is translated in to affordable or accessible service provision for PWDs. Although some hospitals and clinics do provide specialist services, the majority of those living with mobility, hearing or visual impairments cannot afford the treatment and equipment that would give them greater dignity, mobility and access and improve their chances for societal integration. The challenge is even bigger for the majority of the population who live in rural areas where service provision is underdeveloped, and poverty levels are greater.

Although the Congolese constitution guarantees access to schooling for all children 'regardless of physical, mental or sensory state'<sup>15</sup>, efforts to improve the inclusiveness of education - through, for example, teacher training, curriculum adaptation and enhancement of school facilities - have been minimal. The vast majority of CWDs remain out of school. PWDs also face discrimination, prejudice and social isolation further inhibiting their ability to participate in society. In some cases, stigmatisation is tied to superstition, and disability is perceived to be the result of witchcraft which has led on occasion to extreme ostracising and even violence directed at PWDs or CWDs.<sup>16</sup> The burden of care for those with severe disabilities in most cases falls to family members, thereby reducing the household's income-generating potential and increasing its poverty risk. The combination of these factors means that, according to the 2013 African Disability Rights Yearbook, most PWDs in DRC live beneath the poverty line.<sup>17</sup>

### 1.3 The Study Area: High Plateau of Fizi, Mwenga and Uvira

The high plateau of Fizi, Mwenga and Uvira in South Kivu, eastern DRC, is an extremely isolated, impoverished rural location with a heavy reliance on subsistence agriculture. Large households of 7+ members survive on a combined income of just \$57 a month and many eat just one meal a day. The high plateau continues to be affected by inter-ethnic violence which causes displacement, destroys livelihoods and disrupts schooling. Eastern DRC has come to be known as 'the worst place to be a woman'<sup>18</sup> because of the very high prevalence of gender-based violence and entrenched gender inequalities. More than a third of women in South Kivu have been victims of sexual violence<sup>19</sup> and as many as two thirds of girls on the high plateau are married below the age of 18<sup>20</sup>.

The high plateau is a particularly challenging environment for anyone with a physical or cognitive disability. Most of the plateau has no roads and the only way to travel is by foot which presents a major difficulty to children with mobility problems. Medical/ health provision across the plateau is minimal and lacking the specialist treatment and support that many CWDs require. This study explores to what extent and in what ways these challenges and others impact on the lives of CWDs and their families.

## 2. Study Rationale and Objectives

Through subsidiary Children in Crisis, Street Child has been working on the high plateau in South Kivu since 2007, supporting schools, teachers and communities to increase the quality of and access to schooling. As our programmes evolve, we have been increasingly targeting our interventions to more effectively address the needs of the most vulnerable groups including the most impoverished households, girls, marginalised ethnic groups and, more recently, CWDs.

By revealing the challenges for CWDs living in the high plateau area, this study has the dual purpose of informing Street Child’s development of targeted interventions to meet the needs of CWDs as well as contributing more broadly to sector understanding of the impact of disability among children in a remote and conflict-affected part of eastern DRC.

The specific objectives of the study are:

- To make an estimation of the prevalence of disability among children and the most common forms of disability that present in this area.
- To understand the main barriers to attending school for CWDs and to estimate approximately what proportion of CWDs are out of school.
- To understand what support exists, particularly in schools and health clinics on the plateau, to address the needs of CWDs.
- To gain an understanding of the social and economic impacts of disability on both the CWD and their family.

### 3. Methodology

#### 3.1 Data Collection Approach and Tools

Data was collected in August, September and October 2018 by a team from Congolese NGO EMI, who has been Street Child’s partner since 2007. Data collection took place in two locations: Minembwe and surrounding villages towards the southern end of the high plateau, and three axes (Marungu, Katobo-Lemera and Bijojo) at the northern end of the high plateau.

Information was gathered through surveys with four groups of people: health clinic supervisors, head teachers, families of CWDs and village chiefs or other local leaders. A total of 154 individuals were surveyed as follows:

	Northern Axes	Southern Axes	Total
Head teachers	30	5	<b>35</b>
Parents of CWDs	71	17	<b>88</b>
Health clinic supervisors	12	2	<b>14</b>
Village chiefs/local leaders	14	3	<b>17</b>
<b>Total</b>	<b>127</b>	<b>27</b>	<b>154</b>

The surveys used for each group comprised a range of questions aimed at providing insight in to the principal areas of investigation highlighted above. Questions based on the Washington Group Extended Set were used to ascertain information about forms of disability from parents. Health clinic data was the primary source of information regarding prevalence, triangulated by estimates provided by village chiefs and other local leaders. Information regarding barriers to attending school, existing support for CWDs and the social and economic impacts of disability were obtained through a mix of quantitative and qualitative questions with head teachers, parents and local leaders, enabling a range of viewpoints to be taken in to account and synthesised. The table below summarises the type of data collected and the tools used to gather information on each area of investigation.

