2. FROM THE COLONIAL ERA TO THE PRESENT DEMOGRAPHY OF ZAIRE

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1. Definition of demography and sources of data

Demography is the quantitative and qualitative study of populations. A young science at the crossroads of several disciplines (sociology, economics, medicine, history, etc.), it covers both the static and the dynamic aspects of populations. It thus studies a group of individuals forming a whole, and their breakdown at a given moment according to a selected number of characteristics. For instance, it studies population structure with respect to age, sex, marital status, regional distribution, etc. This is static demography. The dynamic description consists of analysing a whole series of phenomena likely to change the volume and structure of a population. Demography is thus concerned with birth, fertility and marriage rates, death rates, and migration.

A distinction is generally made between demography in its strict and in its broad sense. The first is confined to analysing the importance of the three phenomena mentioned above and their temporal patterns, while demography in its broad sense tries to go beyond simply measuring such phenomena and to explain them, by studying determinants and causes.

This branch of science is interesting for several reasons. First of all, it not only provides economic, social, and health planners with the statistics needed for their work, but also gives them information on a number of facts such as unemployment rates, the size of the labour force, active life expectancy, literacy rates, mortality for specific causes, and the incidence and prevalence of diseases. It also provides policy-makers with an indispensable tool (demographic forecasts) for drawing up good social, demographic, and other policies.

Having said this, we shall now briefly review the sources of population data in Zaire.

Zaire, like most of the countries of Black Africa, does not have a long-standing tradition of record-keeping. The statistical bases of demographic analysis were laid only recently, beginning in the early twenties when an “administrative census” was instituted.

2. Demography of Zaire from 1887 to the present

Data collection was carried out in four distinct phases:

- the first phase extends from the start of colonization until 1920,
- the second from 1920 to 1945;
- and the third from 1945 to independence (1960);
- the fourth phase began in 1967, date of the first postcolonial data collection operation.

Since 1967 the number of population sample surveys has increased. Two censuses were also taken – the first in 1970 and the second in 1984.

All these operations increasingly clarified the puzzle of Zairean demography. However, the quality of their contributions varied over the years, according to the nature and aim of the study (for details, see: Romaniuk, 1959 and 1967; Ngondo and Pitshandang 1974; Sala-Diakanda, 1980; Latutala Mumpasi, 1982). They ranged from mediocre for information on marital status (especially in rural areas), index card censuses (used until the mid-fifties), and random sampling techniques (insufficient statistical bases, lack of representativeness), to good for population sample surveys as a whole.

2.1. Demographic situation from 1887 to 1920

It is difficult to sketch a demographic picture of the Belgian Congo (present-day Zaire) at the time of H. M. Stanley’s explorations. A. Romaniuk writes, “The accounts left to posterity by the first explorers, administrators and missionaries are not sufficient to give a realistic picture of the demographic situation in the country at the time” (Romaniuk, 1967, p.130). However, we think that Zaire during this period was characterized by a primitive demographic pattern, with high birth and death rates.

The high birth rate could be explained by the desire to ensure the survival of the group, gain power, gain social prestige, and maintain a large work force (Caldwell, 1980, pp. 7-8). The high death rate would reflect the effects of natural regulation or Savvy’s famous triad: epidemics-famine-war. When the first whites arrived, several areas of the Congo were affected by sleeping sickness, malaria, and a host of other parasitic and infectious diseases. Famine was severe in various areas, especially towards Kwilu-Kwango, while tribal warfare continued to rage. It should be noted that such wars took as heavy a toll as slavery (Romaniuk, 1967, p.133). The result was a low rate of natural increase.

The importance of migration during this period was minimal. The Zaireans were very attached to the land and, except in some cases of family or clan disputes, almost never left their villages to settle elsewhere. The population of the country was probably almost stationary.
Map 4 – Population density in Zaire
(from Romaniuk, 1967)
2.2. Demographic situation from 1920 to 1945

Despite the start of constant record-keeping of the population and data collection in standard settlements, knowledge of population trends did not really improve. Still, a few pinpoint studies can give us a slight idea of the native population. These include the censuses conducted by FOREAMI (Fonds Reine Elisabeth pour l'Assistance Médicale aux Indigènes) in Bas-Congo (1930-1936) and Kwango (1936-1958).

2.2.1. Population size

According to Romaniuk (1959, p. 567), the Belgian Congo had about 9,500,000 inhabitants around 1920-1925 and 10,400,000 by 1940, an overall annual increase rate of 0.6%. These figures, however, mask the regional differences which characterize the country.

Areas where population growth was low alternated with those where it was high. It seems reasonable to come to the conclusion that the rates of annual increase in Eastern Province (today's Haut-Zaïre or Upper Zaïre Region) and Equator Province, two areas whose populations were falling off at this time (see: Schwers, 1945; Ledent, 1944; Paradis, 1947), were below the national average of 0.6%, while Leopoldville Province (currently three regions: Metropolitain Kinshasa, Bandundu Region, and Bas-Zaïre or Lower Zaïre Region), Kivu Province, and Katanga Province (Shaba) had increase rates above the national average (Romaniuk, 1959, p. 595). For example, the rate of annual increase in Kivu Province, excluding Maniema, between 1920 and 1950 may have been 2% (Carael et al., 1979, p. 8).

The population density was very low. It was about 4 inhabitants per square kilometer in 1925, (Romaniuk 1959) and had hardly changed by 1940, as it was 4.4 per sq. km. The Congo thus seems to have been slightly underpopulated at this time. It should be remembered that population density with respect to total surface area gives only a rough idea of the population's spatial distribution, and that the most appropriate measure is that based on population density per unit of arable land. However, there were great regional variations.

Population density in 1948 as seen in Map 4 (from Romaniuk, 1967) shows that the central basin, the north, and the southeast were underpopulated. Their population densities were generally below the national average of 4 inhabitants per sq. km. They were bordered by two large and quite densely populated areas. The first was a belt extending from the border with Cabinda to Kabinda in Kasai Province, the second covered the interlacustrine areas of the west from the border with Burundi to that with Southern Sudan. As the rural population makes up more than 80% of the total population, this map matches up most probably with that of the total population. There has been however a smoothing-out of the regional differences.

2.2.2. Birth rate

According to the demographic literature of the time, this period was characterized by a steadily decreasing population in the Congo. The crude birth rate (CBR: birth rate over a given period, as a proportion of the mid-period population figure) is said to have dropped from 42% to 31-33% around 1937. A possible explanation for this is that the colonization of the country triggered the disintegration of social cohesion and native social structures and psychic trauma, leading to loss of joie de vivre. This explanation was part of what was called at the time le choc des civilisations (cultural shock). To this hypothesis one must add the harmful effects of slavery on the Congolese before the advent of the European colonists.

Table 1:

<table>
<thead>
<tr>
<th>Year</th>
<th>CBR (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927</td>
<td>(42)</td>
</tr>
<tr>
<td>1931</td>
<td>31</td>
</tr>
<tr>
<td>1935</td>
<td>29</td>
</tr>
<tr>
<td>1937</td>
<td>33</td>
</tr>
</tbody>
</table>

(Rates based on the findings recorded by A. Romaniuk, 1967)

The figures given in table 1 are not entirely comparable. 42 in parentheses refers to one part of the population – which was apparently very prolific – while the remaining statistics are thought to be highly underestimated (see Romaniuk, 1967, p. 137). There are thus grounds for supposing that this period was characterized by a stable birth rate while birth rates declined only in certain distinct groups (MONGO and related groups, Azande and related groups, Ngombe, etc.). This can be seen clearly in Table 2 (on p. 20), which gives the geographic distribution of birth rates in the Congo 1935-1937.

According to the theory of demographic transition, Congo (Zaire) was still at that time at an early stage of development, with a stable birth rate, high mortality and low population growth.

