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"Responding to the Humanitarian, Security, and Governance Crisis in the Central African Republic (CAR)."
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Thank you Chairman Coons, Ranking Member Flake, and other members of the Committee, for providing Médecins Sans Frontières (MSF)/Doctors Without Borders the opportunity to testify at this hearing on the Central African Republic, and to share our field perspective regarding the humanitarian situation there.

I'm a nurse, and I have been working for MSF since 1997. In October and November of this year I worked in C.A.R. for five weeks as a medical coordinator. I worked in the town of Bossangoa, responding to the emergency situation facing its population.

We are encouraged that this subcommittee is turning its attention to the Central African Republic, a country long neglected by the international community while facing a silent crisis. Today, the situation in C.A.R. is exacerbated by additional violence demanding urgent and immediate engagement by the international community, including by the United States.

We regret to report, as we did in an open letter to the United Nations on December 12th, that the humanitarian response in C.A.R. has been wholly inadequate.

Mr. Chairman, I would like to address two fundamental concerns regarding the disastrous humanitarian crisis affecting the Central African people:

- The lack of humanitarian assistance to populations displaced by the ongoing violence in different parts of the country;

- The lack of engagement and attention from the international community to tackle the issues that have long affected C.A.R. and the health of its people. The recent violence comes on top of a state of chronic emergency, characterized by a crippled, if not collapsed, health system. These ongoing problems must be addressed.

MSF OPERATIONAL OVERVIEW IN C.A.R.

MSF has been working in the C.A.R. since 1997. MSF runs seven regular projects in Batangafo, Boguila, Carnot, Kabo, Ndéle, Paoua, and Zémio. This year, MSF opened new emergency projects in response to the increasing humanitarian needs resulting from violence, displacement and the collapse of the health system. MSF opened four emergency projects in Bossangoa,

Bouca, Bria and Bangui. A mobile emergency team provides care in Mbaiki and Yaloké zones, and MSF plans to initiate activities in Bangassou and Ouango.

In response to the recent violence in Bangui, MSF teams are providing life saving emergency care in two hospitals in Bangui, and are providing medical care services to approximately 70,000 displaced people gathering in three sites: Bangui airport, Boy-Rabe Monastery, and the Don Bosco Center. At this very moment, sanitary conditions in these sites, are, in a word, deplorable. Many other needs remain unfulfilled, including food, shelter, and protection.

Between December 5th and 12th, 2013 MSF teams treated more than 350 wounded people in Bangui Community Hospital and tripled the facility's bed capacity. Between December 7th and 12th, MSF teams performed more than 1,700 medical consultations in the three sites, including treating dressing wounds, burns, respiratory tract infections and malaria. The teams also referred medical and surgical emergency cases to hospital structures in the city, including Castor Maternity, the Community Hospital and the Pediatric Complex.

I joined a team of more than 100 international and 1,100 local staff working in seven hospitals, two health centers and 40 health posts across the country.

BACKGROUND

Since the military coup d'etat of March 22, 2013, the political, security, and humanitarian situation in Central African Republic has deteriorated considerably.

Continued political instability in Bangui has led to lawlessness across the country. The health system has collapsed, while medical facilities have been deliberately attacked. The lack of access to medical care has remained a constant challenge for populations in need of urgent humanitarian assistance.

The country has experienced a chronic medical emergency for years, with little international attention and few humanitarian organizations operating on the ground, especially outside Bangui. The recent political and military developments have exacerbated an already desperate situation, producing additional displacements of populations, particularly in isolated rural areas. Medical needs are rising and are far from being covered.

After years of neglect and abandonment, this forgotten country is finally making news headlines because of unprecedented levels of violence exacted on the population since the coup. Civilians, terrified by gruesome targeted killings and made even more vulnerable by forced displacement, are in even greater need of protection and assistance. Aid organizations are failing to deliver basic relief services.

Violence is today greatly impacting the lives of civilians. Immediate humanitarian assistance is required. However, given the chronic nature of C.A.R.'s challenges, a long-term perspective and strategy, encompassing funding and programmatic planning, must be adopted.