Area of investigation	Data type	Tool used
Prevalence of disability among children	Health Clinic data Estimated rates	Clinic Supervisor survey Local leader survey



Prevalence of different forms of disability among children	Washington Group Questions Estimated rates	Parents survey Local leader + teacher survey
Barriers to attending school for CWDs	Parent/child experiences Third party observations	Parents survey Local leader + teacher survey
Estimate for proportion of CWDs who are OOSC	Estimated rates	Teacher survey Local leader survey
Existing support for CWDs	Observations by research team Parent/child experiences Third party observations	Research team feedback Clinic Supervisor survey Parent survey Local leader + teacher survey
Social and economic impacts of disability	Observations by research team Parent/child experiences Third party observations	Research team feedback Clinic Supervisor survey Parent survey Local leader + teacher survey

### 3.2 Limitations of the Study

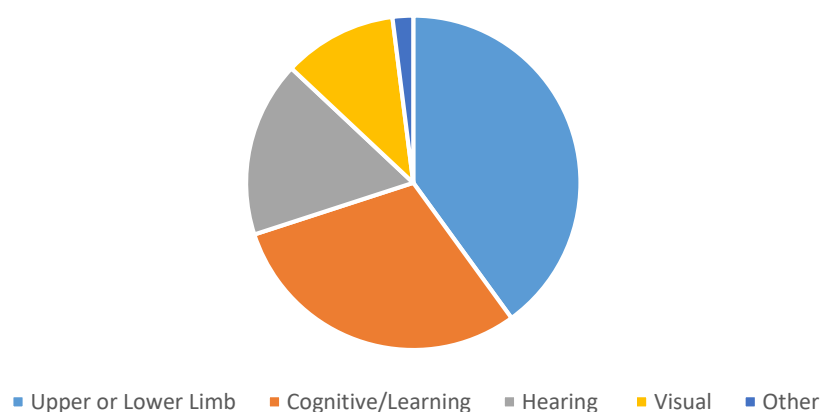
This was a small-scale rapid assessment aimed at providing approximate indications of prevalence of disability among children, the proportion of CWDs out of school and broader qualitative information around barriers, support and impacts. The scope of the study did not allow for comprehensive door-to-door data collection which would have provided more accurate information on prevalence of disability and the proportion of CWDs out of school. Instead it relied on health clinic figures plus estimations of prevalence as perceived by local authorities which has the disadvantage of introducing potential reporter bias and/ or misconception. Unfortunately, time and resource constraints prevented the study team from working with CWDs directly for this small study. It is hoped that an enlarged study in the future will allow scope for comprehensive engagement with CWDs. Finally, this rapid assessment did not allow for a statistically significant sample. The accuracy of the results should therefore be considered with these methodological limitations in mind.

## 4. Results

### 4.1 Forms of Disability among Children and an Estimation of Prevalence

There was a high level of consistency across the data in terms of the proportion of different forms of disability among children, and this also aligned closely with the trends highlighted in the 2012 OOSC report cited above.<sup>21</sup> Clinic data and figures put forward by teachers and chiefs all cited physical impairments (upper and lower body) as the most common form of disability among children with estimations falling between 36 – 40%. Cognitive/ learning disabilities followed as the next most common disability occurring in 27 – 30% of cases. Hearing impairments followed at around 17%, and visual impairments at around 11 – 13%. Other disabilities including chronic illness registered between 2 – 6%. It should be noted that the study focused on primary disability and did not capture whether the identified children had other disabilities alongside their primary disability.

Fig1: Prevalence of different forms of disability among children



The methodology used to estimate prevalence of disability among the under-18s produced a range of results from 1 – 10%. This is likely to be below the true rate of prevalence for several reasons. In the first place, while health clinic data put prevalence of disability among children at between 1% and 6% these figures are based on CWDs registered and known to the clinic. These are therefore likely to be an underestimate since many CWDs may have never attended a clinic as a result of the prohibitive costs and long distances between clinics. Estimates provided by local chiefs for the number of CWDs in their communities ranged from 3-10%. But, as noted above, these figures are based on subjective estimates which are more likely to underestimate the number of CWDs, since many remain largely housebound and hence invisible. In the light of the elevated risk factors for disability in this part of DRC (see 1.1), the true rate of prevalence is likely to be closer to the global average of 15%, and quite possibly in excess of this.