19
**Table 2:**

<table>
<thead>
<tr>
<th>DISTRICTS AND PROVINCES</th>
<th>CBR (% 1935-37)</th>
<th>CMR (% 1955-57)</th>
<th>IMR (%)</th>
<th>TFR</th>
<th>Life Expectancy (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leopoldville</td>
<td>53.5</td>
<td>11.6</td>
<td>78</td>
<td>7.51</td>
<td>57.0</td>
</tr>
<tr>
<td>Leopold II Lake (Tumba Lake)</td>
<td>45.9</td>
<td>31.4</td>
<td>20.5</td>
<td>142</td>
<td>6.13</td>
</tr>
<tr>
<td>Kwili</td>
<td>47.6</td>
<td>42.7</td>
<td>26.2</td>
<td>178</td>
<td>6.27</td>
</tr>
<tr>
<td>Kwango</td>
<td>53.8</td>
<td>32.3</td>
<td>212</td>
<td>7.90</td>
<td>32.5</td>
</tr>
<tr>
<td>Bas-Congo</td>
<td>47.8</td>
<td>40.5</td>
<td>26.1</td>
<td>175</td>
<td>6.39</td>
</tr>
<tr>
<td>Cataracts</td>
<td>50.2</td>
<td>25.9</td>
<td>174</td>
<td>8.04</td>
<td>37.8</td>
</tr>
<tr>
<td>LEOPOLDVILLE PROVINCE</td>
<td>49.0</td>
<td>37.4</td>
<td>24.8</td>
<td>164</td>
<td>6.74</td>
</tr>
<tr>
<td>Equator</td>
<td>32.5</td>
<td>17.9</td>
<td>11.0</td>
<td>4.20</td>
<td>49.5</td>
</tr>
<tr>
<td>Tshuapa</td>
<td>28.6</td>
<td>24.9</td>
<td>167</td>
<td>5.64</td>
<td>39.0</td>
</tr>
<tr>
<td>Mongala</td>
<td>42.6</td>
<td>35.5</td>
<td>19.3</td>
<td>166</td>
<td>6.09</td>
</tr>
<tr>
<td>Ubangi</td>
<td>45.9</td>
<td>25.5</td>
<td>174</td>
<td>3.69</td>
<td>37.8</td>
</tr>
<tr>
<td>EQUATOR PROVINCE</td>
<td>38.8</td>
<td>28.1</td>
<td>23.1</td>
<td>168</td>
<td>5.03</td>
</tr>
<tr>
<td>Stanleyville</td>
<td>35.3</td>
<td>29.9</td>
<td>21.2</td>
<td>144</td>
<td>4.32</td>
</tr>
<tr>
<td>Ituri</td>
<td>44.1</td>
<td>34.8</td>
<td>27.8</td>
<td>173</td>
<td>2.88</td>
</tr>
<tr>
<td>Bas-Uele</td>
<td>21.4</td>
<td>24.4</td>
<td>24.1</td>
<td>153</td>
<td>3.19</td>
</tr>
<tr>
<td>Haut-Uele</td>
<td>24.7</td>
<td>30.7</td>
<td>23.6</td>
<td>157</td>
<td>4.04</td>
</tr>
<tr>
<td>EASTERN PROVINCE</td>
<td>32.2</td>
<td>30.7</td>
<td>23.6</td>
<td>157</td>
<td>4.04</td>
</tr>
<tr>
<td>South-Kivu</td>
<td>60.4</td>
<td>44.7</td>
<td>38.3</td>
<td>230</td>
<td>8.49</td>
</tr>
<tr>
<td>North-Kivu</td>
<td>57.9</td>
<td>27.0</td>
<td>173</td>
<td>8.02</td>
<td>38.0</td>
</tr>
<tr>
<td>Maniema</td>
<td>37.2</td>
<td>28.0</td>
<td>26.0</td>
<td>178</td>
<td>4.51</td>
</tr>
<tr>
<td>KIVU PROVINCE</td>
<td>53.4</td>
<td>38.6</td>
<td>29.7</td>
<td>197</td>
<td>7.13</td>
</tr>
<tr>
<td>Elisabethville</td>
<td>58.7</td>
<td>15.9</td>
<td>104</td>
<td>8.32</td>
<td>50.8</td>
</tr>
<tr>
<td>Tanganyika</td>
<td>50.9</td>
<td>28.8</td>
<td>20.8</td>
<td>138</td>
<td>6.72</td>
</tr>
<tr>
<td>Lualaba</td>
<td>47.8</td>
<td>29.0</td>
<td>18.6</td>
<td>127</td>
<td>6.13</td>
</tr>
<tr>
<td>Haut-Lomami</td>
<td>48.3</td>
<td>26.4</td>
<td>179</td>
<td>6.39</td>
<td>37.0</td>
</tr>
<tr>
<td>Luapula-Moero</td>
<td>58.0</td>
<td>36.8</td>
<td>23.3</td>
<td>146</td>
<td>8.31</td>
</tr>
<tr>
<td>KATANGA PROVINCE</td>
<td>51.9</td>
<td>31.5</td>
<td>21.8</td>
<td>146</td>
<td>8.20</td>
</tr>
<tr>
<td>Lulua</td>
<td>48.5</td>
<td>34.1</td>
<td>232</td>
<td>6.33</td>
<td>30.8</td>
</tr>
<tr>
<td>Sankuru</td>
<td>41.7</td>
<td>25.4</td>
<td>24.3</td>
<td>166</td>
<td>5.20</td>
</tr>
<tr>
<td>Kabinda</td>
<td>48.3</td>
<td>24.1</td>
<td>164</td>
<td>6.29</td>
<td>39.3</td>
</tr>
<tr>
<td>Kasai</td>
<td>49.1</td>
<td>33.3</td>
<td>37.0</td>
<td>250</td>
<td>6.50</td>
</tr>
<tr>
<td>KASAI PROVINCE</td>
<td>45.2</td>
<td>31.3</td>
<td>30.0</td>
<td>204</td>
<td>5.87</td>
</tr>
<tr>
<td>CONGO</td>
<td>45.2</td>
<td>31.1</td>
<td>25.5</td>
<td>173</td>
<td>5.91</td>
</tr>
</tbody>
</table>

Although the birth rates given in Table 2 are most probably underestimated, they enable us to locate, even approximately, areas where birth rates are low compared with the country as a whole. Thus, Equator and Eastern Provinces appeared to be the least prolific of the provinces, while Leopoldville and Kivu Provinces showed the most vitality. At district level, Equateur, Tshuapa, Bas-Uele, Haut-Uele, and Maniema Districts experienced the worst situations, while the best were reported for Kwili, Bas-Congo – Cataracts, and North and South Kivu Districts. These observations were confirmed by a regional sterility study of Congolese women (discussed on p. 27). However these conclusions should be accepted with great reservation, for it would have been more reliable to standardize these crude birth rates to eliminate structure effects and thus make a valid comparison.

### 2.2.3. Death rate

There are no reliable data for this period that might allow us to determine death rates in the Congo. However, the crude mortality rate (CMR) can be estimated, given an overall rate of annual increase of 0.6% and a birth rate of about 35%. If we assume that migration did not contribute at all to the overall population increase, the latter was equivalent to the rate of natural increase (RNI), giving a crude mortality rate (CBR – RNI) of approximately 30%. As an example, we might point to the crude mortality rates of 28.8% and 34.8% recorded by FOREAM in the medical sectors of (respectively) Bas-Congo Province in 1936 and Kwango in 1938 (FOREAM, Annual report, 1936 and Activity report by P. De Brauwere, FOREAM, 1947).
One might hypothesize very high infant mortality rates (IMR) of approximately 300-350%. Indeed, according to Governor P. Ryckmans (1933), the IMR for the Congo was 330% around 1930, which seems a fair reflection of the situation at the time. We can also cite Janssens’ study of infant mortality in the Kilo mines between 1937 and 1945, in which the calculated IMRs ranged from 400% in 1937 to 288% in 1943 (Romaniuk, 1967; Janssens, 1950).

