



CENTRAL AFRICAN REPUBLIC: A STATE OF SILENT CRISIS

November 2011

SUMMARY

This is a plea for the Central African Republic.

The Central African Republic (CAR) today finds itself in a state of chronic medical emergency. Five separate retrospective mortality surveys, carried out by MSF and other researchers, in prefectures accounting for the majority of the population, show excess mortality above what is considered to be the "emergency threshold."¹

And yet the commitment by the country's government and by the international community is going in the wrong direction. The government has been decreasing its investments in health, as have international donors, while humanitarian assistance has failed to reduce the widespread medical crisis.

The risk is high that the Central African Republic will become trapped: not considered urgent enough for significant emergency aid; not considered trustworthy enough for meaningful development assistance.

For the sake of CAR's 4.4 million people, this cannot be allowed to happen. Existing levels of medical assistance are plainly insufficient to the scale of the needs. The country needs more actors conducting larger medical operations that reach more of the population.

In this paper, we outline the experiences, analyses and concerns of Médecins Sans Frontières (MSF) after 14 years working in the country. The report opens with a summary of the published evidence on CAR's mortality over the past 18 months by MSF and other researchers. We then analyse the various causes for this before summarising the inadequate existing levels of assistance provided by all the various actors, including firstly the government of CAR, but also the international community including ourselves. We conclude with a call for greater medical assistance to the country.

MSF'S PROGRAMMES IN CAR

Médecins Sans Frontières has been working in the Central African Republic since 1997 and, at the end of 2010, had 1,243 staff present in the country.

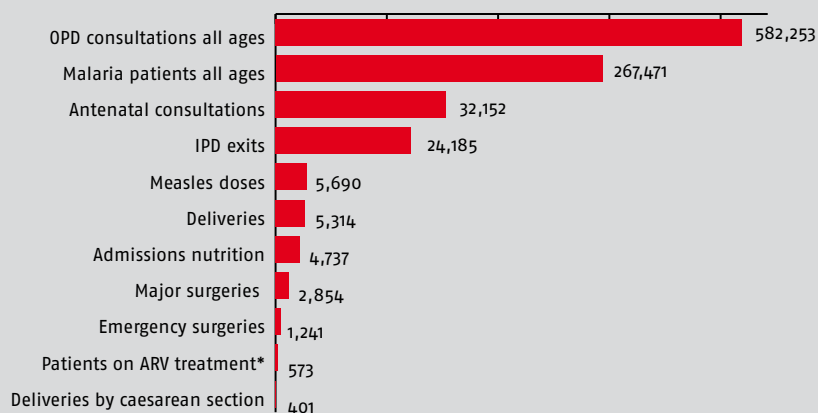
MSF works in five of the country's 17 prefectures, mostly but not only in the country's more unstable border areas. We run projects in Gadzi and Carnot in Mambéré-Kadei; Paoua in Ouham-Pendé; Boguila, Maitikoulou, Kabo and Batangafo in Ouham; Ndele in Bamingui-Bangoran; and Zémio in Haut Mbomou.

Our missions support nine hospitals and 36 health centres and health posts. In all cases, we work in Ministry of Health facilities, seeking as close cooperation as is possible. In 2010, we treated 582,253 people as outpatients and 24,185 people as inpatients in the country.



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Summary of all medical activities, 2010



* MSF opened a project focused on HIV and TB in Carnot in late 2010. As of July 2011, an additional 500 patients have been put on treatment for HIV and 513 on treatment for TB in this project.

¹ Defined as 1 death/10,000 population/day for the general population and two deaths/10,000 population/day for under-fives. F Checchi et al (2007) *Public health in crisis-affected populations: A practical guide for decision-makers*. ODI-HPN: London.

PART I: CRITICAL LEVELS OF MORTALITY

The citizens of the Central African Republic face frighteningly high rates of mortality. The Central African Republic has the second lowest life expectancy in the world at 48 years.² Indeed, mortality is generally above the level considered to be the "emergency threshold", indicating an emergency requiring immediate medical assistance.

Médecins Sans Frontières has, in the past 18 months, conducted four retrospective mortality surveys in three different prefectures:

- A sentinel site survey³ conducted in the sub-prefectures of Boda, Boganda, Boganangone and Gadzi between February and November 2010 found a crude mortality rate (CMR) of 1.0/10,000/day (95% confidence interval, 0.8–1.2), with higher peaks in the May–September wet season and a peak in November. The under-five mortality rate was 2.0/10,000/day (95% CI, 1.5–2.6). This is right on the emergency threshold.
- A study⁴ in the sub-prefectures of Carnot and Gadzi in June 2011 found that in three rural communes of Carnot, Gadzi and Senkpa Mpaéré, 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). 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 crude mortality results are at least three times the emergency threshold, and indicate a situation normally considered "out of control", even though neither sub-prefecture is conflict-affected or has large numbers of displaced people.
- An August 2011 survey⁵ investigated further the situation in the urban commune of Carnot, with a finding of a crude mortality rate of 3.7/10,000/day (95% CI, 2.96–4.61) and a U5MR of 7.0/10,000/day (95% CI, 5.26–9.34).

- An April 2011 study⁶ in the area around the MSF hospital in Maitikoulou, in the Markounda sub-prefecture of Ouham–Pendé prefecture, found a crude mortality rate of 0.83/10,000/day (95% CI, 0.51–1.33) and a U5MR of 1.81/10,000/day (95% CI, 0.92–3.56). These mortality rates do not exceed the emergency threshold, although the upper level of the confidence interval doesn't allow this to be ruled out altogether.

For the main survey carried out by Epicentre at sentinel sites in the sub-prefectures of Boda, Boganda, Boganangone and Gadzi, a chronic health crisis was found with death rates greatly "in excess of the plausible baseline and with additional worrying levels of malnutrition".⁷ There is clear evidence of excess mortality⁸, suggesting a protracted health crisis in 2010 at least in the areas covered by the survey. The Epicentre report suggests that economic deficits partly explain this, insofar as the partial or complete closure of diamond mines during 2009–10 removed the main source of income for most households. For both the crude and under-five mortality, the peak (in October–November 2010) was attributed to an epidemic.

Further, researchers from the University of California, Berkeley, published a mortality survey in August 2010⁹ which reports a crude mortality rate, across five prefectures which together account for 52% of the population, of 4.93/1,000/month (95% CI, 4.65–5.13).¹⁰ This is the equivalent of 1.64 deaths per 10,000 population per day, again above the emergency threshold. The highest rates were in those prefectures most recently affected by conflict and displacement (Ouham and Ouham–Pendé, with CMRs of 2.21 and 2.07 per 10,000 per day respectively), but the rates in the calmer prefectures of Lobaye, Ombella M'Poko and Bangui were also above the emergency threshold.

² WHO (2011), "Mortality and burden of disease: Life expectancy". *Global Health Observatory Data Repository*. [Database.] Accessed 7 October 2011, at: <http://apps.who.int/ghodata/>.

³ Caleo G et al (2011), *Sentinel site mortality surveillance of mortality and nutritional status: Boda, Boganda, Boganangone and Gadzi sous-prefectures, Central African Republic, 2010*. Epicentre: Paris.

⁴ Cohuet S, C Marquer, S Abdallah (2011), *Enquête de mortalité rétrospective et de couverture vaccinale dans les sous-prefectures de Carnot et de Gadzi, République Centrafricaine*. Epicentre: Paris.