A CRISIS ON TOP OF A CRISIS

MSF has long sought to mobilize the international humanitarian community in C.A.R. Since 2011, we have illustrated the chronic medical emergency situation with retrospective mortality surveys in non-conflict areas of the country. In November 2011, we released a report titled "*A State of Silent*

Crisis" that raised the alarm over mortality rates in excess of emergency thresholds in large parts of the country[1].

Based on mortality surveys undertaken by MSF epidemiological teams and other researchers over an 18-month period, the survey highlighted the inadequate levels of assistance provided by various aid actors to respond to this forgotten chronic medical crisis.

The survey noted decreasing expenditure levels on health by the government, but also a lack of long-term investment by the international community. The report concluded that greater medical assistance was necessary throughout the country. However, despite consistent advocacy and lobbying efforts, conditions on the ground were deemed not critical enough to warrant emergency assistance. The country was also unable to qualify for structural development funds.

C.A.R.'s health statistics continue to rank among the worst in the world. It has one of the world's lowest life expectancies at 48 years. All health indicators are beyond alarming, and, disturbingly, figures are certainly underreported.

- There is one doctor for every 55,000 people, and a nurse or midwife for every 7,000;

- 164 out of 1,000 children die before the age of five;

- Of men between the ages of 15 and 60, 466 out of 1,000 perish; among women 420 die — a nearly fifty percent death rate[2]

The military takeover by *Seleka* would prove to be the catalyst for further descent towards chaos, as looting and attacks targeting civilians for their meager resources became the norm, including in the capital city of Bangui. State buildings, ministries, schools, hospitals and private homes have been robbed and damaged while most civil servants have fled, and the country's archives have been destroyed. It is estimated that 60 percent of health structures were looted or destroyed since December 2012; 80 percent of health workers fled and took refuge in Bangui; drugs, vaccines and medical supplies can't be distributed from the capital to the rural areas. Ninety percent of the country's medical structures have run out of medical stocks.

Violence between different armed groups, such as ex-Seleka forces and bush-based civilian militias (also known as "self-defense groups" or 'anti-Balaka') has fundamentally disrupted crucial aspects of people's lives, including schooling for children, agricultural production, access to functioning markets, and the degradation of essential infrastructure, including the few functioning health centers and hospitals. It is estimated that the country has more than 400,000 internally displaced people, roughly ten percent of the country's population.

We are now facing a crisis on top of a crisis.

HEALTH SYSTEM ANALYSIS: PRIOR WEAK FUNCTIONING AND 2013 COLLAPSE

Over several years, MSF has witnessed the weaknesses of C.A.R.'s health system. Our operational goal was to support the Ministry of Health's provision of medical services. Yet since December 2012, we have only observed the system's collapse. As a result, MSF today fulfills many of the Ministry's functions. The public health system is more a phantom than a reality.

[1] Central African Republic: A State of Silent Crisis, November 2011: http://www.doctorswithoutborders.org/publications/reports/2011/A%20State%20of%20Silent%20Crisis%20EN.pdf

[2] WHO, Central African Republic, Health Profile 2011, http://www.who.int/gho/countries/caf.pdf

In our projects, we see a massive prevalence, incidence, and mortality attributed to preventable and treatable diseases.

Compounding this dire situation is an unknown number of forcibly displaced people scattered in the bush without any access to basic services.

Malaria

Malaria is holoendemic in C.A.R., meaning every individual in the population is infected at least once per year. It is the country's main killer and is the principal cause of morbidity and mortality among children.

The country's policy of free malaria treatment for children under five is in name only. The system is not functional and is plagued by essential drug stock ruptures and logistical constraints.

Frequent displacement of people into the bush since December 2012 has contributed to increased exposure to malaria. Prevention and treatment measures have been largely absent since the political crisis began. The large-scale mosquito net distribution planned by the Ministry of Health for 2013 was cancelled because of insecurity. The supply of malaria drugs to rural areas has also been disrupted.