2.2.4. Migrations

Migratory movements in the Congo during this period were closely linked to the moves of the colonial power to industrialize and exploit the country. At the very dawn of the colonial period Belgium began by setting up dozens of industries with a view to mining the country’s soil and underground resources. These included the Union Minière du Haut-Katanga (UMHK) and Forminière, both founded in 1906, the Société des Mines d’or de Kilo-Moto, founded in 1905, which is now the Office of the Mines of Kilo-Moto, the textile mills set up in Kinshasa after 1924, the Lukala Cement Plant (1920) and the Colonial Transportation Office (Office des Transports Coloniaux; OTRACO, 1929).

The colonial government, anxious to meet the manpower needs of the fledgling industries and to create a strong army to keep order in the colony, organized the recruitment of able-bodied adult males. A maximum of 25% of the able-bodied adult males were allowed to leave their villages in order to work for the Europeans (Romaniuk, 1967, p. 160; Fetter, 1973, p. 15). The Christian missions also took advantage of this to recruit catechists and porters. Two of the consequences of these actions were to depopulate various rural areas and to bring about long-distance migration.

The trust authorities also transplanted population groups, especially Rwandese, in order to reduce congestion in overpopulated areas and to develop underpopulated ones. Finally the attraction of the cities, which were for the most part created by the colonists, must also be taken into account. This marked the start of the rural exodus.

The movement was strengthened by a system set up by Belgium that made peasant life increasingly difficult, namely, one based on land expropriations, imposed crops, and taxation payable in cash rather than kind. With regard to this, Merlier asserts that “in the Congo, the rural exodus is explained not by the slow differentiation of the peasants and worsening social conflicts in rural areas of the country, but by extraordinary colonial oppression, which caused millions of peasants to flee to the cities over half a century” (1962, p. 149).

The number of inhabitants in areas outside the jurisdiction of customary law rose from some tens of thousands on the eve of the First World War to 1 million in 1940 (figures given by Romaniuk, 1967, p. 15). The population of Leopoldville’s native quarter (Cité indigène), according to Table 3, doubled between 1926 (22,506 inhabitants) and 1940 (46,884 inhabitants) and then again increased between 1940 and 1945 from 46,884 inhabitants to 96,116 inhabitants.

Table 3:

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1926</td>
<td>22,506</td>
</tr>
<tr>
<td>1930</td>
<td>31,380</td>
</tr>
<tr>
<td>1935</td>
<td>26,622</td>
</tr>
<tr>
<td>1940</td>
<td>46,884</td>
</tr>
<tr>
<td>1942</td>
<td>67,198</td>
</tr>
<tr>
<td>1944</td>
<td>78,814</td>
</tr>
<tr>
<td>1945</td>
<td>96,116</td>
</tr>
</tbody>
</table>

Source: L. Baeck (1956).

During this period the growth of the urban population reflected the world economic picture. “Each important economic crisis slowed their (the cities’) expansion and even caused part of the labour force to return to the countryside, whereas during periods of high commodity prices, economic growth, and conflicts, the job market expanded quickly” (Merlier, 1962, p. 196). This phenomenon is illustrated rather well by the example of Leopoldville, where the steady decline in population from 1929 to 1935 (negative overall annual increase of –6.8%) and rapid growth between 1940 and 1945 (with an overall annual increase rate of 15%) correlate with the Depression of 1929 and the Second World War respectively.

2.3. Demographic situation from 1945 to 1960

To date, this is the best period as far as knowledge of demographic patterns in the country is concerned. The quality of population records improved. Censuses covered a large part of the population, while the percentage of the population included in Registry Office’s records rose steadily, to peak at 95.7% in 1958. Nevertheless, the number of registered deaths
was far from reality (50%), while close to 80% of all births were entered (see A. Romanuik, 1968, pp. 248-251). Aside from these two sources, one may also refer to an excellent demographic sample survey carried out between 1955 and 1957.

2.3.1. Population size

This period was characterized by a considerable increase in the Congolese population, which rose from 10,400,000 in 1940 to 13,175,000 in 1957, or an annual growth rate of 1.4%. This was largely due to the combination of a high birth rate and a declining mortality rate.

Leopoldville (Kinshasa) led the provinces in 1955-1957 with 24% of the entire population. It was followed by Eastern Province (18%), Kasai Province (17%), and Kivu Province (16%). Equator and Katanga brought up the rear with 14% and 12% respectively.

The population density did not change much. It was 5.5 per sq. km in 1955 as against 4.4 in 1940. Nor did its spatial distribution vary to a great extent (see Map 4 on p. 18). This map shows the same pattern of densely and sparsely populated areas as in 1948.

2.3.2. Birth rate

Thanks to the 1955-1957 demographic sample survey, this parameter can be measured quite accurately. In addition, there are some fairly reliable statistics on female sterility for this period.

The survey revealed that the Congo’s CBR between 1955 and 1957 was 45.2‰. This was close to Burundi’s CBR (46‰ in 1953-1957) and lower than Rwanda’s (50‰ in 1955-1957; figures from Coale and Lorimer, 1968, p.268; see table).

Table 4:

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Percentage of Childless Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONGALA (1)</td>
<td></td>
</tr>
<tr>
<td>Banga</td>
<td>26.6</td>
</tr>
<tr>
<td>Ngbandi</td>
<td>20.2</td>
</tr>
<tr>
<td>Ngombe</td>
<td>20.4</td>
</tr>
<tr>
<td>Mongo</td>
<td>31.4</td>
</tr>
<tr>
<td>EQUATOR (1)</td>
<td></td>
</tr>
<tr>
<td>Ngombe</td>
<td>23.0</td>
</tr>
<tr>
<td>Nkundo</td>
<td>33.2</td>
</tr>
<tr>
<td>Mongo</td>
<td>33.7</td>
</tr>
<tr>
<td>Niomba</td>
<td>27.7</td>
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<tr>
<td>STANLEYVILLE (2)</td>
<td></td>
</tr>
<tr>
<td>Babati</td>
<td>26.4</td>
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<td>Bakuma</td>
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<td>HAUT-UELE (2)</td>
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<td>Balika</td>
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<td>Bayoyo</td>
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</tr>
<tr>
<td>Loge</td>
<td>22.3</td>
</tr>
<tr>
<td>Maboko</td>
<td>24.9</td>
</tr>
<tr>
<td>Manvu</td>
<td>43.6</td>
</tr>
<tr>
<td>Mangbetu</td>
<td>28.5</td>
</tr>
<tr>
<td>Medge</td>
<td>32.3</td>
</tr>
</tbody>
</table>

Sources: (1) A. Romanuik (1967)  
(2) Th. Verheest (1978)

* Women over 55 years of age

The geographical distribution remained the same as for the preceding period. The CBRS for Equator and Eastern Provinces were below the national average, despite possible rises in their birth rates. Kivu (53.4‰), Katanga (51.9‰), and Leopoldville (49.0‰) Provinces had the highest CBR. This is confirmed by examination of the total fertility rates (Table 3).

2.3.3. Infertility

The differences revealed are largely due to high infertility in certain districts and, as one might expect, to differences in age structures (this is especially true for the CBR). The proportion of childless women of age to procreate ranged from 17.97% in Kwango
District to 45.82% in Bas-Uele District. Definitive sterility – in women 55 years of age and older – ranged from 4.66% in Kwango District to 34.27% or 7.4 times higher – in Maniema District.

