

Central African Republic: abandoned to its fate?



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Summary

Central African Republic (CAR) is once again struggling through a period of profound instability, and its population needs help. Most humanitarian organizations, however, have either left the country or reduced their presence because of the general insecurity and a spate of targeted attacks on international NGOs.

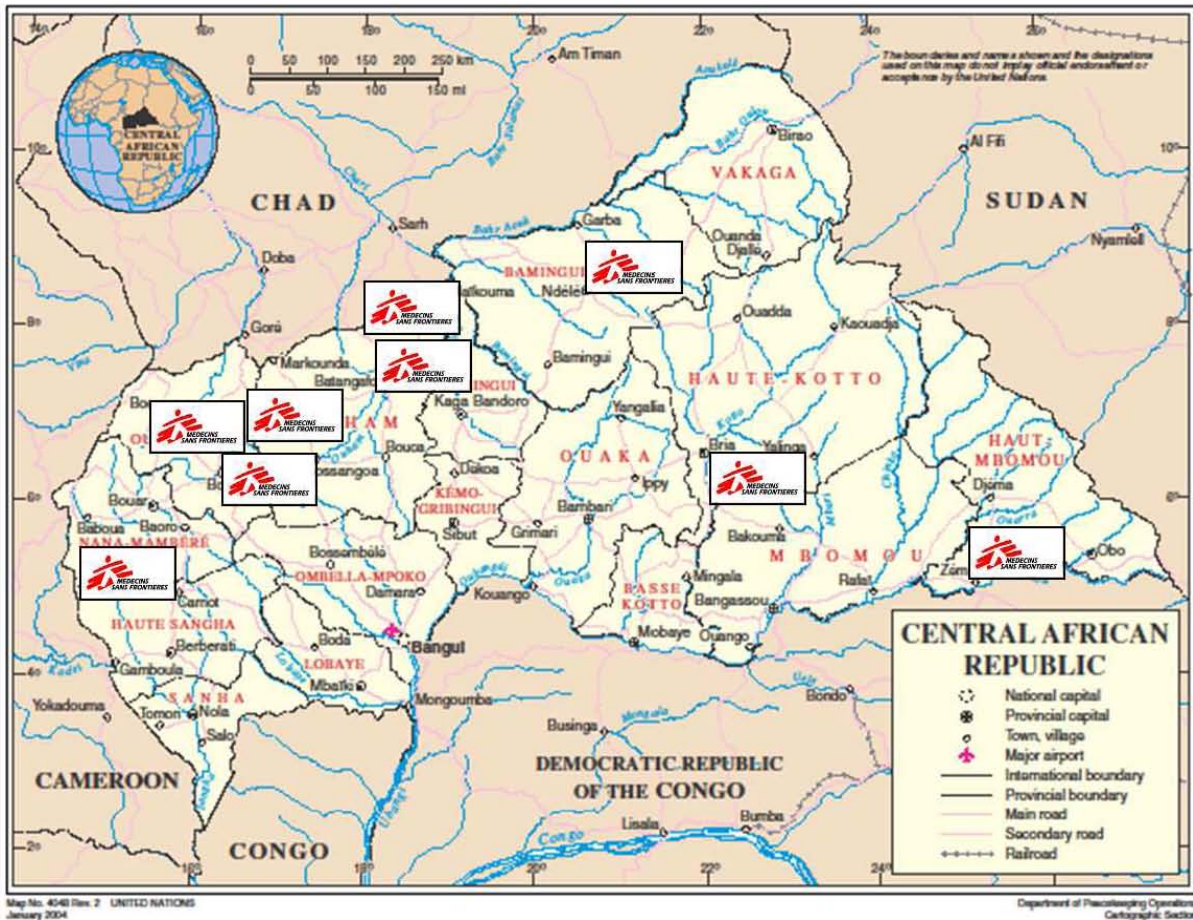
The circumstances notwithstanding, the international community must work to create conditions that will enable the delivery of emergency relief to people in need. CAR already lags far behind most other countries in health indicators. **Humanitarian and development agencies must maintain, and indeed scale up, their commitments, taking adequate measures to respond both to emergency and long-term needs.**

Background

In December 2012, the Seleka rebel coalition launched an offensive against CAR's government. A month later, the warring parties signed a cease-fire agreement, but on March 24, 2013, Seleka took control of Bangui, the capital, and effectively overthrew the government. The state security forces largely disbanded. President François Bozizé fled the country, and Michel Djotodia, a Seleka leader, proclaimed himself the new president.

