MSF Report
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Trapped and abandoned: The lack of humanitarian access and assistance for CAR's most vulnerable

MEDECINS SANS FRONTIERES

I
Introduction

For the past two years, the people of northern Central African Republic (CAR) have suffered from the increasing impact of ongoing insecurity, violence and displacement, far from the eyes and the attention of the international public. Their plight can neither be reduced to isolated emergency needs within a development context, nor to a spill-over from the regional tensions in Chad and Darfur. Despite the current attention to CAR, this forgotten conflict has been ongoing for years, with peaks of extreme violence resulting in widespread vulnerability in conflict-affected areas throughout the north.

Today, parts of CAR's population remain trapped by abuses of armed actors, roadside banditry and repeated displacement, surviving in a precarious situation in which it is just as unsafe for them to flee as it is to stay in their homes. Together with fragile, and often non-existent medical infrastructures throughout the country, these ongoing outbreaks of violence and displacement have left the population just barely coping with an untenable situation and vulnerable to disease.

Patients waiting at the health center, Markounda region © MARJA SCHOLTEN

Médecins Sans Frontières (MSF) has been present in CAR since 1997, addressing the needs of the population in violence-affected and often remote areas. Despite the killing of an MSF volunteer in June 2007, MSF continues to provide primary and secondary health care through a network of hospitals, health centres and mobile clinics serving the main violence-affected northern regions of CAR, in Ouham, Ouham-Pendé, Nana Grébizi and Vakaga provinces. Projects work in and/or around the major northern towns including Paoua, Boguila, Markounda, Batangafo, Kabo and Kaga Bandoro in the northwest, and Gordil and Birao in the northeast. During the first five months of 2007, MSF-supported health structures performed over 100,000 medical consultations. Our activities include management of common diseases, surgery, nutrition, care for victims of violence and sexual abuse, and programs addressing HIV/AIDS, tuberculosis and Human African Trypanosomiasis. MSF programs also ensure epidemiological surveillance, routine vaccinations, non-food item distributions and emergency response. In addition, MSF works to assist CAR refugees along the eastern border of Cameroon, conducting active nutritional screening and providing supplementary food rations along with medical and nutritional care for urgent cases.

Through our daily work, MSF witnesses firsthand the continued humanitarian needs in northern CAR and the difficulties for humanitarians to assist the population and for patients to access much-needed medical care. It is our aim to document the precarious living conditions facing the people in northern CAR, isolating them from medical care and endangering their lives and health.

II
Background

Since mid-2005, CAR has been the backdrop of conflicts between government and different rebel forces in the northeast and in the northwest. Both conflicts are characterized by periods of low-intensity insecurity alternating with acute phases of extreme violence often directly aimed at the civilian population, and regularly breaching international humanitarian law.

In the northeast, the rebel group UFDR (*Union des forces démocratiques pour le rassemblement*) has launched attacks on Birao in Vakaga province in October 2006 and again in March 2007.

In the northwest, since September 2005, the APRD (*Armée populaire pour la restauration de la république et la démocratie*) –more recently the FDPC (Front démocratique du peuple centrafricain)– have engaged in scattered clashes with government forces, including in and around Markounda, Paoua and Kabo in Ouham and Ouham-Pende provinces.

III

Humanitarian consequences of the violence

Throughout northern CAR, many communities continue to face ongoing violence. Although in places like Birao some families started to return and rebuild their houses, tens of thousands of Central Africans have fled as refugees to Chad or Cameroon. Yet the majority of displaced people remain in the bush, usually only a few kilometres away from their villages of burnt or deserted homes, or move between their village and the bush to survive. Along the axes Batangafo-Kabo-Kaga Bandoro in Ouham province, 18 out of 33 villages along the main roads had lost some or all their homes by September 2007.

"My house is burnt, all houses around the market have been burnt. Everything is gone. The soldiers shot four men in my neighbourhood, accusing them of being rebels but they were just hiding in their house".

Man, 35, Birao, Vakaga province.

Burnt village in Vakaga province © MARJA SCHOLTEN

Between mid-2006 and June 2007, MSF provided essential household items to some 2500 households and medical assistance for 140,000 people, including an estimated 35,000 displaced people. This reflects the widespread humanitarian need resulting from insecurity and displacement. In some locations, as on the Markounda–Maitikoulou axis in Ouham province, populations have remained displaced since the end of 2005.

At the same time, the civilian population reported being subjected to constant intimidation, extortion and violence.