For the most part, the ethnic groups from Equator, Mongala, Stanleyville, Haut- and Bas-Uele, and Maniema Districts were affected most by this problem (see Table 4). The Manvus of Haut-Uele held the record for definitive female sterility with 43.6%. The phenomenon had many causes, including contraceptive methods, abortions and venereal diseases, whose spread was facilitated by loose sexual behavior (for more information on this subject see Retel-Laurentin, 1974 and 1978; Romaniuk, 1963).

In terms of residential areas, in 1955-1957 city dwellers showed the highest crude birth rate: 55%, as against 51% for mixed areas and 43% in rural areas. The same pattern is seen for the combined fertility index (6.1 children per adult female in towns compared with 5.3 in mixed areas and 4.8 in rural areas). These differences are explained by a number of factors, of which Romaniuk mentions four:

1) the implementation of a family allowance system for wage-earning workers;
2) mass construction of urban housing;
3) the increasing number of maternity centers;
4) intensified efforts to control venereal diseases and a decline in their contagiousness (1967, p. 177).

All this was done to improve urban living conditions, at the expense of the countryside.

2.3.4. General and infant mortality rate and life expectancy

As mortality statistics were not very complete, it is difficult to quantify this phenomenon. Still, Romaniuk was able to calculate some interesting indices (see Table 2 p. 20) on the basis of selected indirect estimation techniques (standard mortality tables, Brass’s method based on child survival rates).

It thus appears that the Congo had a CMR of 25.5% in 1955-1957 and a life expectancy at birth of 38 years. Infant mortality at the time was 173%. The value of regional comparisons is questionable, because a number of outside factors may have been responsible for any detectable differences. We shall look at population structure by age and the extent to which deaths were registered. The inhabitants of Kivu Province, for example, were reluctant to report deaths to the administration (Romaniuk, 1959, p. 590), resulting in underestimation of the mortality rate. Another factor is that the towns and cities had younger populations than the average village, so that their CMRs tended to be lower. Thus the figures would be twisted in favor of highly urbanized districts such as Leopoldville (Kinshasa) and Elisabethville (Lubumbashi), if the basis of comparison were the CMR alone.

Table 3 shows the best situation to be in Katanga Province, with a life expectancy of 42.5 years and IMR (infant mortality rate) of 146‰, followed by Eastern and Equator Provinces. Kivu and Kasai Provinces were the worst off, with life expectancies of 34.6 and 33.8 years and IMR of 197 and 204‰, respectively. Katanga apparently benefited from better social, economic, and health and sanitation policies than the other provinces. The district with the best statistics was Leopoldville, with a life expectancy of 57 years and IMR of 78‰. This IMR seems to fall short of reality for there is no reason why health conditions in Leopoldville (Kinshasa) should have been far better than those in Elisabethville (Lubumbashi). According to Baecck (1956) the IMR in the capital was 140 ‰ in 1955. Now, as the IMR in cities was probably lower than in rural areas, we do not understand how a rural district’s IMR could be lower than that of a city. We thus believe that an IMR in the order of 100-120 ‰ in 1955-1957 would be closer to reality than one of 78 ‰.

In terms of environment, the highest life expectancy at birth was recorded for towns and cities (49.8 years in 1955-1957). Mixed areas were next with 42.8 years, and rural populations third with 34.5 years.

2.3.5. Migrations

1945-1960 was a period characterized by an increase in migratory movements, especially over long distances and towards the towns. Leopoldville, for example, received 48,734 immigrants from the western Congo between 1951 and 1955. This influx consisted of inhabitants from Cataracts District (23,721 immigrants), Kwango (10,212 immigrants), and Kwilu (7,985 immigrants). By immigrant we mean a person foreign to the area whose stay in Leopoldville town varies from one to five years (see: Enquêtes Démographiques, Cité Indigène de Léopoldville, Fascicule A, September 1957, cited by Lututala, 1982, p. 18).

A consequence of this mass exodus and the development of means of transportation and internal exchanges was that small towns began springing up, most of them serving as stopping points between the bush and the city (Merrier, 1962, p. 145). Table 5 illustrates this phenomenon in Cataracts District fairly well.
As table 5 shows, the larger cities went on growing at the expense of the smaller. Figures for Leopoldville show an overall increase. Kasangula, about 60 km from Leopoldville, experienced a net inflow, attracting residents from Madimba, Thysville, and Luozi. Thysville attracted populations only from its neighbors Madimba and Luozi, so that its inflows and outflows cancelled each other out. Madimba’s situation was better only than Luozi’s; it tended to have a net outflow of population. Finally, Luozi, the least urbanized of the territories, lost inhabitants to all of the others and received none in return.

During this same period (1945-1960) the urban population rose sharply, especially between 1950 and 1955, moving from 14.8% in 1945 to 23.7% (2.8 million inhabitants) in 1955. Several cities doubled or tripled, such as Elisabethville, Matadi, Coquilhatville, and Stanleyville (Merlier, 1962, p. 146). See also the final remarks pp. 31-32.

2.4. Demographic situation of Zaire from 1960 to the present

The study of population statistics for Zaire after its independence may be divided into two main periods. The first was from 1960 to 1967, and was characterized by a sharp break in the collection and quality of population statistics. The second began in 1967, with the organization of a socio-demographic survey of Kinshasa, and has continued uninterrupted until today. It is characterized by a clear improvement in the quality and number of operations to collect population statistics, as compared with the first period. Fifteen data collections on population statistics were carried out in Zaire between 1967 and 1985.

Interestingly enough, the major reason for the deterioration in the quality and continuity of demographic data-gathering between 1960 and 1967 was essentially political. Indeed, “...the Registry Office records and the permanent files met with a variable fate after the disturbances in the regional situation. The division of the country into a multitude of small provinces, followed by their recombination in stages to form a smaller number of provinces, was cause for habitual transfers of documents, leading to deterioration and losses. Unrest and rebellions had a similar effect, even resulting, in some places, in the complete disappearance of the documentation” (Boute, 1970).

These troubles were so detrimental to the collection of population statistics that it is very difficult today to determine the exact demographic trends between 1960 and 1967.

The period after 1967, on the other hand, benefited from the calm brought by the new political regime, established in 1965, which was able to set the administrative wheels in motion once more and consequently resume collecting data.

Before going on to look at the demographic trends, it seems appropriate to point out that various administrative changes took place after the country gained its independence. Indeed, just as the Democratic Republic of the Congo became the Republic of Zaire in 1967, administrative terms and territorial subdivisions likewise changed considerably. The former Province of Leopoldville gave rise to three new Regions (formerly provinces), namely Bas-Zaïre (Lower Zaïre), encompassing the subregions (former districts) of Bas-Fleuve (former Bas-Congo) and Cataracts; Bandundu, consisting of the subregions of Kwilu, Kwango, and Mai-Ndombe (ex-Leopold II Lake); and Metropolitain Kinshasa (the former metropolitan area of Leopoldville plus such suburbs as Malaka, N’sele, Kimwenza, etc., which formerly belonged to Cataracts District). Kasai Province was split into two new regions, Kasai Occidental (Western Kasai), consisting of Lulua and Kasai subregions; with Kasai Oriental (Eastern Kasai), consisting of Kabinda and Sankuru subregions. The boundaries of the other regions – Équateur, Haut-Zaïre (formerly Eastern Province)
and Shaba (formerly Katanga Province) — remained the same, and the former district capitals became urban subregions. The term territory or commune (for urban centers) was replaced by zone. The towns of Stanleyville, Elisabethville, Coquilhatville, Lu­lun­bourg, and Baningville were renamed Kisangani, Lubumbashi, Nbandaka, Kananga and Bandundu respectively.

2.4.1. Population size and average annual increase

The total population reportedly increased from 13,984,170 inhabitants in 1959 (Service des Affaires Indigènes et de la Main-d’Œuvre, AIMO: Department of the Administration for Native Affairs and Labour) to 29,671,407 in 1984 (1984 Census), which corresponds to an annual increase of 31.0 % (Table 6 below).