In the first quarter of 2013, health facilities supported by MSF treated 74,729 patients for malaria, an increase of 33 percent over the same period in 2012, when 50,442 patients were treated. 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, for example, 61 percent of outpatient consultations of children under five were for malaria during the first quarter of the year, compared with 41 percent a year ago. While several factors could explain the increasing numbers in MSF-supported facilities, we believe the disruption of services provided by the Ministry of Health and other aid organizations certainly play a crucial role.

Huge challenges remain to increase access to diagnosis and treatment. Prior plans to decentralize care to primary health structures and to community health workers are now shelved. The objective of ensuring unbroken availability of life-saving artemisinin-based combination therapy (ACT) and rapid diagnostic tests in health centers and health posts has evaporated.

HIV-AIDS

C.A.R. features the highest HIV prevalence in Central Africa. The epidemic is generalized among the adult population, with most transmission occurring sexually. Nonetheless, before the onset of recent violence, small gains were detected.

A national seroprevalence survey conducted in 2010 found a 5.9 percent infection rate among 15-49 year-olds, a slight decrease from the previous study result of 6.2 percent. While the rate in that age group had risen among men (4.3% to 5.4%), it had fallen among women (7.8% to 6.3%).[3]

The highest geographic concentration is in the capital (10.7%) and in areas affected by conflict. UNAIDS estimates that 110,000 adults and 17,000 children are HIV positive, while 11,000 people die each year from HIV-related complications. 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, require antiretroviral (ARV) treatment.

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

But, at present, only some 15,000 people are receiving ARV treatment, just one third of those who need it. MSF has 1,700 patients on first line antiretroviral treatment.

The drug supply system has been disrupted for months. Widespread looting of medical facilities since the March 2013 coup has led the Global Fund to Fight AIDS, Tuberculosis and Malaria to cease maintaining drug stocks in the country. These supply problems have had serious consequences on adherence to treatment and have led to 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.

This situation poses serious questions about potential risks of resistance to antiretroviral treatment, but also about the continuity of the national HIV program given the collapse of the health system and the lack of international and national actors to implement such a program.

Vaccination/Expanded Program on Immunization (EPI)
Vaccination coverage for childhood illnesses is poor and contributes to high levels of mortality from preventable childhood diseases.

One case of wild polio virus was reported near MSF's Batangafo project in late 2011; the child's father confirmed that their village had not been visited during polio vaccination campaigns in 2008 and 2011, due to permanent insecurity and armed clashes in the zone.

Immunization activities are usually functional at hospital level but, at health centers and in communities, these activities are more or less non-existent. There are also no programs in place to bring immunization activities to more isolated areas. Furthermore, there have been recurrent stock ruptures of BCG, polio and tetanus vaccine, while the majority of health centers no longer have functioning cold chain equipment. There have been a number of ad hoc supplementary immunization activities undertaken, but with questionable coverage and quality.

Routine vaccination is one of the country's healthcare black holes. It can be safely assumed that most newborns since December 2012 have not had access to the routine vaccination package (EPI). This has increased the risk of outbreaks of diseases like measles, meningitis and pertussis (whooping cough) over the coming two years, and has created a cohort of children particularly susceptible to such diseases.

With the support of the international community, a measles vaccination campaign was carried out in May 2013 by UNICEF and its remaining in-country partners. However, it was conducted in difficult circumstances, and was targeted primarily at children in Bangui and the surrounding area. Nothing has been proposed for the 1.5 million children living outside the capital. The withdrawal of most international assistance organizations leaves a phantom health system in C.A.R. already unable to carry out adequate surveillance and monitoring of rural areas at risk of outbreaks.

Throughout the 2013 crisis, the health system has not been spared. Ministry of Health facilities have been looted of drugs, diagnostic tools, patient records, and even furniture. Most medical staff have fled their posts, especially those working outside the capital. These attacks have deprived an already vulnerable population of access to even basic medical treatment.

In sum, on the medical front, we are facing a chronic emergency situation.