"The people flee back and forth between their villages and the bush. When the rebels come, they demand that you give them food, goats, money... if you go out to the fields, they come and tear your skirt off if you are a woman. They take your coins and they insult you. And if you are a man, they beat you."

Woman, 40, village by Batangafo, Ouham province. [1]

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All quotes contained in this document date from February-June 2007

CAR's civilian population finds itself in the untenable situation of being targeted by opposing armed groups and repeatedly displaced in the quest for security. In the vacuum left by armed conflict, roadside bandits known as coupeurs de route or zaraguinas, attack and kidnap village inhabitants. Villagers and displaced people have reported incidents where bandits stole their clothes and possessions, and harassed, beat, raped, kidnapped or killed people.

Recently, a relative stand-still in the conflict has allowed the population greater opportunities to travel on the roads and engage in commercial activities in some areas, such as around Paoua, Boguila, Batangafo, Kaga Bandoro and Birao. However, the situation remains extremely volatile. While continuing insecurity and displacement directly impact on the lives of populations in violence-affected areas, even more people are suffering from indirect consequences of this insecurity that has weakened their already fragile ability to cope.

A family in front of its rudimentary shelter in the bush, region of Kaga Bandoro © ALOÏS HUG

Living conditions in northern CAR vary widely, and repeated displacement over time is impacting on the physical health and human dignity of the population. Some displaced may live in sturdy shelters not dissimilar to the ones they abandoned in their villages, filled with belongings rescued from their houses, and where they can continue to cultivate nearby fields established in the bush. Others cope under extremely rudimentary conditions, sheltering under improvised palm roofing and living off of wild plants, game and water available in the bush.

"Since five months, we have been living in the bush and suffer illness and wounds from living there. We have no real shelter and only eat one meal a day. The last time I ate, it was just some millet flour mixed with water. Our food provisions and our seed stocks are gone because we have eaten everything already. I want to return to my village, but we are too afraid of getting shot there."

Woman, 26, village near Kabo, Ouham province. She had given birth in the bush to a premature baby.

“We fled deep into the bush. Once we abandoned our fields, cattle herds trampled the crops and the birds took away the harvest. Now we have no food anymore. In the little pots we managed to rescue, we cook leaves and yams. Whatever the monkeys eat, that is what we eat.”

Man, village near Kaga Bandoro, Ouham province.

To date, even with this precarious situation, malnutrition remains mainly moderate. 120 severe[2] and 418 moderate cases were treated in the area of Batangafo-Kabo-Kaga Bandoro, 449 moderate cases in Boguila and Markounda, and 153 moderate cases in northeastern Vakaga province from January to August 2007.

For many displaced people, a lack of safe drinking water is a problem—if they are functional, hand pumps in the villages force displaced people to brave insecurity to find water—or else to risk illness by drinking from unprotected water sources in the bush.

Water source in the bush © ALOÏS HUG

“Where we live in the bush, we drink from natural water sources, but these are limited so sometimes we drink marsh water. Because of this, we suffer from a lot of diarrhoea and malaria.”

Man, village near Batangafo, Ouham province.

Due to ongoing and/or repeated displacement, most of our patients suffer from typical pathologies afflicting populations living in poor living conditions, above all malaria, acute respiratory infections (ARIs) and diarrhoea. These conditions are only exacerbated by repeated flight, living in the rough, and exposure to mosquitoes and unprotected water sources.

From January to August 2007, despite mobile strategies, MSF treated a relatively low proportion of expected patients. In the north-western zone of Batangafo-Kabo-Kaga Bandoro, MSF treated 19,344 patients for malaria, 9563 for respiratory infections and 3203 for diarrhoea, out of 75,873 total outpatient consultations. The official catchment population of the area is 140,000. Similarly, in Boguila and Markounda, 16,962 patients were treated for malaria, as the main health problem. In north-eastern Vakaga province, out of the 24,123 consultations, 6,760 patients were treated for malaria, 2,070 for respiratory tract

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1% of those screened.

infections and 1437 for diarrhoea. The catchment population of the MSF intervention in Vakaga is 35,000 people. The low level of medical consultations, and a relatively high level of eye infections [3] and skin infections [4], resulting from poor hygienic conditions, may be the signs of lack of easy access to medical care.