The choice of such a long period (25 years) is justified by the fact that the population figure given by the 1970 census, that is 21,637, 876, seems very strange to us. If we calculate the mean rate of annual increase between 1959 and 1970 we get the figure of 40.5 %, which, as Boute asserts, “exceeds all of the known rates in Africa and the world. The countries with populations of more than 10 million having the highest rates at the same period were Mexico, the Philippines, and Venezuela, with growth rates at this time in the neighborhood of 35 %” (Boute, 1973, p. 5).

The Planning Department forecast that the total population would be 22,582,230 in 1975, 26,377,260 in 1980, and 29,992,348 in 1984 (Saint-Moulin, 1980). The last figure, which is off by only 1% compared with the last census figures, confirms the hypotheses underlying the Department’s demographic forecasts. We can thus calculate that the average rates of annual increase were 31.6% for 1975-1980 and 32.6% for 1980-1985.

The rate of natural increase (RNI) showed a relatively large increase between 1955-1957 (20.1%) and 1975-1977 (26.6%).

In our opinion, the gains in natural increase seen in Zaire were due mainly to a decline in general mortality combined with a continued high birth rate. The crude death rate for Zaire, which had been estimated at 25.5% in 1955-1957 (Romainiu, 1968), was only 17.2% in 1975-1977 (UN estimate, 1985). This was a decline of 8.3 deaths per thousand, or an increase in life expectancy of 10.1 years over two decades: 38 years in 1955-1957 (Romainiu, 1968), versus 48.1 years in 1975-1977 (UN, 1985). Readers are reminded that these estimates are approximations only, to be interpreted with reservation.

The fertility indices shown in Table 7 on p. 26 reveal that the fertility rate remained practically unchanged at a relatively high level.

Still, Zaire’s rate of natural increase in 1975-1977 was lower than that of the African continent as a whole (28.2% according to the UN Population Debate, Vol. 1, p. 192), and to that of Rwanda (33.0%), the Sudan (27.0%), Zambia (31.9%), and Tanzania (34.1%). It was, however, higher than those of Burundi (25.3%) and the Congo-Brazzaville (24.6%). The rates of natural increases are calculated by using crude birth and death rates of UN Demographic Yearbook, 1985, pp. 289-283.

As for the regions, thorough examination of the figures in Table 6 show that Kinshasa led the pack with 78%, more than twice the rate of natural increase in Eastern Kasai, which came second (Pain, 1984). This high growth rate was due largely to the considerable

<table>
<thead>
<tr>
<th>Region</th>
<th>Cens. 1959</th>
<th>Cens. 1984</th>
<th>Increase % 1959-84</th>
<th>Surface Km²</th>
<th>Density in 1959</th>
<th>Density in 1984</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinshasa</td>
<td>403,310</td>
<td>2,653,558</td>
<td>78</td>
<td>2,016</td>
<td>200.1</td>
<td>1,289.5</td>
</tr>
<tr>
<td>Bas-Zaire</td>
<td>979,268</td>
<td>1,971,520</td>
<td>28</td>
<td>61,869</td>
<td>5.5</td>
<td>32.7</td>
</tr>
<tr>
<td>Bandundu</td>
<td>1,954,291</td>
<td>3,582,845</td>
<td>26</td>
<td>295,658</td>
<td>4.6</td>
<td>8.4</td>
</tr>
<tr>
<td>Equator</td>
<td>1,843,523</td>
<td>3,405,512</td>
<td>25</td>
<td>403,293</td>
<td>4.6</td>
<td>8.4</td>
</tr>
<tr>
<td>Haut-Zaire</td>
<td>2,523,392</td>
<td>4,206,069</td>
<td>21</td>
<td>503,239</td>
<td>5.0</td>
<td>8.4</td>
</tr>
<tr>
<td>Kivu</td>
<td>2,344,378</td>
<td>5,187,865</td>
<td>32</td>
<td>256,662</td>
<td>9.1</td>
<td>20.2</td>
</tr>
<tr>
<td>Shaba</td>
<td>1,743,733</td>
<td>3,874,019</td>
<td>32</td>
<td>496,965</td>
<td>3.5</td>
<td>7.8</td>
</tr>
<tr>
<td>Eastern Kasai</td>
<td>943,374</td>
<td>2,402,603</td>
<td>38</td>
<td>168,216</td>
<td>5.6</td>
<td>14.3</td>
</tr>
<tr>
<td>Western Kasai</td>
<td>1,246,901</td>
<td>2,287,416</td>
<td>25</td>
<td>156,967</td>
<td>7.9</td>
<td>14.6</td>
</tr>
<tr>
<td>Rep. of Zaire</td>
<td>13,984,170</td>
<td>29,671,407</td>
<td>31</td>
<td>2,344,885</td>
<td>6.0</td>
<td>12.7</td>
</tr>
</tbody>
</table>

Sources: 1959: Department of the Administration of Native Affairs and Labour
1984: INS (National Institute of Statistics)
Census 1984 preliminary results 1985, Kinshasa.
influx of immigrants into the Kinshasa Region (for more details see Migration at 2.4.5.).

As for the spatial distribution of population density, Table 6 shows that the population density increased significantly between 1959 and 1984 in all nine regions of the country. In Kinshasa city it increased phenomenally – six hundredfold – between 1959 and 1984. Densities in the other regions of the country also practically doubled in the space of 25 years. The effects of natural movement, especially declining mortality rates, were instrumental.

Map 4, p. 18, however, shows that the two main axes of high density remained practically the same. The first linked the mouth of the Zaire River to Kabinda, in Kasai subregion; and the second stretched in a belt from Aru to Uvira. Still, by 1970 two new secondary axes of high population density had emerged; one between Gemena and Kisangani and the second between Zongo and Aru.

This network of high-density areas fits very closely to the three main axes of the country’s current urban network (see Iba Ngambong, 1976, pp. 8-9). This convergence of the high-density and urban networks probably originated in precolonial Zaire (Saint-Moulin, 1974, p. 141), contrary to the claims of a number of other authors, such as Denis (1956, pp. 80-87), who attributed the emergence of the Zairean urban network to the colonial period.

2.4.2. Birth rate

Now let us look at the demographic phenomena likely to explain the growth and density of Zaire’s population.

In order to study the birth rate trend in Zaire, we use in addition to the CBR, the general fertility rate (GFR), the total fertility rate (TFR), the proportion of women 25-34 years of age who have never procreated and the infertility (definitive sterility) pertaining to women 55 years of age and older.

The GFR is the ratio of births over the number of women of childbearing age.

The CBR, which is a rough index of the birth rate, should be used with caution, because it is very sensitive to the effects of the structure of the population by age. The probability of dying between 0 and 5 years must also be taken into account.

Our analysis of the trends in fertility rates at the regional level will include only the following subregions, investigated by EDOZA (1977) in 1975-1976: Bas-Fleuve, Cataracts, Kwango, Kwilu, Mai-Ndombe, Kasai, Lualua, Equator, and Tshuapa, or a total of four regions, namely Bas-Zaïre, Bandundu, Equator, and Western Kasai.

All of the indices needed to study changes in fertility rates in Western Zaire as well as the entire country are given in Table 7.

Up to 1955-1957, both the fertility rate and the number of barren women aged 25-34 years in Zaire were high (A. Romaniuk 1967 and 1968). Table 7 shows that the country’s CBR fell slightly in 1975-1976 compared with 1955-1957; this decline occurred in Western Zaire as well as over the entire country.

The GFR and the TFR both rose very slightly over this twenty-year period. The proportion of nulliparous women 25-34 years old – an inadequate measure of sterility that nevertheless gives a rough idea of the phenomenon – seemed to have dropped throughout the country, including Western Zaire, between 1955-1957 and 1975-1976.