⁵ E Espié (2011), *Enquête de mortalité rétrospective dans la ville de Carnot, préfecture de Mambéré–Kadéi, République Centrafricaine*. Epicentre: Paris.

⁶ D Rasella (2011), *Retrospective Mortality Survey: Axe Maitikoulou–Kdajama Kota*. [Unpublished.]

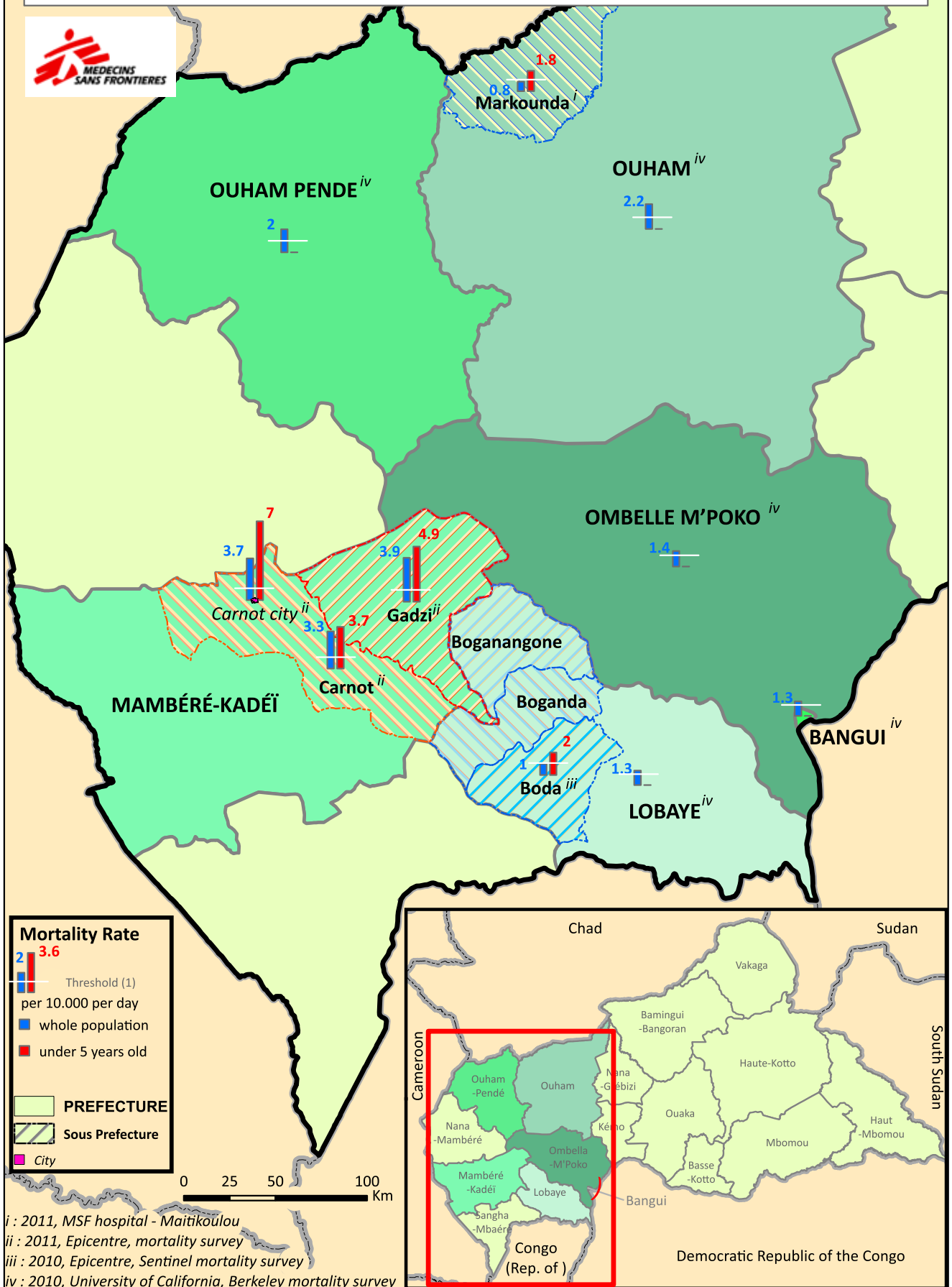
⁷ Caleo (2011), op. cit. p3.

⁸ Calculation of excess deaths requires a baseline, pre-emergency mortality rate, which is often difficult to obtain. Hypothetically, this could be the number of deaths caused by the emergency itself, or rather the number of deaths that would not have occurred had the emergency not happened. The difference between this baseline and the mortality rate found in the survey is then multiplied by the population size to obtain the number of excess deaths. The number of excess deaths is heavily dependent on what pre-emergency mortality is assumed and on the estimated population size.

⁹ 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. No assessment of the under-five mortality rates was conducted during this study.

¹⁰ The University of California, Berkeley study expressed deaths per 1,000 population per month rather than 10,000 population per day, as it was considered that the latter is associated with crisis situations, whereas the situation in CAR was described as chronic.

Mortality studies - Western Central African Rep. - 2011



Mortality Rate

2 | 3.6

Threshold (1) per 10.000 per day

Whole population (blue bar)

Under 5 years old (red bar)

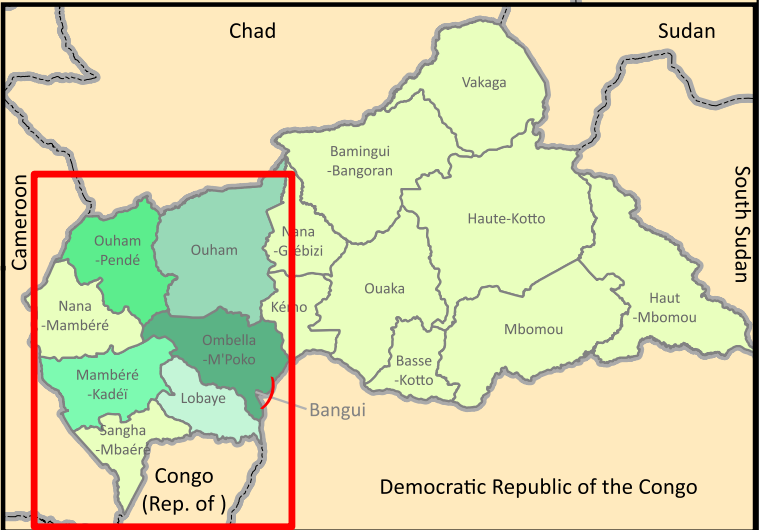
PREFECTURE (light green)

Sous Prefecture (hatched)

City (pink)

0 25 50 100 Km

i : 2011, MSF hospital - Maitikoulou
 ii : 2011, Epicentre, mortality survey
 iii : 2010, Epicentre, Sentinel mortality survey
 iv : 2010, University of California, Berkeley mortality survey



PART II: FACTORS CONTRIBUTING TO EXCESSIVE MORTALITY

Determining the exact causes of this excessive mortality for CAR is difficult: in the absence of a functioning health system in the country, there is no reliable country-wide cause-related mortality data; nor did the above-mentioned surveys conduct a comprehensive collection and analysis of cause of death.¹¹ Nevertheless, based on our experience in the country, MSF would identify three significant contributing factors to this mortality:

- Massive prevalence, incidence and mortality of preventable and treatable diseases.
- Crisis, conflict and displacement which disrupts people's lives and livelihoods.
- A phantom healthcare system which has failed to make even minimum-quality care available and accessible to the population.