One month later, on April 18, an Economic Community of Central African States (ECCAS) conference in N'Djamena, Chad, recognized Djotodia as the head of a transitional government that was mandated to hold elections in the country within 18 months. ECCAS also authorized the deployment of an additional contingent of 1,500 soldiers to strengthen the existing Mission for the Consolidation of Peace in the Central African Republic (MICOPAX), which ECCAS has overseen since 2008.

Doctors Without Borders/Médecins Sans Frontières (MSF), which has been working continuously in CAR since 1996, scaled up its programs to respond to increasing needs in the wake of the change in government. Despite general insecurity and specific incidents such as robberies that forced the temporary evacuation of staff, MSF has never suspended activities. Currently MSF operates nine programs: in Carnot, Paoua, Boguila, Bossangoa, Batangafo, Kabo, Ndele, Bria, and Zemio.



1. A country in chaos

The Seleka's move on the capital plunged CAR into chaos. Violence and looting have been widespread. **State buildings, ministries, schools, hospital, and private homes have been robbed and damaged.** Most civil servants have fled. Archives and databases have been destroyed. When people have resisted or defended themselves or their property, the recriminations have been swift and severe.¹ And the rebels have not demobilized or disarmed, which means that hundreds of armed men who have yet to receive the salaries they were promised are circulating in a city with no real police force.

Elsewhere in the country, Seleka supporters and other armed groups have carried out robberies and attacks against the civilian population. The situation has also exacerbated pre-existing tensions between nomadic and more solitary communities.

Humanitarian organizations in the country have been targets as well. In Bangui, offices and guesthouses used by the United Nations and other international NGOs have been repeatedly looted.²

¹ On April 14, more than 20 people were killed in Boy-Rabe district. More recently, June 28, six people were killed and at least 25 wounded in fighting between civilians and Seleka supporters.

² One MSF office in Bangui has been completely looted, as has one house in Bangui. Another house has been robbed and three cars have been stolen.

Staff have been threatened and harassed as well. Almost all international personnel working outside the capital were evacuated as soon as the crisis began, and national staff were brought to Bangui, too. Bases outside the capital have been robbed, and vehicles stolen.³

Evacuation from Batangafo

MSF's team in Batangafo, which included 48 people (42 of them medical personnel) was evacuated on April 10 after a serious security incident during which armed men forced their way into an MSF compound. As a result, activities in Batangafo's main hospital were reduced for four weeks and activities at surrounding health centers were suspended.

This meant a great deal of medical needs went unmet because more than 110,000 people live in the Batangafo area and MSF is the only health service provider. As the rebels advanced through the region on their way to Bangui, the population had fled into the bush. At the same time, more than 20 villages were burned down and around 8,000 people were displaced during unrelated clashes between nomadic herders and local farmers that occur on an almost annual basis.

Marie Noelle, a young mother, explained to MSF staff that she fled the village of Gbadéné with her neighbors in mid-April after hearing that nomadic herders were going to set the village on fire. She spent the night in nearby fields, and her village went up in flames the following day. Everything was burned down, including the tools villagers needed to tend their crops. Some weeks later, an MSF team carrying out a mobile clinic to help the displaced found her with a malnourished one-year-old child. All around her were displaced people who were now more vulnerable to malaria.

The health system has not been spared. Ministry of Health facilities have been robbed and looted of drugs, diagnostic tools, patient records, even furniture.⁴ Most medical staff, especially those working outside the capital, fled their posts.

These attacks have deprived an already vulnerable population—4.4 million people spread across a country bigger than France—of access to even basic medical treatment. **In a country that already had the second-lowest life expectancy in the world, at just 48 years, the people are now even more at risk.**⁵

³ To refer only to MSF bases, four cars have been stolen (Boguila, Ndele, Batangafo) and three offices and houses have been robbed (Ndele, Batangafo, Boguila) on several occasions.