<table>
<thead>
<tr>
<th>Subregion (actual name)</th>
<th>Crude Birth Rate %c</th>
<th>General Fertility Rate %c</th>
<th>% Childless women*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bas-Fleuve</td>
<td>47.8</td>
<td>35.0</td>
<td>42.8</td>
</tr>
<tr>
<td>Cataracts</td>
<td>50.2</td>
<td>38.0</td>
<td>43.0</td>
</tr>
<tr>
<td>Kwango</td>
<td>53.8</td>
<td>44.9</td>
<td>43.4</td>
</tr>
<tr>
<td>Kwilu</td>
<td>47.6</td>
<td>41.2</td>
<td>43.2</td>
</tr>
<tr>
<td>Mai-Ndombe</td>
<td>45.9</td>
<td>41.0</td>
<td>45.5</td>
</tr>
<tr>
<td>Kasai</td>
<td>49.1</td>
<td>42.0</td>
<td>42.5</td>
</tr>
<tr>
<td>Lualua</td>
<td>48.3</td>
<td>37.9</td>
<td>36.2</td>
</tr>
<tr>
<td>Equator</td>
<td>32.5</td>
<td>27.6</td>
<td>38.8</td>
</tr>
<tr>
<td>Tshuapa</td>
<td>28.6</td>
<td>20.5</td>
<td>33.3</td>
</tr>
</tbody>
</table>

Data 1955-57 from A. Romaniuk (1967).

* Childless women 25-34 years.


26
2.4.3. Infertility and definitive sterility

Sterility in Central Africa, especially in Zaire, is poorly understood, despite the fact that various authors such as Retel-Laurentin (1971, p. 8, and 1974, p. 188), have stressed the magnitude of the problem. Sala-Diakanda, pursuing Retel-Laurentin’s line of thought, shows how widespread the phenomenon in Zaire, raising the fact, “that with at least fifty of its ethnic groups ravaged by sterility, Zaire clearly seems to be one of the Central African countries worst affected by the phenomenon” (Sala-Diakanda, 1980, p. 136).

A comparison of the fertility indices in the regions of Western Zaire shows disparities between the spatial distributions of fertility and quasi-sterility in 1955-1957. These disparities seem to have disappeared by 1975-1976 with, as Table 7 shows, a noticeable rise in fertility and a decline in barrenness among women 25-34 years old (Tabutin, 1982).

After comparing the 1955-1957 and 1975-1976 figures for women (25-35 years old) who had never had children, D. Tabutin reached the conclusion that “the infertility rate dropped everywhere in the western subregions, but all the more rapidly as its level was high in 1955-1957” (Tabutin, 1982, pp. 36-37). The gaps between subregions or ethnic groups in the interval between the two studies had also narrowed (Sala-Diakanda, 1980, p.140). However although the very large variations among subregions seen in 1955-1957 did lessen, they did not disappear; for two subregions – Equator and Tshuapa – still had high proportions of nulliparous young women (10% and 13% respectively; see Tabutin, 1982, p. 37).

2.4.4. Death rate

Analysis of the mortality indices presented in Table 8 (CMR, child mortality quotient, 0-5 years, and life expectancy at birth) can give a rough idea of mortality rate trends in the western subregions as well as in the whole country. However, like Sala-Diakanda (1980, p. 176), we recognize that the estimated mortality rates – especially for the deaths of children occurring some time before the investigation – are not very reliable, and that more than one author takes it for granted that the mortality rate was declining (Tabutin, 1980, pp. 44-46, and Tableau général de la démographie congolaise, 1961). Sala-Diakanda also stresses the fact that, while it is almost impossible to set a reliable level for the IMR, the results of various methods for estimating this rate suggest nevertheless that the hypothesis of a declining mortality rate over this twenty-year period cannot be dismissed.

However, the decline varied from one ethnic group to the next (Sala-Diakanda, 1980, pp. 176-179).

Table 8:

<table>
<thead>
<tr>
<th>Subregion</th>
<th>Crude Mortality Rate</th>
<th>Probability of dying between 0 and 5 years (%)</th>
<th>Life expectancy at Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataracts</td>
<td>25.9</td>
<td>17.1</td>
<td>294</td>
</tr>
<tr>
<td>Bas-Flleurs</td>
<td>26.1</td>
<td>15.5</td>
<td>295</td>
</tr>
<tr>
<td>Kwango</td>
<td>32.3</td>
<td>22.5</td>
<td>354</td>
</tr>
<tr>
<td>Kivu</td>
<td>36.2</td>
<td>22.4</td>
<td>299</td>
</tr>
<tr>
<td>Mai-Ndombe</td>
<td>20.5</td>
<td>20.1</td>
<td>236</td>
</tr>
<tr>
<td>Lulua</td>
<td>34.1</td>
<td>22.5</td>
<td>381</td>
</tr>
<tr>
<td>Kasai</td>
<td>37.0</td>
<td>21.4</td>
<td>408</td>
</tr>
<tr>
<td>Equator</td>
<td>27.1</td>
<td>21.9</td>
<td>185</td>
</tr>
<tr>
<td>Tshuapa</td>
<td>24.9</td>
<td>21.3</td>
<td>279</td>
</tr>
<tr>
<td>Kinshasa</td>
<td>11.6</td>
<td>15.0</td>
<td>128</td>
</tr>
</tbody>
</table>

Source: D. Tabutin (1980, p.27)

The CMR seems to have declined generally, except in the subregion of Equator, where it increased (see Table 8). This may well indicate faulty data, making interpretation difficult. The probability of decease between 0 and 5 years dropped in all the subregions concerned between 1955-1957 and 1975-1976. A not insignificant improvement in life expectancy at birth was also seen in all the western subregions studied, with the exception, of course, of Kinshasa and Equator subregion, whose statistics must be viewed with caution.

Finally, we must emphasize the fact that the subregional (district) variations observed in 1955-1957 generally seemed to be disappearing in 1975-1976.
2.4.5. Migrations

Given the current state of the relevant data, it is not possible to determine the annual volume of either international or internal migration. If we refer to the number of foreigners counted at each census, immigration from other countries appears to be negligible. The AIMO (Affaires Indigènes et de la Main-d’Œuvre) counted 119,749 foreigners, or 0.86% of the total population, during the 1959 census (Statistical appendix to the Governor General’s speech, Leopoldville, 1959). There were 932,042 foreigners, or 4.31% of the total population, in Zaire in 1970 (1970 census, Political Affairs Department, 3rd Directorate), and 637,605 foreign residents, or 2.15% of the total population, in 1984 (provisional figures of the 1984 census, Zairean National Statistics Institute, 1984, p. 27).

It also seems that the migratory movements in Zaire were mainly internal and dominated by the rural exodus. A study conducted by the Institute of Economic and Social Research (IRES) of Kinshasa University evaluated the total number of migrants who left rural areas for the towns during 1955-1965 at 715,332 individuals (Knoop, 1967, p.103).

As for the rest, the urban population surged ahead between 1965-1975, thanks to the influx of immigrants from rural areas; especially between 1965 and 1970, the urban population, which made up only 12.18% of the population in 1958, rose to 14.62% of the population in 1965 (IRES estimates used by Knoop, 1967, p. 103), then climbed to 24.3% in 1970 (J. Boute, 1973, p. 4), and finally reached 31.0% in 1975 (Iba, 1976, p. 29). Based on the Planning Department’s demographic forecasts, Zaire’s rate of urbanization should have reached 34.16% in 1980, 38.38% in 1984, and 39.50% in 1985 (rates calculated using the predictions of Boute and Saint-Moulin, 1980, p. 21-63).