FACTOR 1: MASSIVE PREVALENCE OF PREVENTABLE AND TREATABLE DISEASE

The Central African Republic has the fifth highest rate of death from infectious and parasitic disease in the world, at 754.9 per 100,000 population in 2008.¹² While MSF is a significant health actor in the country, we cannot provide a comprehensive picture of the country's health situation; however, we are able to describe what we see daily.

Malaria

Malaria is holoendemic in CAR; every individual in the population is infected at least once per year. Malaria is certainly the major threat to public health in CAR and the principal cause of morbidity and mortality among children:

- Malaria is by far the principal morbidity seen in MSF's outpatient facilities: of a total of 582,253 people treated as outpatients in 2010, 45.9% (or 267,471 people) were diagnosed and treated for malaria.
- MSF's data indicates very high caseloads throughout the year, but with a significant peak in the months of July and August each year (the "pique palu"). For example, in Paoua, the average number of paediatric admissions is 220/month; during the peak season this rises an average of 55% to 338 admissions/month.



¹¹ One of the studies mentioned above did include a "verbal autopsy" – which found that the principal causes of death were, as would be expected, diarrhoeal diseases (20.5% of all deaths) and malaria (14.1%) – but this method is self-reported and prone to error. See: Espié (2011), op cit.

¹² WHO (2011), "Mortality and burden of disease: Cause-specific mortality, 2008", *Global Health Observatory: Data Repository*. [Database.] Last accessed 17 October 2011, available at: <http://apps.who.int/ghodata/>.

- Malaria is a major killer: in hospital facilities, malaria is the greatest single cause of inpatient death.¹³ Nationwide, of 1,997 recorded deaths in 2009, 670 were from severe malaria and a further 330 from anaemia (most likely malaria-related, 50% for both causes); the proportion was greater among under-fives: of 1,375 deaths in hospital in this age group, 544 were from malaria and 270 from anaemia (59.2% combined).¹⁴ This tallies with our own experience: for example, in Boguila hospital, of deaths of under-fives admitted as inpatients, 33 out of 67 were from malaria (49%), which was by far the single largest cause of death in children.
- The disease is grossly underreported and seriously undertreated: only some 6.4% of expected cases are detected and treated.¹⁵

The challenges are principally related to expanding access to diagnosis and treatment by decentralising care to primary health structures and to community health workers, and by ensuring unbroken availability of artemisinin-based combination therapy (ACT) and rapid diagnostic tests in health centres and health posts. The country has a policy of free malaria treatment for children under five, but this system is not functional; it is plagued by stockouts of essential drugs, logistical constraints and disincentives, meaning free access is rarely the reality.

The reach and efficacy of longlasting bednet distribution programmes also needs to be improved: while very large numbers of bednets are claimed to have been distributed in the past few years, it does not appear to have resulted in any significant reduction in transmission. Other effective prevention and treatment options should also be favourably considered: introducing intermittent prevention treatment for infants, and switching to artesunate for severe malaria in hospitals.

¹³ There are no strong country-wide mortality data for malaria for CAR. The WHO estimate is 192.1 deaths per 100,000 population (ibid.), but given widespread under-reporting of malaria cases this seems unlikely. This rate would be lower than the malaria death rate in Chad and below the HIV death rate in CAR, which similarly seems unlikely (certainly it does not tally with MSF experience in our own programmes in CAR or in Chad).

¹⁴ MSPP (2011), *Bulletin Annuel d'Information Sanitaire 2009*, p39. MSPP: Bangui.

¹⁵ One of the very few prevalence studies (MICS 2000) estimated that 31.8% of children had had a fever during the previous two weeks. From this, it was extrapolated that in 2007 there should be a total of 5,692,495 cases of malaria, of which 2,213,747 cases should be in 0-5 year olds. This would signify 1,323 cases per 1,000 general population, and 1,698 cases per 1,000 under-fives. However, in 2009, the MSPP estimated only 175,210 reported cases, while MSF treated an additional 187,736 on top of that, meaning that only some 6.4% of expected cases were detected and treated. See: MSPP (2000), *Multiple Indicators Cluster Survey 2*. [Online.] Last accessed 4 February 2011, available at: http://www.childinfo.org/mics2_car.html.

HIV /Tuberculosis

CAR has the highest HIV prevalence in Central Africa. The HIV epidemic is generalised among the adult population, with most transmission occurring sexually. A national seroprevalence survey conducted in the country in 2010¹⁶ found a prevalence of HIV among the age group 15-49 years of 5.9%, a slight decrease from the previous study result of 6.2%.¹⁷ The rate in that age group had risen among men (4.3% to 5.4%), but fallen among women (7.8% to 6.3%). The highest geographic concentration is in the capital (10.7%) and in areas affected by conflict (such as Haut Mbomou, with 14.8%).

UNAIDS estimates that the number of people who are HIV-positive in the country are 110,000 adults and 17,000 children, while a total of 11,000 people die each year from HIV-related complications.¹⁸ The Centre National de Lutte contre le Sida (CNLS, or National Centre for the Struggle against AIDS) has estimated that 45,000 people, including 14,000 children, need antiretroviral (ARV) treatment now. However, at present, only some 15,000 people have started ARV treatment, or 33.3% of the needs.¹⁹ In our own facilities, on 31 December 2010, MSF was treating 573 HIV-positive patients with antiretrovirals; by July 2011 this number has risen to 998 patients.



¹⁶ UNFPA (2011), *Présentation des principaux résultats de la sérologie VIH prévalence du VIH de la Quatrième Enquête Nationale à Indicateurs Multiples 2010*. [Powerpoint presentation.]

¹⁷ Ministère de l'Economie, du Plan et de la Coopération Internationale (2007), *Résultats de l'enquête à indicateurs multiples couplée avec la sérologie VIH et anémie en RCA2006*. Last accessed October 11, 2011 at www.childinfo.org/files/MICS3_CAR_PreliminaryReport_2006_Fr.pdf. If people had access to proper treatment you would expect prevalence rates to actually increase.

¹⁸ UNAIDS (2011), *Central African Republic: HIV and AIDS estimates (2009)*. Last accessed October 11, 2011 at <http://www.unaids.org/en/regionscountries/countries/centralafricanrepublic/>. This extrapolation is based on the previous prevalence data, from 2006.

¹⁹ Delaunay S (2011), *Etat des lieux de l'infection VIH en République de Centrafrique et pistes de réflexion pour MSF*. MSF: New York.

Tuberculosis (TB) is also a major killer in CAR – both in patients co-infected with HIV and otherwise. The estimated prevalence, incidence and mortality rates of TB²⁰ all doubled between 1990 and 2009. Less than 20% of the 19,000 people presently thought to have the disease accessed treatment in 2009. This is based on a rate of 424 per 100,000, which is certainly an under-estimate given the lack of diagnostic facilities in most of the country.