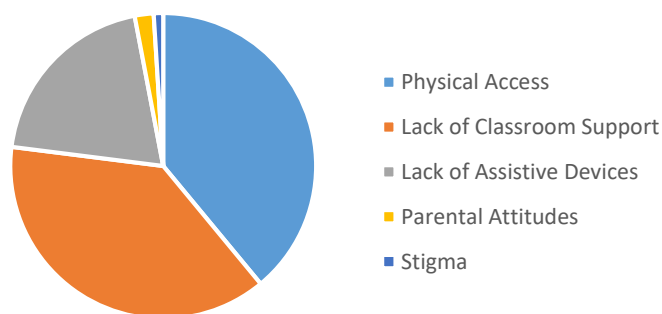
### 4.2 Barriers to Education and Rate of CWDs out of school

In terms of the percentage of CWDs among the OOSC population the study found, as expected, that very few children with disabilities were to be found in school. Primary schools averaging 200 students have on average 1.2 female and 1.5 male students who have any form of disability. In other words, CWDs make up only 1% of the primary school population, with boys very slightly better represented

than girls. The percentage of CWDs in secondary schools is similar, although with enrolment for girls on average at 39%, the number of girls with disabilities in school is significantly less. This implies that the out of school population of CWDs is particularly high. For all children, the out of school population for the plateau is around 35%, while evidence gathered through this survey suggest that for CWDs it is 90% or more. This is significantly higher than the 54% cited at national level by the OOSC report of 2012.

The study highlighted five principal barriers to education for CWDs on the high plateau. In descending order of significance these are: physical access, lack of in-school support, lack of out-of-school support/services, parental attitudes and stigma.

**Fig2: Principle Barriers to Education for CWDs on the High Plateau**



Physical access was cited by 39% of parents as the primary reason their child was not attending school. Most of the high plateau has no road access and journeys are undertaken on foot. Distance to school may be as much as an hour and a half walk each way. But even for shorter distances, the journey is too burdensome for most children with lower limb disabilities and therefore a principal reason for non-attendance. Very few schools have any adaptations (e.g. ramps, accessible latrines) to help children with mobility difficulties, presenting a further barrier to attendance.

Interviews with parents and teachers made it clear that very little support is given in the classroom to students with special needs. Only 25% of parents with CWDs attending school said there was any form of support for them. The kind of support mentioned was, for example, giving children with visual impairments a seat at the front of the class, ensuring CWDs are included in lessons and, in a small number of cases, waiving school fees if the parents are unable to pay. However, for most CWDs in school, teachers are not able or willing to make any adaptations to their teaching to take account of their special needs. Indeed, a lack of support in-school for children with hearing, visual, speech or mild learning difficulties was cited as the primary reason for non-attendance by 38% of parents surveyed. According to these parents, their children have either no or otherwise mild cognitive impairments, but the lack of in-classroom support or teaching adaptation prevents them from learning effectively.

20% of parents cited a lack of assistive devices as the primary reason why their child is not attending school. The two groups of devices most commonly cited were glasses and crutches/ mobility aids. These parents said that with these devices, the children would be able to participate effectively in schooling, however no clinics on the plateau offer these services.

Surveys undertaken with head teachers and community chiefs also highlighted two other interconnected barriers which play a smaller but still significant role. The first are parental attitudes which are not in the best interest of the child. For example, a small number of parents may choose to keep a child with a disability at home despite the fact that they have no cognitive barrier to learning, this may be due to a lack of understanding about disability or may be connected to the second issue, stigma. A number of respondents mentioned that disability carries a certain level of stigma for the child as well as the family and that this may cause some parents to keep their children out of the public eye.

### 4.3 Health Services and Support for CWDs

The under-equipped health clinics on the plateau are very limited in what they can provide to CWDs. A small number of survey respondents alluded to treatment for malnutrition and painkillers that their children had received in local plateau clinics. However, none of the existing health centres are equipped to provide specialist services such as provision of assistive devices (glasses, hearing aids, crutches or wheelchairs), surgery to correct deformities, physiotherapy, or any kind of psychiatric or mental health services. To receive these treatments, families have to take their children to Lemera on the mid plateau, Bukavu (e.g. Heri Kwetu centre) or Uvira (e.g. Don Bosco centre). All of these locations can take a day or more to travel to for families in isolated locations and both the travel and the treatment have considerable cost implications. A small number of families surveyed have sent their children further afield for treatment, notably Burundi and Rwanda. None of the parents surveyed said they had received NGO or government support for the treatment of their child and instead had to finance it themselves. This represents a huge financial burden for families, many of whom are extremely poor. In some cases, it has led families in to heavy levels of debt.