This rapid increase in the urban population at the expense of the countryside was largely due to the unbalanced socio-economic development of these two areas (concentration of factories, schools, recreational facilities, etc. in the towns). Besides Kinshasa we should like also to cite the examples of Bukavu and Goma, two cities whose average rates of annual increase between 1950 and 1970 were 9.5% and 19.8% respectively (figures from Carael, Tondeur, and Wils, 1979, p. 10).

Before ending this section on migration, let us also take a look at internal mobility in a few regions of Western Zaire.

Table 9 shows on the one hand that men were generally more inclined to migrate than women and, on the other hand, that Kwilu and Cataracts lost more inhabitants than any of the other subregions, with Kinshasa being the main pole of attraction.

In addition, everyone will agree, based on Vilquin’s study of urban immigration in Zaire in 1975, that in general less than half of the populations remained sedentary (Vilquin, 1979, p. 12).

The changes in Zaire’s demography after independence were accompanied by problems of fertility, mortality, migration, and the spatial distribution of the population. This raises the matter of the demographic policies drawn up and implemented by the Zairean government. Accordingly we shall thus close this chapter with an analysis of Zaire’s demographic policies.
3. Demographic policy

We use here Berelson’s definition, quoted by D. Van De Kaa (1978) whereby demographic policy means:
- any policy aimed directly at influencing demographic situations;
- any policy adopted basically for other reasons but in which demographic factors play a certain role;
- any policy which, while adopted without any thought for demographic concerns, nevertheless has appreciable immediate or long-term demographic consequences.

We have made a distinction between Zaire’s demographic policies before and after the country’s independence.

3.1. Belgian demographic policies in the Congo

These consisted of three types of intervention. The first concerned birth rates, the second morbidity/mortality, and the third migration.

3.1.1. Direct pro-natalist measures

The colonial government worked out a consistent social doctrine aimed at, at least, improving the general welfare, if not boosting the falling birth rate (Romaniuk, 1967, p.162).

One of the administration’s primary objectives was to control the declining birth rate. Abortion and contraceptive practices, considered to be two of the main causes, were severely repressed. The law was very clear on this subject: whoever displays or distributes objects specially intended for contraception and advertises to promote their sale would be liable to legal prosecution. Likewise, the penal code punished “the person who, by means of food, draughts, medicine, violent action, or any other means, causes a woman to abort”, and condemned any woman, who had undergone an abortion or caused herself to abort, to from two to five years in prison (Bianga Ghu-Gha, 1978, p. 191).

Emphasis was also placed on controlling venereal disease, a factor involved in the high sterility rates found in certain Zairean milieux. A 1921 decree thus made it mandatory for any person recognized as being syphilitic to undergo appropriate treatment, (Bianga Ghu-Gha, 1978, p.191). Along these lines, any person leaving his or her tribal administrative district for the city had to receive a transfer passport (see p. 30), which was issued following a medical examination. This measure was also intended to control the native’s movements.

3.1.2. Indirect pro-natalist measures

These measures included family allowances, exemptions from income tax after a certain number of children, the prohibition of polygamy (both polygyny and polyandry), medals for family merit, and housing priority for large families.

All workers had the right to receive family allowances for each legitimate child born of a monogamous civil, traditional, or religious marriage that could be legally recognized, or legitimized by such a marriage, (Bianga, 1978, p.192). Furthermore, non-polygamous fathers of at least four children born of one or more monogamous marriages were exempted from paying taxes. A decree of July 17, 1914 also provided for the possibility of a tax-cut for monogamous husbands with three-child families. In 1953, some legal provisions were adopted whereby the contributions of monogamous heads of households were reduced by 5% for each dependent.

Marriage was officially promoted, and was facilitated by legal dispositions. For instance, one legal clause says that at the time of recruitment, the advances allowed may not exceed the value of three months of the promised pay; however, provision for a dowry may reach six months’ earnings (Bianga, 1978).

Polygamy, on the other hand, was gradually abolished between 1915 and 1951. A law prohibiting it was finally promulgated on January 1, 1951, stipulating that “no one may contract a new marriage under customary law before the dissolution or annulment of (the) previous marriage(s).” Concerning taxes, any polygamous Congolese or foreigner of similar status residing on the Colony’s territory had to pay additional income tax for each of his able-bodied wives, minus one. Furthermore, he was not eligible for the exemption and exonerations for dependents (see decrees of July 17 and September 10, 1951).

As for housing, “the allocation of a house or of building loans was dependent on the size of the household; large families had priority over small ones”. (Romaniuk, 1967, p.166).

3.1.3. Measures to lower the mortality

All of the measures taken were aimed at reducing death rates. Medical care, individual and public hygiene, and diet were the main means used.

In the beginning, this task was carried out by mobile medical teams. It was then taken over by semi-public services: Fonds Reine Elisabeth pour l’Assistance
MEDICALE AUX INDIGENES - FOREAMI (Queen Elisabeth Fund for medical well-being of Natives) and FONDS POUR LE BIEN-ETRE INDIGENE - FBEI (Fund for Native Well-being), etc., and private medical services organized by firms and religious missions.

Measures to improve hygiene dated back to 1899. An ordonnance-loi of April 24, 1899 established hygiene committees. A decree of July 19, 1926 organized the hygiene and public health services. A royal decree of April 23, 1927 created the Higher Council of Colonial Hygiene (for information on this subject see Bianga Ghu-Gha, 1978). We should also note the creation of social centres, where hygiene and home economics classes were given to young girls and mothers.

Some orders were issued so as to improve the population’s nutritional intake. These included the employer’s obligation to provide workers with sufficient quantities of healthy food. Family allowances were generally in kind. Programs were also set up to distribute dairy products and vitamin-rich foods to families and in schools.

The number of cases of illness treated by the Government and FOREAMI’s medical services rose from 1,210,000 in 1944 to 3,450,000 in 1957.

3.1.4. Migration measures

These measures can be divided into two groups, depending on whether their motivations were economic or demographic.

a) Economic measures

As we have already indicated, the colonial authorities forcibly recruited adult male peasants who were sent away from their home areas in order to meet the manpower needs of the fledgling Congolese industry. Thousands of people were deported from Kivu and Kasai to Katanga (Shaba) around 1906 in order to work in the mines. This scenario was repeated around 1920, except that this time inhabitants of Equator and Kwilu were sent to Leopoldville (Kinshasa; see Iba Ngambong, 1979, p. 7).

b) Demographic measures

These measures were aimed first and foremost at relieving congestion in overpopulated areas and checking the rural exodus.

From 1937 the colonial authorities undertook to transplant some of the Banyarwandas to North Kivu in an attempt to counteract overpopulation in Rwanda and Burundi and to encourage the development of the peasant population in Kivu by the organized influx of men and livestock, (Iba Ngambong, ibid., p. 8). A commissioner at the time testified to this.

“Rwanda-Urundi,” he declared, “which is already overpopulated and whose population is steadily rising at a regular pace, cannot feed its people and livestock; the surplus population must ineluctably emigrate or vegetate, or even perish...” (Spitaels, 1953).

As for attempts to control the rural exodus, the colonial administration required all rural inhabitants wishing to move out of their chieftaintries to obtain a transfer passport. We will also mention in passing the experiment of the IBO (INTERNATIONALE BOUW-ORDE) and the Volunteers for Constructions (COMPAGNONS BATISSIERS) in Kasai from 1957 to 1963, whose aim was to help populations in distress. The original goal of their programmes was not to displace the populations, but to stimulate the creation of production-oriented activities among the peasants. The colonial government nevertheless gave its support, because it hoped in this way to check the rural exodus.

Apart from the displacement of Banyarwandas from overcrowded areas, the authorities wanted not only to prevent the emigration of Congolese and also to foster the entrance to the country of European specialists and of population from border areas (article 1 of the decree dated 27 December 1948).