The national programmes for HIV and TB are weak, and connections between them are only embryonic. Major issues include catastrophic nationwide ruptures in medicine supply that can last for months: for example, in the 30 months following July 2008, the national HIV reference centre (the Centre National de Référence des Infections Antirétrovirales et de la Thérapie Antirétrovirale) was out of stock for some first-line drugs for 18 of those months.²¹ In June 2011, there was also a catastrophic rupture of all first-line anti-TB drugs; this was only solved by a one-time donation of a nine-month supply by a charity. Lack of qualified human resources presents a challenge to both the scale-up and quality of HIV care in the country. A recent study²² indicates shockingly high rates of resistance to first-line drugs: up to 30% in adults and 50% in children.

As the world shifts the focus towards early treatment of HIV to prevent the spread of the virus, in CAR patients who are dying from HIV are unable to access treatment. New WHO treatment protocols introduced in 2010 emphasise the need for earlier access to treatment (CD4²³ threshold 350) and better drug regimens. In CAR, this would mean increasing the number of people on ARV treatment by more than five times, for which there is as yet no plan or capacity.

Sleeping sickness

The Central African Republic has four of sub-Saharan Africa's few remaining pockets of sleeping sickness (human African trypanosomiasis),²⁴ a parasitic neglected tropical disease transmitted to humans by the tsetse fly. Fatal if untreated, people in the Ouham pocket, in the country's northwest, became at greater risk of infection (or of having the disease) when control efforts collapsed during the conflict. The population would have been more exposed to the tsetse fly when in "the bush", whilst having less access to healthcare facilities

²⁰ World Health Organisation (2010) *World Tuberculosis Report*. WHO: Geneva.

²¹ Delaunay S (2011), op cit.

²² Esther (2011), *Discussion on preliminary results of a study into resistance to first-line medicines for HIV*. [Personal communication.]

²³ CD4+ cells are a type of T cell involved in protecting against infection. The destruction of CD4+ cells is the major cause of immunodeficiency, and measurement of CD4 is used to monitor the progression of the virus.

²⁴ Simarro P et al. (2010), "The Atlas of human African trypanosomiasis: a contribution to global mapping of neglected tropical diseases". *International Journal of Health Geographics* 9:57. Last accessed 11 October 2011 at <http://www.ij-healthgeographics.com/content/9/1/57>.



to treat the disease. In 2009, the country had 1,054 reported cases, the second-highest in the world.²⁵

MSF has been involved in sleeping sickness control in the country since the mid-1990s and is presently undertaking two projects aimed at eliminating sleeping sickness in the Ouham pocket. One project, in Maitikoulou, is on track to complete that task by the end of 2012: in 2010, 6,365 people were actively screened, with 56 found to be positive (a positive rate of 0.9%), and 49 treated. In Batangafo, also in Ouham prefecture, a total of 2,462 patients were treated out of 147,265 people screened between 2007 and 2010. However, active screening has been disrupted by insecurity and so only 340 patients were treated and 45,388 people were screened in 2010. The lack of active screening activities means the majority of patients on the Kambakota axis remain undiagnosed and untreated and so prevalence on that axis remains at 3.2%.

Meanwhile, diagnostic and treatment options do need to be improved and adapted to this context. The incorporation of nifurtimox-eflornithine combination therapy (NECT) into both protocol and practice in CAR is a priority and is happening in MSF projects. This improved treatment is a step in the right direction, combining the oral nifurtimox for 10 days with a reduced number of infusions of the eflornithine treatment, from 56 over two weeks to just 14 over 7 days.

Vaccinations

Vaccination coverage for childhood illnesses is poor and contributes to high levels of mortality from preventable childhood diseases. In 2009, only nine out of 24 districts achieved an 80% coverage for DTP3 (diphtheria, tetanus and pertussis), while only five achieved a 90% coverage for measles vaccination.²⁶ Coverage of measles immunisation, either with or without a vaccination card, was estimated in

²⁵ WHO (2011) op cit. This is partly a good thing, due to more active screening and therefore greater case finding and treatment.

²⁶ UNICEF (2011), *Immunization summary: A statistical reference containing data through 2009*, p33. UNICEF: New York. [Online.] Accessed 18 October 2011, available at: http://www.childinfo.org/files/32775_UNICEF.pdf.



rural Carnot and Gadzi sub-prefectures at 26.3% (95% CI, 16.4–36.2) and in urban Carnot at 55.5% (95% CI, 48.7%–62.2%).²⁷ A wider household survey in six prefectures found that 37% were completely vaccinated according to their age.²⁸

Cases of vaccine-preventable disease occurred in 2011, including measles, meningitis, neonatal tetanus, pertussis, yellow fever and polio. One case of wild polio virus was reported near our Batangafo project. The child's father confirmed to MSF that their village had not been visited during polio vaccination campaigns either in 2008 or in April and June 2011, because of the more or less permanent insecurity and armed clashes in the zone.

EPI activities are usually functional at hospital level but, at health centres and in the community, the activities are more or less non-existent, and there are no advanced or mobile strategies in place. In 2010 and 2011, there have been recurrent stockouts of BCG, polio and tetanus vaccine, while the majority of health centres have no cold chain equipment. There have been a number of supplementary immunisation activities undertaken, but with questionable coverage and quality.

A study conducted in Batangafo²⁹ in 2011 found 46.2% coverage for measles in children aged 9–11 months. The reasons for

non-vaccination advanced by the community were: the distance from the vaccination sessions (53% of those interviewed), problems of service availability (20% of the people interviewed), and problems of public health education (4%).

Despite having nearly 582,253 consultations in our facilities in 2010 (approximately 60% children under five), MSF itself only succeeded in vaccinating 5,690 children against measles. The recent change in vaccination strategy, to vaccinate only those children aged 9–12 months, will mean many thousands of missed opportunities for routine vaccinations.

Nutrition

Médecins Sans Frontières and Epicentre conducted a community surveillance survey in the sub-prefectures of Boda, Boganda, Boganangone and Gadzi between February and December 2010 which found the prevalence of global acute malnutrition (GAM) to be 11.9% (95% CI 9.1–15.5).³⁰ The prevalence of severe acute malnutrition (SAM) was 3% (95% CI 2.3–4.0), of which half had signs of the presence of kwashiorkor. SAM prevalence appeared to peak in April–May 2010, and in June–October.

Whilst malnutrition is seen to be a major underlying cause of childhood mortality, the relative stability of nutritional indicators over time suggests that the crisis is sub-acute and of long duration. This indicates that interventions designed for nutritional emergencies may not be entirely appropriate in this setting, particularly if not accompanied by control of major childhood diseases.

²⁷ Cohuet S, C Marquer, S Abdallah (2011), op cit.

²⁸ Ministère de Santé Publique, de la Population et de la Lutte contre le SIDA (2010). *Résultats de l'Enquête Ménage et de l'Enquête Qualité de Base Pour le programme Achat de Performance dans six Préfectures (Basse Kotto, Haut Mbomou, Mbomou, Lobaye, Ombella Mpoko et Nana Mambéré)*. MSPP: Bangui.

²⁹ Epicentre (2011), *Enquête de couverture vaccinale après une campagne de vaccination de masse contre la rougeole : Sous-préfecture de Batangafo, République Centrafricaine*. Epicentre: Paris.

³⁰ Caleo G et al (2011), op cit.