⁴ While the hospitals in Bossangoa and Mbaiki were completely looted during the Seleka offensive, other health facilities around the country (in Allindao, Bangassou, Gambo, Grimari, Kembe, Kongbo, Mala, Mobaye, and Ouango) were damaged during the weeks preceding and following the coup.

⁵ WHO, 2011, "Mortality and burden of disease: Life expectancy", *Global Health Observatory Data Repository*.

2. A crisis on top of a crisis

Not considered to be in a sufficiently acute situation to attract emergency funds, nor able to fulfill the requirements to receive structural funds for development, the country is trapped between a state of 'emergency' and one of 'development'. As a result, **CAR has been in a state of silent, chronic medical crisis for many years.** A recent MSF study⁶ on the country reported:

- **Mortality rates above the emergency threshold.** Four retrospective mortality surveys carried out by MSF in the south and northwest of the country between 2010 and 2011 revealed extremely high mortality rates.⁷ One survey, in June 2011, revealed that *even in areas not affected by conflict, the indicators were well above the emergency threshold*: the crude mortality rate was 3.3/10,000/day (95% CI, 2.3-4.8), while the under-five mortality rate (U5MR) was 3.7/10,000/day (95% CI, 2.4-5.6).⁸ In the urban commune of Carnot, the CMR was 3.9/10,000/day (95% CI, 3.0-5.2) and the U5MR was 4.9/10,000/day (95% CI, 2.6-8.8).

The survey found the crude mortality rates in the Carnot, Gadzi and Senkpa Mpaéré communes were at least three times the emergency threshold, with an under-five mortality rate three times as high as in Kenya's Dadaab refugee camp for Somali refugees.⁹

- **High mortality and morbidity** caused by easily treatable and preventable diseases. CAR has a high burden of malaria, diseases that should be preventable by vaccination, and chronic diseases such as HIV/AIDS; malnutrition is also on the rise.^{10 11}

- **A health system with far too few facilities, skilled medical workers, diagnostic or treatment tools, medicines and supplies, and surveillance capabilities.** It is, for all intents and purposes, a "phantom" system that does not really function.

This was before the recent crisis. Now people are afraid to move, which means they have even less access to health care, and the loss of income incurred has made it even more difficult to pay medical fees. An already unreliable drug supply system has completely collapsed. And mortality rates are like to worsen in the coming months.

⁶ MSF, 2011, *Central African Republic: A State of Silent Crisis*.

⁷ Caleo G et al., 2011, *Sentinel site mortality surveillance of mortality and nutritional status: Boda, Boganda, Boganangone and Gadzi sous-préfectures, Central African Republic, 2010*, Epicentre, Paris. Espié E, 2011, *Enquête de mortalité rétrospective dans la ville de Carnot, préfecture de Mambéré-Kadéi, République Centrafricaine*, Epicentre, Paris. Rasella D, 2011, *Retrospective Mortality Survey: Axe Maitikoulou-Kdajama Kota*, [Unpublished.]. See as well the retrospective mortality survey published University of California, Berkeley : Vinck P and P Pham, 2011, "Association of exposure to violence and potential traumatic events with self-reported physical and mental health status in the Central African Republic", *Journal of the American Medical Association*. 304(5): 544-552.

⁸ Cohuet S, C Marquer, S Abdallah, 2011, *Enquête de mortalité rétrospective et de couverture vaccinale dans les sous-préfectures de Carnot et de Gadzi, République Centrafricaine*, Epicentre, Paris.

⁹ The crude mortality rate (CMR) was 3.3/10,000/day (95% CI, 2.3-4.8), while the under-five mortality rate (U5MR) was 3.7/10,000/day (95% CI, 2.4-5.6). In the urban commune of Carnot, the CMR was 3.9/10,000/day (95% CI, 3.0-5.2) and the U5MR was 4.9/10,000/day (95% CI, 2.6-8.8).

^{10 11} Malaria is by far the most common illness seen in MSF's outpatient facilities: of a total of 582,253 people treated as outpatients in 2010, 46 per cent (or 267,471 people) were diagnosed with and treated for malaria. Malaria is the greatest single cause of inpatient death in CAR's hospitals.