Some displaced people have lived for over a year in the bush and developed coping mechanisms to survive (i.e., roofs of plastic sheeting, or food stocks of wild roots) — but even those who have sought refuge in the bush are not safe. Along the axis Ouandago-Kaga Bandoro, village populations were first displaced to the bush by armed groups in late 2006, but then were forced to flee back to their homes in late June 2007 as *coupeurs* de route began to prey on them in the bush. Following the October 2006 attack on Birao in Vakaga province, inhabitants of one nearby village fled to the bush for two months, abandoning their money, belongings and livestock to rebel forces. After they finally returned, they were displaced again in March 2007.

From January to August 2007, MSF projects in the northern CAR treated over 296 patients for violent trauma requiring medical and/or surgical intervention.

On the axis Batangafo-Kabo, 44 patients treated for violent trauma between January and May 2007 spoke with MSF about their injuries; of these, 24 had been wounded in attacks by armed groups or *coupeurs de route* in their villages or on the roads, or were caught up in clashes between armed actors. The majority of these patients told MSF that others still remaining in their village had been intimidated, displaced, wounded or even killed during the same incidents. Many forms of abuse and intimidation cited by the local population would infrequently appear in medical consultations, such as beatings with a stick to the back, tying the arms for long periods of time, or tying people up to trees and depriving them of food and water. As a result, the medical care MSF has provided for violent trauma may only represent a fraction of injuries sustained in the overall insecurity.

MSF medical staff has also observed patients suffering from mental health distress as a result of the ongoing conflict. In the Northwest, seventy out of 102 patients MSF treated have been directly impacted by the conflict — threatened with weapons, seeing their houses burnt, or experiencing severe physical or sexual violence. Teams reported observing severe anxiety and related symptoms, mood disorders, sleep difficulties, and hyper-vigilance among patients in CAR.

Medical consultation of a man that has been beaten, Paoua © RÉMI VALLET

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6599 in Batangafo-Kabo-Kaga Bandoro, 2963 in Boguila and Markounda, 515 in Vakaga province.

4
5146 in Batangafo-Kabo-Kaga Bandoro, 668 in Boguila and Markounda.

"At the moment, people have returned to the village and life is resuming some normalcy. Weddings are resuming. But the community lives in a constant state of fear. People get up in the morning, not being sure of what the day will bring, they live with constant uncertainty and most feel hopeless. This is no real life. This feeling is reflected in the outward state of the community. Most people... appear listless."

Woman, Vakaga province.

While our work in CAR does not reveal large-scale mortality and morbidity directly connected with the conflict, the indirect consequences of continued violence and displacement on the population are very real—and complicated by insecurity blocking both humanitarian assistance to the population as well as patients' access to urgently needed medical care.

IV
Accessing care

In June 2006, MSF reported that there was one medical centre for 6000 inhabitants in CAR. Many health structures had already been destroyed in prior conflicts of 2001 and 2003. Since then, armed groups and *coupeurs de route* continued to attack, pillage and destroy health posts, while qualified medical staff have fled to safety elsewhere. Some medical staff, including key personnel in health structures where MSF currently works, have been personally targeted.

"The health posts were closed because everyone fled to the bush. Sometimes there were infirmiers-secourists[5] who could provide basic first aid or do injections, but they have shut down their work in the health posts… and ended up just working in their fields like everyone else. The health centre in [a nearby village] was attacked last year. *Coupeurs de route* pillaged all the medications and everything else that was inside. Not even a chair was left behind. Overall, there are fewer health centres around here than a year ago. But medications have been lacking for years now."

Man, Batangafo, Ouham province.

Triage at MSF outpatient department in Paoua
© RÉMI VALLET

The few functional health structures where the Ministry of Health is present without international assistance, often resort to cost recovery, forcing impoverished and violence-affected populations to pay for health care services and thus creating an additional obstacle to accessing already scarce medical care.

In much of northern CAR, MSF has been one of the main providers of primary and secondary health care. In the northwest, some communities are able to access clinics or hospitals in Chad, but normally these are extremely far and accessible only to very few, as services in Chad are too expensive for most to afford.

In north-eastern Vakaga province, there are no secondary health services as Birao hospital was left completely vacant when medical staff fled the conflict in 2006. In Vakaga province, MSF strives to provide care for a population of 35,000 people— yet from the period of January to August 2007, MSF conducted some 30,000 consultations, fewer than the 33,000-60,000 consultations

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People trained in basic first aid.

normally foreseen for this time period. Impassable roads during the rainy season, long distance and insecurity on the roads come together to limit humanitarian access to people as well as to bar patients' access to basic services.