FACTOR 2: CRISIS, CONFLICT AND DISPLACEMENT

The Central African Republic has been trapped in a cycle of constant and interminable conflict since at least the late 1990s. While President Bozizé won re-election for a new mandate in January 2011, the state cannot guarantee the security of its citizens or its borders, and armed groups are more or less free to move and act at will.

While the number of battle-related deaths is low,³¹ there has been significant violence, including against civilians³² and humanitarians, and a substantial impact on people's health.³³ While absolute numbers can be low, the proportion of those affected and displaced by conflict in some areas can be very high, up to as much as half the population. The health effects of these conflicts are considerable, but these situations have also had serious impacts on other, crucial aspects of people's lives, including schooling for children, agricultural production, access to functioning markets and the degradation of essential infrastructure including roads. It is estimated that the country presently has 103,153 internally displaced people, of which 22,180 were displaced in 2011.³⁴

Despite some progress in formal negotiations between the government and various rebel forces, and some progress in disarmament, demobilisation and reintegration in the northwest, seven out of 17 prefectures are conflict-affected and 10 separate armed actors are active in the country.³⁵

It should also be noted that conflict is not the only reason for localised crises which affect people's livelihoods and health. In the west of the country, excessive mortality is more closely associated with collapse of livelihoods in the diamond-mining industry.

East: Haut Mbomou and Mbomou

The Lord's Resistance Army (LRA) has been present in CAR since March 2008. Following a lengthy series of attacks on villages, which included killings, rapes, abductions and house-burnings, some 19,000 people, or one-third of the population of Haut Mbomou, were displaced to the major towns, including Zémio, Mboki and Obo. These people experienced the direct

physical and psychosocial consequences of violence, rape and abduction. Added to this, the health consequences have included the collapse of healthcare in villages, as healthcare workers fled and medical supplies was restricted, while the nutritional level has worsened due to reduced food security. Insecurity and violence on the roads also severely restricts movements, including for humanitarians.

Triangle: Ouham and Nana Grebizi

Insecurity in this area, between Kabo, Kago Bandoro and Batangafo, is mounting. The FPR,³⁶ a rebel group from Chad, is gaining strength while the other main armed actor, the FDPC,³⁷ has fragmented; armed clashes are also increasing with the APRD,³⁸ present in the west of the zone. Attacks against humanitarian aid workers have led to suspensions of operations and affected the capacity to assist the civilian population. Half the population of the prefecture has become displaced, either internally or by fleeing to Chad. The rest is trapped in their villages by violence and insecurity and are dependent on humanitarian agencies for medical and other needs.

North: Bamingui-Bangoran, Vakaga and Haut-Kotto

The conflict between the FACA,³⁹ the CPJP⁴⁰ and the UFDR⁴¹ has included assaults on major towns, the destruction of villages and blocking of roads, and inter-ethnic violence between Runga and Gula militias. In June and July 2011, the two wings of the CPJP signed the Libreville Accord with the government, but in September serious violence between the CPJP and the UFDR led to widespread killings, house-burnings and displacement in the areas around Sikkikede, Bria and Ouandja. Some 12,000 refugees have fled into neighbouring Chad, while 6,000 were displaced in the town of Bria in September 2011. The rest is in a situation of entrapment, cut off from external assistance and unable to flee.

State provision of health services has ceased in many zones, and humanitarian access has been extremely limited throughout the north and northeast. Not only are the axes difficult and unsafe, but the FACA has closed altogether humanitarian access along two of them out of Ndélé. Humanitarians have also been kidnapped in this zone. This left some

³¹ According to definitions used by the Armed Conflict Dataset (UCDP/PRIO), CAR would not meet the 1000 battle-related deaths per year definition of "war", but rather the definition of "intermediate armed conflict", causing between 25 and 1000 battle-related deaths per year. See: Uppsala Conflict Data Program (2011), *UCDP/PRIO Conflict Dataset*. [Database.] Accessed 9 November 2011, available at: <http://www.pcr.uu.se/research/UCDP/>.

³² Potts A, K Myer and Roberts (2011), "Measuring human rights violations in a conflict-affected country: results from a nationwide cluster survey in Central African Republic". *Conflict and Health*. 5:4.

³³ Vinck P and P Pham (2011), op cit.

³⁴ UN OCHA (2011), *Overview of displacement in the Central African Republic*. OCHA: Geneva. Accessed 9 November 2011, available at: <http://reliefweb.int/node/458067>.

³⁵ OCHA (2011), *Central African Republic: Humanitarian access constraints*. [Map.] Accessed 18 October 2011, available at: <http://reliefweb.int/node/19217>.

³⁶ Front Populaire pour la Reconstruction, or Popular Front for Reconstruction.

³⁷ Front Démocratique du Peuple Centrafricain, or Democratic Front of the People of the Central African Republic.

³⁸ L'Armée Populaire pour la Restauration de la Démocratie, or Popular Army for the Restoration of Democracy.

³⁹ Forces Armées Centrafricaines, or Armed Forces of the Central African Republic. This is the military of the CAR state.

⁴⁰ Convention des Patriotes pour la Justice et la Paix, or Convention of Patriots for Justice and Peace.

⁴¹ Union des Forces Démocratiques pour le Rassemblement, or Union of Democratic Forces for Unity.

villages with no access to any form of healthcare; similarly livelihoods, schooling, water and sanitation have all been severely degraded.

Northwest: Ouham and Ouham-Pendé

The signing of the Libreville Peace Accord in 2008 by the APRD brought an end to five years of conflict in the northwest prefectures of Ouham and Ouham-Pendé. Since the elections in February 2011, the disarmament process seems to be advancing and many weapons have been surrendered. Further, while the formal numbers of internally displaced people (44,000) and refugees in Chad and Cameroon (159,000) remain high, some 36,000 have already returned home and many others have likely resettled where they are.⁴² Nevertheless, there are significant sub-regional variations: the western zone around Paoua is far more settled than the eastern zone between Maitikoulou and Batangafo. Further, the state has not yet re-established itself. While the population does have access to land for farming, people have had to rebuild their lives and livelihoods from scratch.

Southwest: Mambéré-Kadei

While conflict is the principal cause of crisis in CAR, it is not the only one: there have also been economic crises caused by a combination of the government's attempts to assert control over the diamond trade and a fall in the price of industrial diamonds.⁴³ The southwest of the country, around Carnot, suffers among the worst mortality rates in the country. The area is the site of a mining industry, which collapsed in 2009. The result was the impoverishment of a large part of the population and soaring health needs, including malnutrition.



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⁴² OCHA (2011), *Overview of displacement in the Central African Republic*. OCHA: Bangui. Accessed 18 November 2011, available at: <http://reliefweb.int/node/458067>.

⁴³ International Crisis Group (2010), *Dangerous little stones: Diamonds in the Central African Republic*. Africa Report 167. ICG: Brussels.