¹¹ MSF and Epicentre conducted a community surveillance survey (Caleo G et al., op cit.) in the subprefectures of Boda, Boganda, Boganangone and Gadzi between February and December 2010, which found the prevalence of global acute malnutrition to be 11.9 per cent (95 per cent CI 9.1-15.5). The prevalence of severe acute malnutrition (SAM) was 3 per cent (95 per cent CI 2.3-4.0), of which half the individuals had signs of kwashiorkor. SAM prevalence appeared to peak in April-May 2010, and more markedly between June and October.

Hôpital Communautaire

Jordan is 14 years old and lives in Bangui's Miskine neighborhood. When Seleka entered the capital on March 24, he stayed inside his home. Unfortunately, that did not prevent a stray bullet from flying into his house and hitting him in the leg.

According to Jordan's mother, a local priest helped get her son to the hospital. "Now he's getting better and I hope that he'll be at home soon," she says. Most hospitals in Bangui were not functioning, but Jordan was brought to the Hôpital Communautaire, where MSF had donated drugs, medical supplies, water and fuel to help keep it working. An MSF team also set up an operating theater, where around 40 procedures were carried out in 10 days.

By the end of May, when MSF withdrew, MSF staff had treated more than 1,000 patients, more than a third of whom had been wounded by bullets. Three months after the coup, normal services have resumed at the hospital: staff have returned and the operating theater and sterilization unit are properly equipped. MSF has made sure drug supplies are available in case they are needed.

The overall impact of this most recent political crisis on the health care system is not yet clear, but MSF teams saw a sizable increase in consultations at its projects.

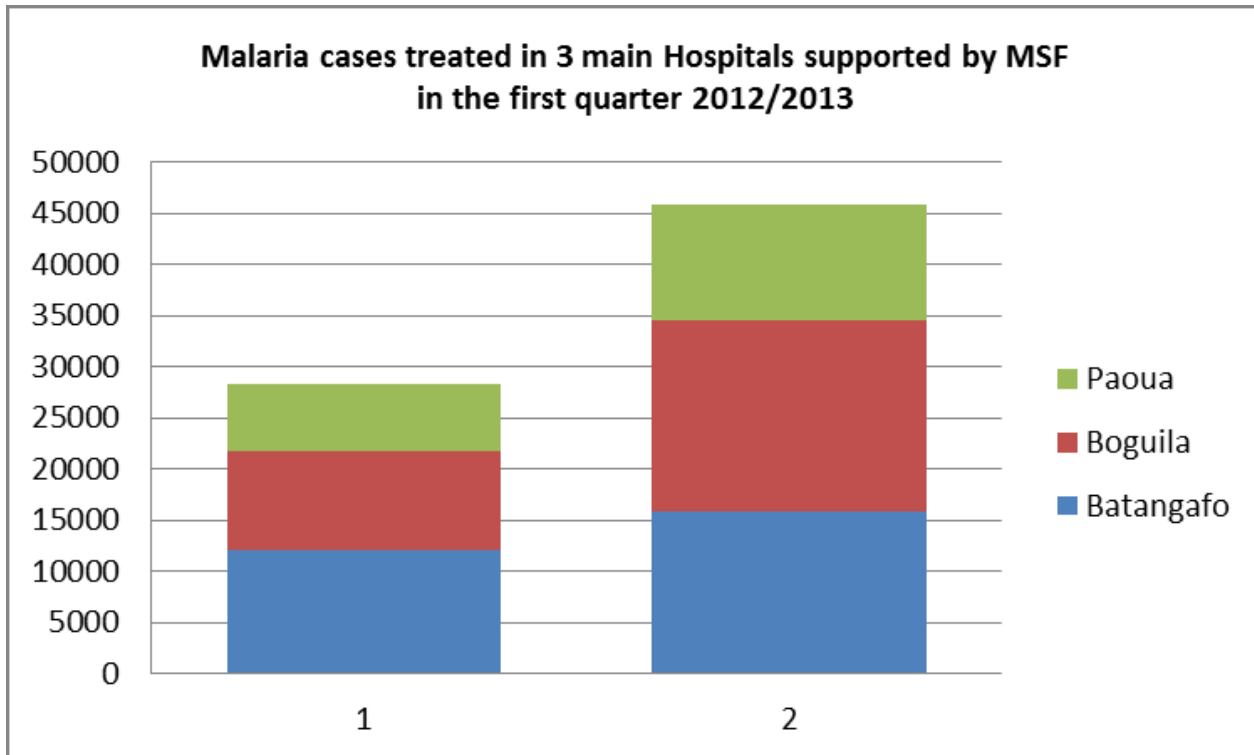
The indicators are alarming, especially when it comes to **malaria, which is holoendemic in CAR**. When people are frequently forced to hide out in the bush, they are more exposed to malaria, largely unable to access any prevention or treatment measures. A large-scale mosquito net distribution planned by the Minister of Health for 2013, for instance, was cancelled because of the insecurity.¹² The supply of malaria drugs to rural areas has been disrupted as well. MSF has committed to assist the National Malaria Program's implementation of the Global Fund's Action Plan and the delivery of malaria treatment to 166 government health facilities around the country, but that still represents only a quarter of the nation's health facilities.¹³