Despite these barriers, a quarter of the CWDs included in this survey had undergone some form of treatment or received an assistive device. Of these 18 children, 8 had attended a clinic on the plateau, 4 had been treated in Bukavu, 3 in Rwanda, 2 in Uvira and 1 in Burundi. Sadly, six of the children who had received treatment in a health centre have not shown any improvement and the parents reported that the child was either still in the same condition or worse off than before the treatment. In the case of corrective surgeries, the lack of medical follow up support and physiotherapy has in many cases reduced or even reversed the benefit of the procedure.

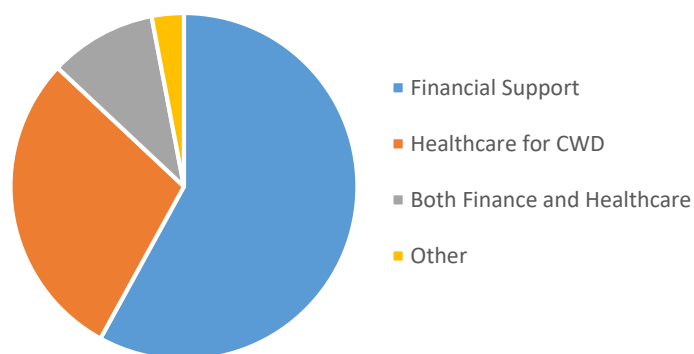
### 4.4 Economic and social impacts of disability

Interviews with the different categories of participants in this survey highlighted the many different economic and social strains that disability can place on a household. The survey revealed that the overwhelming majority (90% or more) of CWDs stay at home with their families. Some with more severe disabilities may require part time or full-time care which reduces the family's capacity for productive work and income generation. With most families already struggling to send their children to school (leading to an estimated 35% of all plateau children being out of school), this opportunity loss may mean that other children in the family miss out on an education. In addition, for the families who seek specialist medical treatment for their children, the costs can quickly mount and in some cases saddle families with unmanageable debt. In other words, having a disabled child in the family entrenches household poverty and has negative knock-on effects to other family members particularly other children.

With very little capacity or knowledge in schools to cater for specialist needs of CWDs, even those children who are lucky enough to attend school may find their ability to learn hampered by challenges

that better trained teachers and more equipped schools might be able to address. The knowledge that their child’s learning ability may be heavily compromised by inadequate facilities and resources in school appears to be an important factor behind parents’ decision to exclude or withdraw their child. A lack of educational opportunities in addition to very poor health and support services, hugely limits the life prospects of children with disabilities and condemns them, in many cases, to a life of dependency and poverty. Not only are very few CWDs able to attend school, the opportunities outside school for gaining a vocation or engaging in productive work are minimal. The result being that CWDs born in to poverty are effectively trapped in poverty with little chance for escape.

**Fig 3: Primary Needs of Families Affected by Disability According to Caregivers**



Among the parents interviewed, 58% said that their primary need was household-level financial support. A further 29% said support for healthcare for the children was most important, and 10% said both financial support and health support were needed. Teachers likewise put financial and health support for CWDs and families at the top of the priorities, but also included training for teachers, transport for children to attend school and teaching materials adapted to CWD’s needs. Local leaders and clinic staff added vocational training/ alternative livelihoods for CWDs who cannot attend school, sensitisation and training for parents on caring for their children, and more and better equipment in local clinics to address diverse needs.

## 5. Conclusion

For the majority of children with disabilities on the high plateau in South Kivu, life prospects are challenging and limited. Only a tiny minority manage to attend school, while the rest are kept out of the education system, often entrenching a dependency on their families that may last their entire lives. For the small number of children with disabilities who are able to access schools, teachers’ lack of knowledge about how to address visual, hearing or learning disabilities, means their educational experience may be highly limited. The possibility of access to treatment or assistive devices is minimal for most children, a consequence of inadequate local health/ support services and the prohibitive costs of seeking services elsewhere. Many families affected by disability are placed under serious economic strain as they lose productive labour as a result of the disability, caring responsibilities or both. Some families are burdened with crippling debt after seeking treatment for their child. In short,

disability creates bleak life prospects for plateau children and their families, with currently very little hope of breaking out of the cycle of deprivation and disadvantage.