FACTOR 3: A PHANTOM HEALTH SYSTEM

The Central African Republic's health system has always been very weak; in many parts of the country, to all intents and purposes, it does not exist. The country lacks all six of the WHO's "building blocks of a health system":⁴⁴

- **Health services:** In rural areas, distances to the nearest health facility are often great: an average of 9.1 km in the five prefectures assessed in a baseline assessment, with the highest being 14.8 km in Ouaka and the lowest 3.8 km in Mbomou.⁴⁵
- **Health workforce:** For 43% of households, the closest health facility has no qualified personnel.⁴⁶ Qualified personnel, especially doctors, are heavily concentrated in the capital.⁴⁷ Since the murder of the region's chief doctor in June 2011, Mbomou and Haut-Mbomou lack any doctor in the public system.
- **Health information:** Surveillance systems are very weak, leading to a significant under-appreciation of the scale of CAR's health needs. For example: WHO reports that there were 175,210 probable and confirmed malaria cases in CAR nationwide in 2009.⁴⁸ This is less than the total number of confirmed cases treated (187,736) by MSF in the country alone.⁴⁹ So CAR appears relatively low-burden, when it most certainly is not.
- **Medical products, vaccines and technologies:** Medicines in health facilities are often in stock rupture: according to one assessment, health centres had 55% of a package of essential medicines, health posts had 38% and hospitals had 47%.⁵⁰ The suspension of Global Fund disbursements because of corruption allegations caused months-long nationwide ruptures in 2010 and 2011 for malaria (ACT), HIV (ARVs) and tuberculosis (first-line) medicines, with serious effects on patients. Further, cost recovery means that patients often need to procure their own medicines

⁴⁴ World Health Organization (2010), *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*. WHO: Geneva.

⁴⁵ MSPP (2010), op cit.

⁴⁶ MSPP (2010), op cit.

⁴⁷ Of the country's 118 generalist medical doctors in 2010 (0.031 per 1,000 population), 54 are in the capital (0.087 per 1,000 population), while only seven MDs cover Region Sanitaire 5, covering Vakaga, Bamingui-Bangoran and Haut-Kotto (0.027 per 1,000 population) and 11 doctors cover Region Sanitaire 3, covering Ouham and Ouham Pendé (0.013 per 1,000 population). See: Morhain A (2011), *Etude interne sur l'accès à la santé en République Centrafricaine et pistes de réflexion pour MSF*. [Unpublished.]

⁴⁸ World Health Organization (2010), *World Malaria Report*. [Online] Last accessed 14 January 2011, available at: http://www.who.int/malaria/world_malaria_report_2010/en/index.html.

⁴⁹ MSF figures are reported to the MSPP.

⁵⁰ The assessment scored facilities on the basis of the presence or absence of the following items: amoxicillin 250mg, artesunate-amodiaquine 50-200mg, cotrimoxazole 480mg, diazepam 10mg/2ml, mebendazole 100mg, methergine 10 units, metronidazole 250mg, paracetamol 500mg, quinine 500mg, ORS, sterile gloves, compresses, and glucose 5% solution. MSPP (2010), op cit.

in the private market, from unlicensed private pharmacies or from itinerant drug sellers, and these are of questionable quality. The private pharmaceutical market is also plagued by poor quality and scandal, and an inability by the government to exercise effective control.⁵¹

- **Health financing:** Despite being one of the poorest countries in Africa, nearly every medical act has to be paid for out of the patient's own pocket: deliveries (average fee US\$26.09), hospitalisations (average fee US\$23.38); consultations (average fee US\$12.92 in a health centre, or US\$6.80 at a health post); lab tests (US\$7.61), antenatal consultations (average fee US\$4.63); medicines (US\$3.19);⁵² even gloves and "table rights" (US\$1.13 each).⁵³ For its own functioning, the Ministry of Public Health (MSPP) is dependent on funding from donor countries and health funders such as the Global Fund.
- **Leadership and governance:** The technical capacity to supervise medical programmes does exist in the various national centres of the MSPP, but it is weak and needs considerable strengthening and resourcing. Health does not appear to be a major priority of the government.

A particularly dire set of health effects has resulted from the suspensions of various grant agreements between the government and the Global Fund to fight AIDS, Tuberculosis and Malaria. As a result of this breakdown, no disbursements were made for malaria in 2010, resulting in a countrywide stockout of ACT:⁵⁴ this means that at least 175,000 people could not receive a potentially lifesaving treatment and instead had either to buy sub-standard treatment in the marketplace or not be treated at all. Similarly, the suspension of HIV grant disbursements has been the principal reason for nationwide stockouts in antiretroviral drugs, interrupting the treatment of some 15,000 HIV-positive patients.

The result of all this is depressingly predictable. Frequently, health services are simply not available in many parts of the country. If they are available, accessibility is restricted by distance and by cost for the patient. If accessible, services are usually of poor quality.

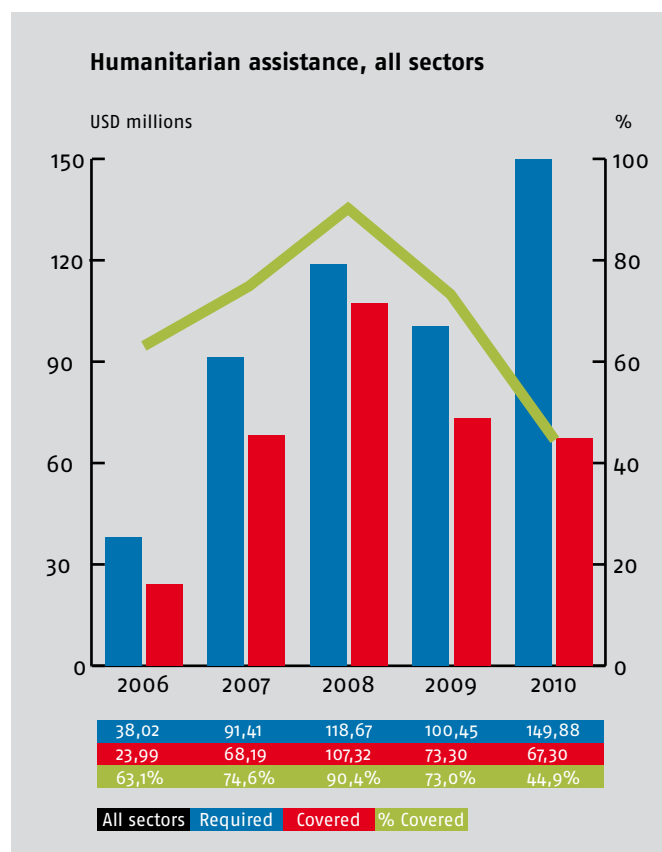
⁵¹ In the case of the Indian manufacturer Shalina, the government signed an agreement with the company to distribute drugs in the country, but without any control over the quality of the medicines, the claims made by (untrained) salesmen or the conditions of storage of the drugs. Despite recommendations that the company's goods be withdrawn from sale, they are still widely available, including in government health centres. See: Courcambeck A (2010), *Assistance Technique pour le projet de renforcement des services de santé publique en République Centrafricaine: Rapport de Mission*. [Unpublished.]

⁵² MSPP (2010), *op cit*.

⁵³ Cohuet S, C Marquer, S Abdallah (2011), *op cit*.

⁵⁴ Artemisinin-based combination therapy, or ACT, is the WHO's recommendation for treating both simple and severe cases of P.falciparum malaria.