In the first quarter of 2013, health facilities supported by MSF treated 74,729 patients for malaria. This is an increase of 33 percent over the same period in 2012, when 50,442 patients were treated for the disease. For children under five years of age, there has been an increase of 46 percent, from 23,910 in 2012 to 44,469 in 2013. In Boguila, 61 percent of outpatient consultations with under-fives were for malaria during the first quarter of the year, compared with 41 per cent a year ago. These data indicate the likelihood of a further increase in consultations during the peak malaria season, which begins in July and which could potentially herald the arrival of one of the **most acute malaria crises of recent years**.

¹² Audit des subventions du Fonds mondial accordées à la République centrafricaine, GF-OIG-13-002, 6 February 2013.

¹³ Source: Micro Plan Sous-Prefectures, Carte Sanitaire 2003.

Hospital	2012	2013	Increase
Batangafo	12,067	15,853	24%
Boguila	9,643	18,661	48%
Paoua	6,651	11,417	42%
Total	28,361	45,931	38%



Chury Baysa, MSF medical coordinator, Bossangoa

“We had a four-year-old boy come to us at the end of May suffering from severe anemia and malaria. He was so sick we had to transfer him by car, along very bumpy roads, from Bossangoa to our hospital in Boguila, so that he could have a blood transfusion. We have seen a number of cases like this, with children falling very sick because of a lack of mosquito nets and malaria drugs.”

The instability has also aggravated pre-existing food security problems. Food stocks were already low and prices already volatile, and then there was a weak harvest. MSF’s recent surveys in southwestern CAR¹⁴ showed that fears of increased levels of malnutrition are likely to be realized.¹⁵ This would make children even more vulnerable to malaria during the peak season.

¹⁴ It is difficult to draw an accurate picture of the malnutrition situation for the population, but MSF made different visits to the areas of Nola, Boda, Berberati, Gamboula and Gadzi, where they carried out rapid screening. The screening revealed increases in global acute malnutrition (GAM) ranging from 6 per cent to 10 per cent, and 1–5 per cent increases in rates of severe acute malnutrition. There were some alarming figures in sites like Boda, Nola and Gadzi.

¹⁵ WFP/FAO, *Evaluation rapide de la sécurité alimentaire en RCA*, June 2013.

The drug supply system has been ruptured for several months now. Again, this is a symptom of the security problems: Due to widespread looting of medical facilities since the coup, the Global Fund to Fight AIDS, Tuberculosis and Malaria stopped keeping stocks of drugs in the country.

The supply problems have had serious consequences for adherence to treatment and the development of drug resistance. MSF estimates that approximately **11,000 HIV-positive people (73 percent of all people who are on antiretroviral treatment in CAR) have had their treatment interrupted** due to drug supply problems during the political upheaval.¹⁶

Interruption of antiretroviral and TB treatment

In Bossangoa, approximately 150,000 people have endured an acute lack of health care since the political upheaval, when health workers fled facilities. Ministry of Health officials estimate that approximately 310 HIV patients were registered at Bossangoa hospital before the coup, 170 of whom were on antiretroviral treatment. In June, MSF began a two-month emergency program at the hospital, providing antiretroviral and TB drugs to patients whose treatment had been disrupted.