For many Central Africans, reaching even the few functional health structures can be a serious problem due to insecurity. Along with long walking distances and the constant threat of harassment, people living within violence-affected areas find it difficult to move between villages, as well as outside their districts towards larger towns. Our patients have spoken about problems encountered en route to the health centre, including the shooting of men as they enter towns, widespread kidnapping of women and their children by coupeurs de route who later ask for ransom or kill the hostages, harassment and arrest in towns by governmental authorities, and extortion of food, money or other goods by armed groups at checkpoints when travelling.

Above all, men face particular obstacles to accessing medical structures.

> "It's a problem to go to town and to the health centre, because you can encounter armed men along the way. If they attack you, they might beat you, asking for money. If you have no money, they might tie you up to a tree and leave you behind. This can happen to anyone."
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> **Man, village near Batangafo, Ouham province.**

This insecurity continues to block the population's access to urgently needed medical care and destabilizes an already fragile health care system struggling to meet the needs of the population.

V

Accessing the population

A MSF team going to Bedarama for a screening, Ouham-Pendé province
© RÉMI VALLET

Insecurity in northern CAR also makes it extremely risky for humanitarian staff to provide health care to the population trapped in these volatile and often remote areas that lack sufficient infrastructure and are sometimes only accessible by roads that become impassable during the rainy season. Throughout northern CAR, MSF activities include mobile clinic teams travelling to remote areas outside towns to provide primary health care to more isolated and vulnerable populations, as well as referral and access to secondary care in more serious cases. Yet maintaining access to locations outside the main towns of northern CAR remains difficult.

When MSF first launched activities in the region of Batangafo-Kabo in July 2006, insecurity prevented all mobile activities outside the towns until December 2006. From January to August 2007, MSF's mobile clinics providing vital primary health care to 6553 persons per month, were suspended 29 times in different locations—the equivalent of four months of care— again due to insecurity. In one region of Vakaga province where MSF has conducted regular mobile medical activities throughout 2007, one armed group recently denied MSF humanitarian access for one month. This denial of humanitarian access and assistance is in direct contravention to humanitarian law.

Violence directed at humanitarian aid workers and their beneficiaries also persists in northern CAR. From January to July 2007, in the north-western region Batangafo-Kabo-Kaga Bandoro, MSF documented 18 incidents in which humanitarian access was blocked by armed groups or where threats and violent incidents were directed at humanitarian aid workers; MSF, two different humanitarian organisations and several UN agencies were affected by this violence. And in the most serious incident so far, an MSF volunteer was killed on June 11, 2007, while carrying out an assessment mission in the area of Ngaoundai-Bocaranga in north-western CAR.

Due to the general insecurity, humanitarian assistance remains under threat throughout northern CAR, to the detriment of the most vulnerable populations. Armed actors' lack of respect for humanitarians— threats, violence and obstruction of access— continue to isolate the already vulnerable populations who must face fear and insecurity to reach the few medical structures available to them.

V
Conclusions

Meeting the needs of CAR's violence-affected population cannot be achieved by dramatizing their situation solely as part of a regional nexus with Chad and Darfur, nor by reducing urgent needs to local variations within a development or recovery context. In CAR, the urgent needs of people trapped between their homes and the bush, and between different armed groups, call for understanding their situation on its own terms.

Despite the extremely precarious living conditions of violence-affected people in CAR, international humanitarian efforts have barely responded to the needs. Few NGOs conduct field-based operations in country, while the UN itself has recently cited statistics showing that despite a 54% increase in aid to Sub-Saharan Africa since 1985, assistance to CAR has plummeted by 60% during the same time period. And despite new agencies coming in, the enormous needs of the people are still far from being met.

Meanwhile, violence, repeated displacement and disregard for humanitarian law by armed actors in northern CAR continue to force populations caught in these zones of insecurity, to live in unacceptable conditions.

The deterioration of health structures and services only exacerbates an already precarious situation. At the same time, humanitarian assistance in CAR remains difficult due to insecurity blocking humanitarian staff and their access to populations affected by violence and isolated in remote areas. The lack of humanitarian access only amplifies the ongoing abuses and barriers to medical care facing CAR's most vulnerable population.

An EU force mandated by the UN Security Council will soon be deployed north-eastern CAR—but it is unclear how it will contribute to the security of the civilian population and humanitarian agencies within the wider context of northern CAR. MSF would like to reaffirm the strictly independent, humanitarian and impartial character of its work in CAR.

MSF underlines the need to maintain the crucial distinction between humanitarian action and military operations. This distinction must be consistently and clearly upheld in order to ensure that humanitarian assistance can reach CAR's most isolated and vulnerable populations.