3.1.5. Assessing Belgian demographic policies in Zaire

Riecken defines evaluation as “the measurement of the desirable consequences of an action undertaken to achieve selected goals,” (Riecken, 1972, p. 365).

The obstacles preventing a complete evaluation in this case include a poor understanding on the part of the political circles and practitioners of the time and the lack of evaluations by the colonial authorities. Also there are no figures through which achievement of the objectives can be measured.

We nevertheless believe that the measures, whether or not demographically oriented, taken by the colonial authorities, together with the health and medical infrastructure established in Zaire during colonization, were largely (if not entirely) responsible for the demographic boom, rapid rate of urbanization, rural exodus, deteriorating conditions of peasant life, and disappearance of the country’s major epidemic diseases, all of which characterized Zaire on the eve of independence.

3.2. Demographic policies after independence

During a seminar on population policies in Africa held in Lomé in 1979 we pointed out that it might seem surprising to speak of demographic policies in the case of Zaire, since some eminent scientists, such as Berelson (1972, pp. 63-71), had as early as 1972 included Zaire among the countries that had nothing – neither a deliberate policy nor an organized programme
FROM THE COLONIAL ERA TO THE PRESENT DEMOGRAPHY OF ZAIRE

— in the way of population measures (Iba Ngambong, 1979, p. 4).

Still, based on Berelson’s own definition (Van de Kaa, 1978), it seems that, without having a deliberate demographic policy, the Zairean government has over the years taken a certain number of measures influencing various components of population growth and movement that have, in practice, borne fruit.

The post-colonial period in Zaire has been characterized by three types of intervention to control population growth and distribution:

a) The earliest, called village regrouping, stemmed from a 1968 government decision. It was a continuation, at national level, of the colonial IBO (Internationale Bouw-Orde) or Volunteers for Constructions’ experiment in Kasai, which petered out after 1964 for lack of an infrastructure (Iba Ngambong, 1979, pp. 10-12). The aim of the 1968 spatial redistribution policy was to improve living conditions in rural areas by means of a correct balance between population size and the economic space to be exploited, so as to create a certain momentum and to spur economic and social development.

The implementation of this policy over five years (1968-1973) yielded visible results. Six of the country’s nine regions were affected, and 12,211 villages, or 4,460,244 villagers, were regrouped (for details see Kabuya, 1973, p. 25).

b) The second type of intervention concerned attempts to lower the death rate. The government’s efforts were aimed at various targets, such as increasing the number of physicians per 1,000 inhabitants, vaccination campaigns against tuberculosis, smallpox, yellow fever, poliomyelitis, measles, etc., in addition to controlling malaria, venereal diseases, and other endemic diseases. The effectiveness of these measures is hard to assess at the current time. However, the 10-year increase in life expectancy at birth observed over a 20-year period (1955-1957 to 1975-1977) can be considered the welcome consequence of health policies implemented both during colonial rule (with important logistic support from the FOREAMI) and after 1969.

c) The third type of intervention concerns the so-called Desirable Births Plan. The first ordinary congress of the MPR (the national political party), held in 1970, had already voiced its desire to influence the natural variables of population growth. It was not until December 5, 1972, that the President of the Republic was able to define the goal of this policy, namely “The role of the State is thus to lower infant mortality as much as possible so that the number of real births can correspond, with a few exceptions, to the number of births desired. This problem is called Family Planning but we prefer the expression desirable births (naissances désirables)”, see Mobutu Sese Seko, 1972, pp. 29-30.

The National Centre for Desirable Births (Centre National des Naissances Désirables – CNND), set up for this purpose, has pursued health objectives rather than demographic objectives per se (see Speech of the Health Minister, Kalonda Lumema, 1974):

- to improve maternal and child health;
- to control infant mortality;
- to reduce infertility and sterility.

Despite a host of branches (81 in all) scattered throughout all of the country’s regions, the CNND is far from reaching the majority of the country’s population, because most of its branches are based in towns (covering 35% of the total population) and attendance (1.75% in Kinshasa in 1977) is not very high. However the total number of people who have used the CNND’s services has shown a gradual rise in the eighties from 166,570 in 1982 to 237,420 in 1983 and 315,905 in 1984 (according to the CNND Annual Reports).

4. Conclusion

To conclude, we should like to review the main ideas marking this chapter.

The demographic position in Zaire until 1920 was close to that of a stationary population with high death and birth rates. The rate of increase was very low, almost nil.

From 1920 to 1945 the overall rate of annual population growth was about 0.6%. Despite great regional differences, the population density was low, approximately 4 inhabitants per sq. km. The crude birth rate (CBR) rose to about 35‰. Kivu and Leopoldville were the provinces with the highest rates (38.6‰ and 37.4‰, respectively), while the lowest were found in the Equator and Eastern Provinces. The crude mortality rate was about 30‰, with an infant mortality rate in the order of 300 to 350‰.

This period was also characterized by a surge in migratory movements far from rural areas. These movements were closely linked to the colonial industrialization and exploitation of the country. The population living in towns, no more under customary law thus reached 1 million in 1940, whereas it had been only a few tens of thousands on the eve of the First World War.

In addition, it must be mentioned that there was a migration from Rwanda to North-Kivu. To alleviate the overpopulation in Rwanda and Burundi the colonial authority organized the transfer of Banyarwanda people to North-Kivu: between 1945 and 1948, some
41,700 persons (or 9,337 families) were settled in the areas of Fizi, west of Lake Tanganyika, Rutshuru, Masisi, Kalehe, North of Bukavu, and Lubero, near Lake Edward.

From 1945 until independence, the overall rate of annual increase exceeded 1%. This was largely due to the combined effects of a high birth rate and a decline in the mortality rate. However, population density barely changed in relation to that of the preceding period. It was 5.15 inhabitants per sq. km in 1955-1957. From 1955 to 1957, the CBR was about 45% in the most prolific provinces, Katanga, Kivu, and Leopoldville. The Eastern and Equator Provinces had widespread sterility in most of the ethnic groups living there, and the CBR was approx. 25% in 1955-1957 and the IMR was about 175%.

Katanga was the province with the lowest death rate, while Leopoldville and Elisabethville had the highest. City dwellers fared better than peasants.

The period from 1945 to 1960 also saw an increase in migration over long distances and towards the cities. A massive rural exodus took place, causing a rapid growth in the urban population, especially between 1950 and 1955. The proportion of the country’s total population living in towns rose from 14.8% in 1945 to 23.7% in 1955 (a total of 2.8 million individuals).

Zaire’s population has increased at high average annual rates (32% on average) since 1960. However, the pattern of high population density along two major axes and two secondary axes that was detected in 1970 was practically unchanged in relation to the pattern during the colonial period.

Natural increases played a major part in the population’s growth, even at the regional level, because the birth rate has remained high almost everywhere while the death rate has shown a noticeable decline.

Faster growth in cities compared with the countryside reflects the rural exodus towards urban areas, which is the main type of internal migration in Zaire. Kinshasa has remained the main pole of attraction.

In terms of demographic policy the colonial authorities took a number of measures, concerning health, migration and birth rates, that influenced the country’s demography throughout the period before independence.

After 1960, three types of demographic policy were implemented by the government in the name of social welfare.

A policy to redistribute the population spatially was begun in 1968, based on the colonial IBO experiment (see p. 30). It affected six of the nine regions and 4,460,244 rural inhabitants. Prophylactic measures to lower the death rate, combined with the training of close to 2,000 national doctors, led to an average increase in life expectancy at birth of about 6 months per year. Finally, the Desirable Births Programme was set up after 1972, although its aims are public-health related rather than dealing strictly with birth control. However, its 81 centers have until now reached only a tiny part of the total population; and only the future can determine whether its achievements become more substantial.

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Map 5 — Main ethnical groups in Zaire, Rwanda and Burundi
(adapted from Vansina, 1966)