Even before the crisis, half of all children did not receive routine vaccinations. It can be safely assumed that most babies born since December 2012 have not had access to the routine vaccination package or the more advisable expanded program on immunization. This has increased the risk of outbreaks of diseases like measles, meningitis and pertussis (whooping cough) in coming years, and created a cohort of children particularly susceptible to such diseases.

The international community's only response has been a **measles vaccination** campaign organized in May by UNICEF and similar activities carried out by its partners remaining in the country.¹⁷ Due to the circumstances, however, this campaign was only able to reach 122,869 children in and around Bangui—not even 20 percent of the target population.¹⁸ Nothing has been proposed for the 1.5 million children living outside the capital.

To add to the problems, the withdrawal of most international assistance organizations means that the phantom health system in CAR is unable to carry out adequate **surveillance** and therefore monitor the rural areas that are more at risk of outbreaks.

¹⁶ UNAIDS, 2011, *Central African Republic: HIV and AIDS Estimates (2009)*. Delaunay S, 2011, *Etat des lieux de l'infection VIH en République Centrafricaine et pistes de réflexion pour MSF*, MSF, New York.

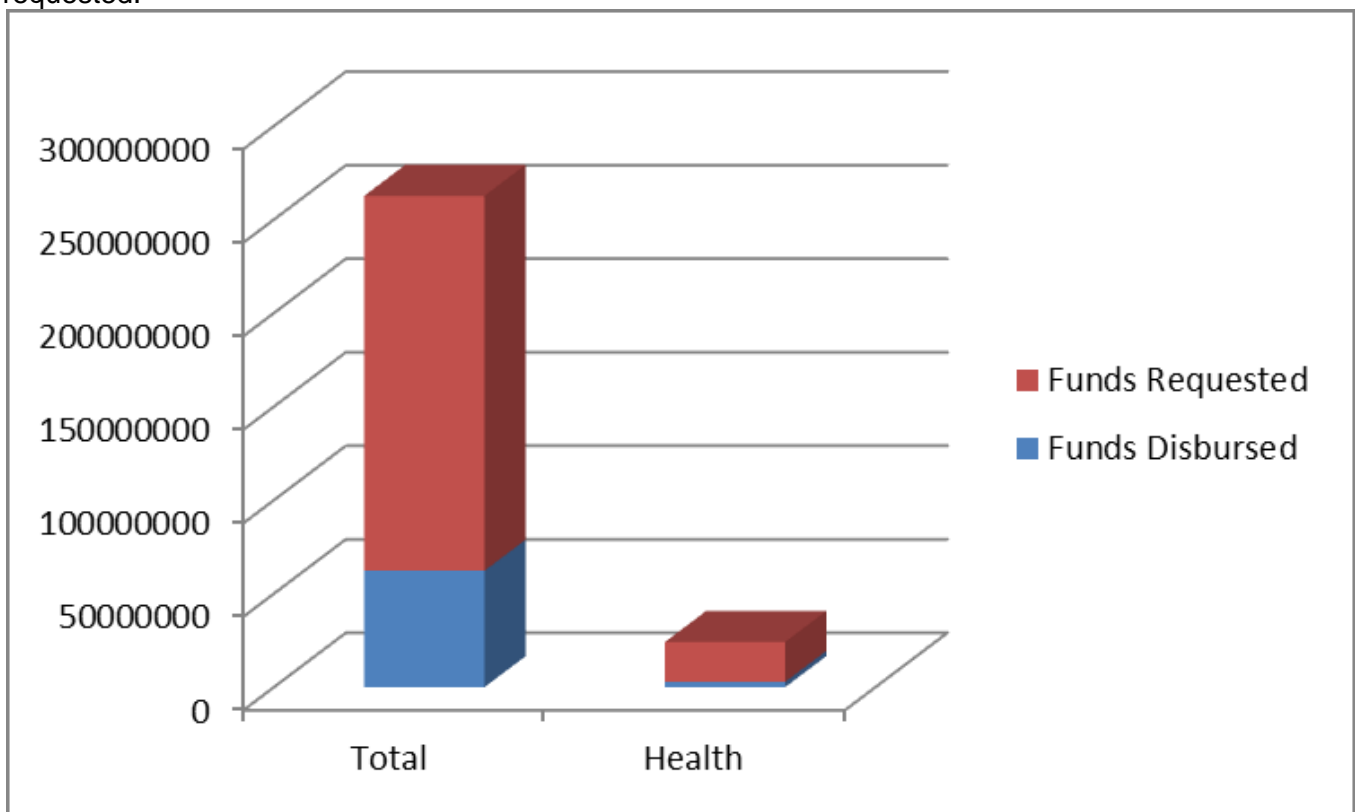
¹⁷ UNICEF, Central African Republic Situation Report: 21 May–13 June.