- **Costs for citizens are high:** Average annual expenditures on health come to 10.7% of income (US\$23.80, from an annual average income of US\$222).⁵⁵
- **Access is restricted to medical care for the poor:** When sick, 48% visit a health centre, but 43% go directly to a pharmacy, mostly (56%) because the pharmacy is less expensive. Of those who go to a pharmacy, 41% are not able to purchase a full treatment, again principally because of cost.⁵⁶
- **Quality is poor:** An assessment conducted in 20 hospitals, 27 health centres and 16 health posts found the average scores against a broad set of quality measures was 43% in hospitals, 33% in health centres (only four achieved 50%) and 21% in health posts (none received 50%).⁵⁷
- **Outcomes are poor:** This is most clearly shown by the mortality rates. Evidently, the health system is making barely a dent in these.



⁵⁵ MSPP (2010), *op cit*.

⁵⁶ *Ibid*.

⁵⁷ *Ibid*. The survey identified a wide range of indicators for "quality of service" and then scored them, out of 100.

PART III: INADEQUATE RESPONSES TO MEDICAL NEEDS

Humanitarian assistance can help lower deaths from endemic and epidemic diseases and from the health effects of crisis, conflict and displacement. But if the country is to have a functioning health system, the government of CAR, in collaboration with its international partners, will need to start taking responsibility for its own citizens' health.

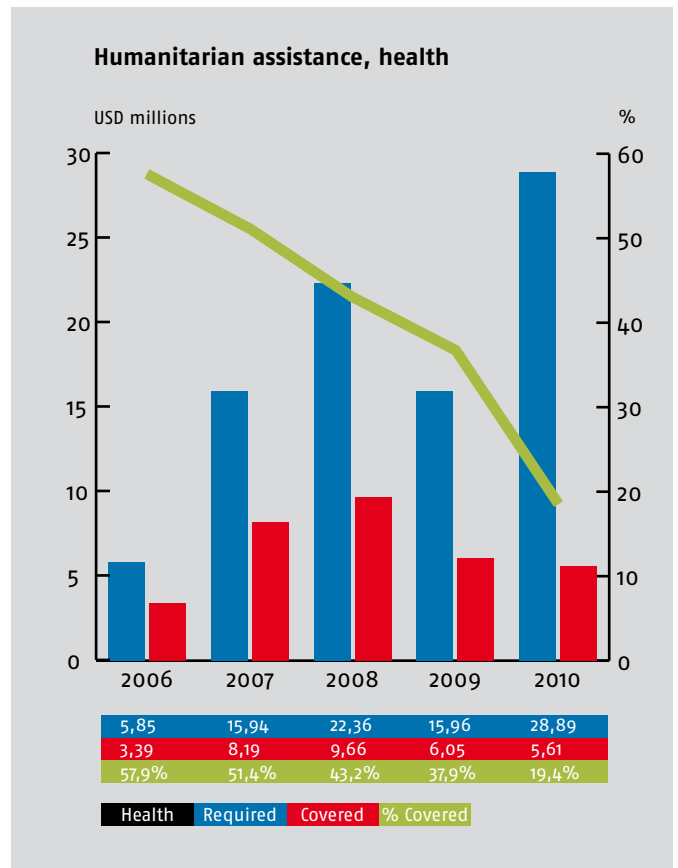
Present levels of commitment, by the government and by international actors (both humanitarian and development), are vastly insufficient for the scale of the health needs. In fact, actors have actually been reducing their commitment to health in CAR. This situation urgently needs to change.

Government of CAR funding

Few state resources are allocated to health: government health spending is only US\$7 per capita per year, the fifth lowest in the world.⁵⁸ The annual health budget is US\$30.8 million, which amounts to 11% of general government expenditure.⁵⁹ The Abuja Declaration, signed by African heads of state in 2001, committed its signatories (of which CAR is one) to allocating at least 15% of government revenues to health. Shockingly, not only has CAR not met that objective, but its contribution to health actually declined between 2001 and 2009.⁶⁰



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Healthcare suffers from a lack of consistent leadership, qualified health workers and policies to guide medical care. The government needs to prioritise healthcare and put in place the conditions that would make greater development aid possible – notably accountability.

Humanitarian assistance

While estimated funding requirements for humanitarian assistance have continually increased over the past five years,⁶¹ the coverage of these requirements by donors peaked in 2008 and has since declined considerably, both for all forms of humanitarian assistance and for the health sector. The mid-year Consolidated Appeal Process (CAP) review for 2011 is so far 43% covered (US\$59.3 million out of US\$139.5 million required), with health 20% covered (US\$5.2 million out of US\$26.5 million required).⁶²

⁵⁸ WHO (2011), "Health systems: Health expenditure per capita." *Global Health Observatory Data Repository*. [Database.] Accessed 7 October 2011, available at: <http://apps.who.int/ghodata/>.

⁵⁹ WHO (2011), "Health systems: Health expenditure ratios." *Global Health Observatory Data Repository*. [Database.] Accessed October 7, 2011, at: <http://apps.who.int/ghodata/>.

⁶⁰ WHO (2011), *The Abuja Declaration: Ten years on*. [Online]. Accessed 18 October 2011, available at <http://www.who.int/healthsystems/publications/Abuja10.pdf>.

⁶¹ OCHA (2011), *Financial Tracking System: Central African Republic*. [Database.] Accessed 10 September 2011, available at <http://fts.unocha.org/pageloader.aspx?page=emerg-emergencyCountryDetails&cc=caf>.

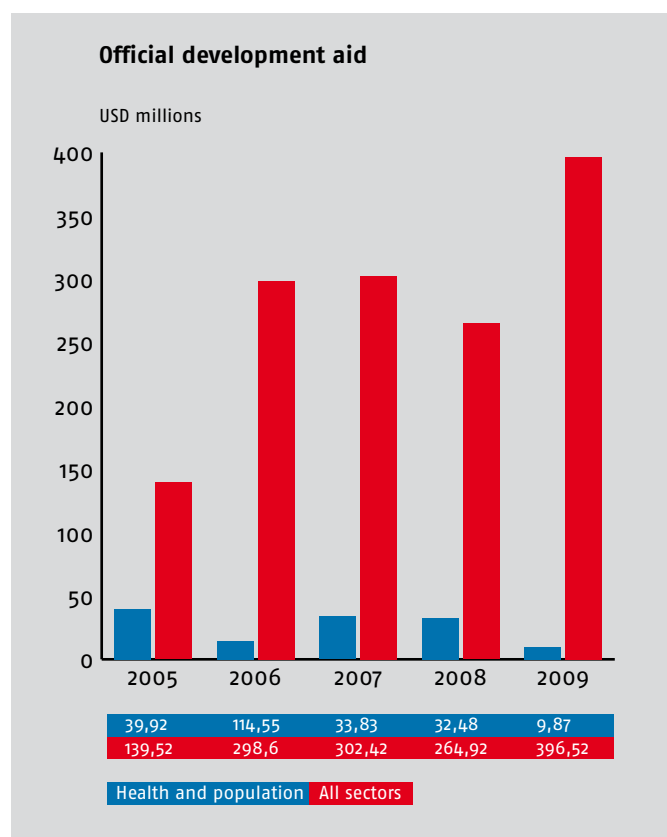
⁶² OCHA (2011), *Central African Republic: 2011 Consolidated Appeal Mid-Year Review*. Accessed 10 September 2011, available at <http://ochaonline.un.org/cap2006/webpage.asp?Page=1957>.

The UN Office for the Coordination of Humanitarian Affairs (OCHA) plays the central role in securing and distributing humanitarian funds in the Central African Republic.⁶³ A concerted effort by OCHA since 2007 has resulted in increased spending. However, the CAPs have focused principally on the zones most touched by conflict.