Addressing the diverse and extensive challenges faced by CWDs and their families on the high plateau requires a holistic, multi-level intervention. Given the range of needs, and the specialist services required in some cases (e.g. in the domain of health), a holistic intervention will require collaboration between different actors (NGO and state where possible/ available) who can offer different specialisms.

Activities that could form part of a holistic intervention include the following.

**Creating a more enabling environment in education and beyond:**

- Provisioning/ equipping of schools with resources to cater for children with diverse disabilities;
- Training of teachers and school management in inclusive education and support for CWDs in the classroom;
- Child-to-child activities to support integration and empowerment of CWDs;
- Community-level sensitisation to increase awareness and tackle stigma around disability.

**Addressing the health and support needs of CWDs:**

- Medical and rehabilitative interventions and assistive devices, and helping to strengthen the capacity/ facilities of plateau clinics to address disability issues;

**Increasing the capacity and resources of care-givers:**

- Economic support for families of CWDs;
- Education/training and support for parents on care management;

**Providing non-school alternatives to CWDs:**

- Alternatives to schooling (e.g. vocational trades) for CWDs for whom formal schooling is not appropriate.

This rapid assessment has provided a valuable initial snapshot of the situation of CWDs on the high plateau. To build on this, we will undertake follow on activities in the near future in order to further inform programme design for upcoming and future programmes. These include: a comprehensive mapping of existing services and actors in South Kivu who might be able to collaborate as part of an intervention; as resources allow, a more detailed piece of research exploring in more depth the constraints faced by families affected by disability, including comprehensive engagement with children with disabilities; engagement with other actors working in the disability field in South Kivu and globally to explore avenues for collaboration, coordination and best practice sharing.

## Appendices – Case Studies

\*All names have been changed.

### Yvette\*: Hearing Impairment a Barrier to Schooling

Yvette is 17 years old. She comes from a family of eight children but sadly three of her siblings passed away. Yvette has a hearing impairment and speaks with difficulty. Otherwise she has no other functional impairment.

Yvette has never been to school. Her mother said her hearing impairment has always prevented her from attending school. She has never received any help from an NGO or health clinic. She did start a tailoring course but had to drop out because the teacher did not adapt the training for her, and she was not able to follow instructions because of her hearing problems.

Yvette helps around the house and works in the field with her mother, looking after the crops and collecting firewood. She is also good at handling money and has been helping the family out by selling soap and salt in the village.



*Yvette (centre in blue) with her mother (2nd from left) and other family members*

With the right support to compensate for her hearing loss, Yvette's mother believes she could have attended school when she was younger. Now, with the right support, she could learn a trade such as tailoring. However, the kind of support she requires is not available.

### Agathe\*: Physical Disability Caused her to Drop Out of School

Agathe is 9 years old. She has four brothers. Agathe contracted polio when she was a baby that left her with a severe deformity in her legs which makes it very difficult for her to walk. She uses a simple wooden stick but cannot travel more than short distances.



*Agathe (second from left) with her mother and three of her brothers*

Agathe attended primary school for a year but found it very difficult to travel the mile or so there and back every day, so she dropped out. Her parents scraped the money together to send her to Rwanda for surgery but unfortunately the treatment didn't work.

None of the clinics in Minembwe provide crutches, wheelchairs or other mobility devices so Agathe continues to use a stick to move herself around.

### Jolie\*: Excluded by Hearing Loss

Jolie is 16 years old and has four brothers and two sisters. She has severe hearing loss that makes it difficult for her to speak. She also has a physical impairment affecting her legs, which makes it hard for her to walk long distances.

Jolie attended primary school for two years but found it was difficult to learn because the teachers made no effort to cater for her disability. She can lip-read well but only when the speaker is face-on. Jolie and her family have never received any support from the health clinic or any NGO.

Both Jolie and her mother would have liked Jolie to attend school. But now they feel she is too old so would instead benefit from vocational training such as tailoring.



*Jolie and her mother*



### Claude, Christophe and Julie\*: Excluded by a Learning Disability

Claude, Christophe and Julie are three siblings from the same family which has seven children in total. All three children suffer from a learning disability. Of the three, Claude (22) is the only one who attends school. He is currently in the 4<sup>th</sup> year of a local primary school. According to his mother, the teachers do not really adapt their teaching to support him.

Christophe (18) and his sister Julie (20) do not attend school. They are both hearing impaired. Julie can speak but Christophe finds it difficult to be understood. Christophe also suffers from a physical disability that makes it hard for him to walk long distances.

Their mother believes that with the right support, Christophe and Julie could also attend school, but that kind of support is not available in any of the schools in the area.



*From Left to Right: Julie, Christophe and Claude with their mother*

## References

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