¹⁸ "Conflict Brings Measles Back to Central African Republic", *UN Dispatch*, 17 June 2012, <http://www.undispatch.com/conflict-brings-measles-back-to-central-african-republic>

3. Lack of response

Despite the increasing needs, the humanitarian presence in the country has been drastically reduced. Most humanitarian organizations have scaled down activities. Some are still in Bangui, waiting for the security situation to allow them to return to their respective project locations. Others have moved their base to neighboring Cameroon. The **United Nations agencies do not have any international staff outside Bangui** due to strict security rules applied since December 2012. Very recently, there have been some exploratory activities outside the capital, but no organization has moved permanently to the regions.

The UN has not allocated sufficient resources to mobilize actors and attract the funds that are needed in CAR. So far, 47 percent of the Consolidated Appeal for CAR 2013, which was drafted before the current crisis, has been disbursed.¹⁹ Only **31 percent** of the revised funding request has **been met**.²⁰ More specifically, only \$ 2.8 million has been disbursed in the health sector—13.2 percent of the \$ 21.2 million requested.²¹



¹⁹ OCHA, CAR Situation Report no. 21 (21 June 2013).

²⁰ Financial Tracking Services, Consolidated Appeal: Central African Republic 2013, Table C: Requirements, Commitments/Contributions and Pledges per Appealing Organization Report as of 04-July2013 (*Appeal launched on 14-December-2012*), http://fts.unocha.org/reports/daily/ocha_R1_A979___1307021923.pdf

²¹ Financial Tracking Service, Central African Republic: Funding Received 2013, at <http://fts.unocha.org/pageloader.aspx?page=emerg-emergencyCountryDetails&cc=caf>

Furthermore, the efforts invested in analyzing the security situation have been inconsistent, making it impossible for humanitarian organizations to plan their return. When combined with the ineffectual coordination of the humanitarian response in CAR, the lack of information and lack of financing make it extremely difficult to find **implementing partners** among international organizations present in CAR and others interested in opening new programs in the country.

As a result, there is a **vacuum of humanitarian assistance outside the capital**: the response is inadequate, and the population is not receiving the assistance it desperately needs. This vacuum is also likely to lead to problems later on, as organizations lose contact with armed actors in the regions, making the negotiation of humanitarian access more difficult in the future.

CAR: A Country in Critical Need

Three months after the coup, the situation in the CAR is critical. The transitional government is still struggling to establish an acceptable level of security in the capital, while there is a complete absence of state authority in the rest of the country, which is at the mercy of uncontrolled armed groups. **Despite the drastic increase in need, however, the humanitarian presence in the country is reaching an historic low.**

MSF is calling for:

- the **international community** (United Nations, European Union, African Union, ECCAS) to keep CAR at the top of its agenda and support this fragile country during transition;

- the **humanitarian community** (United Nations agencies, international NGOs, donors) to maintain its commitment despite the current situation and allocate adequate resources to CAR in order to respond to:

- ○ the **medical crisis**, particularly with regard to malaria;
- ○ the **humanitarian crisis**, by meeting basic needs; and
- ○ the **structural needs**, by providing long-term support to the health system.

- the **transitional government**:

- ○ to guarantee **security conditions** that will allow humanitarian organizations to provide assistance to the population; and
- ○ to immediately commit to meeting the urgent humanitarian and medical needs of the population, with international support.