This focus on the conflict zones is not inappropriate, but it is inadequate. It fails to acknowledge the medical crisis throughout the country, and results in medical activities being closed down due to lack of funding or donor interest. For example, the largest single donor to the country is the European Commission's humanitarian aid department, ECHO, which has prioritised the conflict zones in the east and northeast, and deprioritised the supposedly "post-conflict" northwest, despite the fact that health services in the northwest are nowhere near rebuilt and medical needs are still great.

International donor assistance

International donor assistance to health also shows weak international commitment to the Central African Republic. Official development aid to CAR from the major bilateral and



⁶³ MSF is not a formal member of the cluster system; we have observer status only. We do not receive direct financial support through the CAP, or through any UN agency in CAR.

multilateral donors rose from US\$139.5 million in 2005 to US\$369.5 million in 2009. But gross disbursements to health dropped over the same period, from US\$39.9 million in 2005 to US\$9.9 million in 2009.⁶⁴

More worryingly, commitment to maintaining even these levels of assistance seems to be diminishing. Some major donors are talking about phasing out their assistance to the country, either in the health sector or altogether.

Certainly, CAR is a difficult setting for assistance, as successful programmes would need to be based on a partnership with a government which has great difficulty fulfilling its commitments. Nevertheless, there is a huge need for assistance to CAR to help it build a functioning health system in the long term; success will require both persistence and some creative thinking.

Global Fund engagement

The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) is the single largest funder of health programmes in the country. Eight separate grant agreements have been signed: four for HIV, two for tuberculosis and two for malaria, of which two (for malaria and HIV) are still current.⁶⁵ Between the first grant disbursements in 2003 and 2011, the fund has disbursed US\$61.9 million, against US\$84 million signed – meaning that US\$22.1 million has not been disbursed to date.

Since 2009, there have been massive, often months-long disruptions and suspensions in disbursements; these have been principally due to concerns about accountability. The effect has been most dramatically seen in malaria disbursements, which have flat-lined since 2008, with some years featuring zero disbursements, with major effects on the availability of medicines and therefore on patients. The need to balance accountability to donors and patients is acknowledged; nevertheless, the high burden requires us to find creative solutions to ensure resources for treating HIV, TB and malaria.

MSF's commitment

Médecins Sans Frontières itself spent US\$18.1 million in CAR in 2009,⁶⁶ and US\$22.8 million in 2010. While facing consid-

⁶⁴ OECD DAC (2011), *AidFlows: Central African Republic*. [Database]. Accessed 10 September 2011, available at: <http://siteresources.worldbank.org/CFPEXT/Resources/299947-1266002444164/index.html>. This dataset only includes the 10 major bilateral and multilateral donors in each given year.

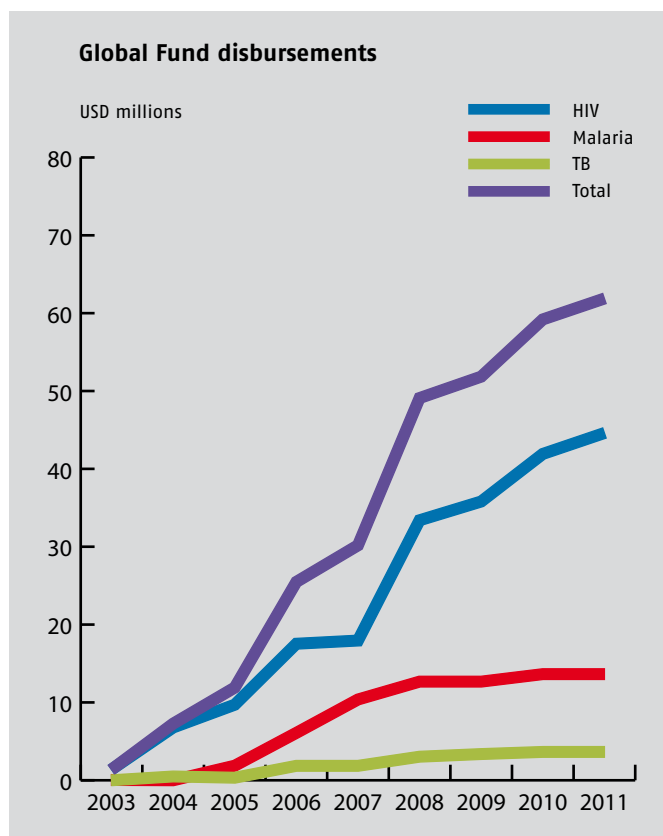
⁶⁵ GFATM (2011), *Central African Republic*. [Online.] Accessed 18 October 2011, available at: <http://portfolio.theglobalfund.org/en/Country/Index/CAF>.

⁶⁶ MSF (2010), *International Financial Report*. [Online.] Accessed 10 September 2011, available at: <http://www.msf.org/msf/articles/2010/07/msf-international-activity-report---2009.cfm>. Converted into US\$ at the rates pertaining on 31 December 2009.

erable challenges in achieving our desired scale of operations in the country, our ambition is to expand coverage of our programmes and better position ourselves to deal with the medical needs.

While our own programmes were originally positioned based on CAR's historical conflicts, we are now re-evaluating our role in the country. We are currently re-orienting some of our operations towards longer-term programmes, aware that it will take years for the situation to improve. For example, MSF is currently evaluating the possibility of a long-term hospital project in Bangui. Other projects in the country, including Kabo, Batangafo and Ndele, also have longer-term timeframes and considerable resource commitments attached to them; other investments in longer-term hospital projects are also under review.

Presently, we see no real exit strategy. This is a significant concern for us, but we feel the nature of the country's crisis provides us with no other option. We are certainly realistic about our inability to solve this medical crisis alone.



CONCLUSION

The Central African Republic today finds itself in a state of chronic medical emergency. While the world, and even the country's own government, looks elsewhere, Central Africans are suffering and dying in unacceptable numbers.

According to classical theory, humanitarian assistance takes place only during the moment of crisis, after which development can begin again. But in the Central African Republic, this simply does not match the reality. The categorization between "humanitarian" or "development" assistance might be relevant for the agencies and donors involved, but it shouldn't be used to mask or ignore the critical unmet medical needs on the ground. Rather, assistance actors should critically re-evaluate their analyses of the country, based on the data presented here. Regardless of theory, the medical reality for this population is shocking and requires immediate action.

The longer-term prognosis is bleak, and unacceptable. While the government functions in Bangui and in the neighbouring prefectures, in much of the country, impunity reigns and the state hardly exists. Without external assistance, the health system would simply not work. Further, many attempts to provide assistance to the country have been severely hampered, if not prevented, by corruption and weak capacity.

We acknowledge the dilemma: levels of dysfunction hamper all aspects of health provision, including the supply of drugs, the quality of care and the accountability of the system, and make it very difficult for international donors. Yet this must surely be balanced against the massive excessive mortality, which demands action.

This situation cannot be allowed to continue. Existing levels of medical assistance are plainly insufficient to the scale of the needs. The country needs more actors conducting larger operations covering more of the population. If old models of assistance have not worked, then new models have to be found.

We appeal to decision-makers inside and outside the country, expressing our extreme concern for the medical emergency inside the Central African Republic, and demanding their action.

IMPRESSUM

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