HUMANITARIAN ACTION: DISMAL EMERGENCY RESPONSE

Humanitarian assistance can help lower deaths caused by endemic and epidemic diseases and by the effects of crisis, conflict and displacement. But greater recent international attention on C.A.R., has yet to translate into a substantial humanitarian response.

Every day the situation becomes worse, and rising humanitarian needs go unmet. It has been nine months since the military coup, a period characterized only by killings, injuries and displacement, and the disruption of basic services. MSF has raised the alarm at local, national, and international levels for months, calling for an immediate and more robust humanitarian response. Our calls have gone largely unanswered.

Today, we continue to witness a limited and slow humanitarian response. Even in Bangui, where most aid agencies are present, there are serious gaps in the humanitarian response to the recent violence.

Mr. Chairman, allow me to illustrate the humanitarian situation through my experience in Bossangoa, which is just one emblematic symbol of the current crisis.

Since early September, MSF has been providing health care and water and sanitation services to the displaced people living in the town. In October we treated 60 wounded people. And in early December we treated 20 people wounded in a new spike of violence.

As you may know, roughly 40,000 displaced people are living in the Catholic Mission's compound, terrified by the prospect of returning to their living quarters only a few hundred meters away or in nearby rural villages east and south of the city.

A full four months after they were displaced, the sanitary conditions at the Catholic Mission still do not meet minimum emergency standards. As of December 10, individuals were provided with only 7.8 liters of water per day, well below the 15-20 liter standard in such settings. There was only one latrine for every 166 persons, far below the recommended ratio of one to 20 persons. Not a single shower facility exists in the compound.

People are living in an area 20 times smaller than what would be required to meet emergency standards. Needs are enormous and MSF teams are observing a gradual rise in malnutrition, without an adequate and coherent response from humanitarian organizations, particularly from UN agencies.

This is an unacceptable situation for one of the rare IDP camps where populations are concentrated in one specific location, and where there could be an easier scale up of services.

Populations living in other areas of the country affected by the recent violence, such as Yaloke, Mbaiki, Bangassou, Ouango, Bouca or Bouar, also do not receive the humanitarian assistance they desperately need. In those locations, there is a limited presence of humanitarian organizations.

The instrumentalized religious antagonisms and targeted brutality, which provoked previously unknown faith-based communal hatred, is alarming. This trend, combined with violence targeting civilians since last summer, has forced people into hiding to avoid being killed. People are abandoning their villages, which often end up burned to the ground by armed groups.

There are reports that up to 150,000 civilians could be trapped in the bush without access to food, water, or health care. The extent of the violence in rural areas and the large geographic scope

where these civilians could be hiding makes it difficult for aid agencies to assess, let alone meet, their needs. People are constantly on the move to avoid slaughter.

The humanitarian situation is expected to worsen even further.

At the moment this hearing takes place, my MSF colleagues are working around the clock in Bangui in response to violence in the capital.

More than 350 wounded patients were treated in the Hospital Communautaire over the last few days. Most have wounds caused by gunshots, or by machetes and knives. MSF teams are strengthening hospital services by opening a second operating theater and increasing hospitalization capacity. A second team is working in Castor Health Center, treating patients with minor wounds and providing health services for pregnant women. A third team is carrying out mobile clinics for roughly 14,000 displaced persons gathered in Bangui airport and in Don Bosco Center.

Outside of a few groups responding to the emergency, the scale up of humanitarian assistance has been dismal, leading to large gaps in aiding civilians fleeing the renewed conflict.

Security

MSF, like other humanitarian organizations, has to work in complex and challenging security environments. C.A.R. is certainly one of those settings. Immediate deployment of relief efforts is both challenging and expensive. But we strongly believe it is possible and urgently required.

Humanitarian emergency response entails risk, but MSF has shown over the last year that an upgrade in capacity through international staff deployment is indeed feasible. Throughout 2013, our teams never fully evacuated from project sites. On the contrary, we expanded our presence in six of the most vulnerable areas of the country.

All the humanitarian organizations working in the country have been affected by security incidents, including MSF. In Bangui, our offices and houses, along with those of United Nations agencies and international non-governmental organizations (NGOs), have been repeatedly looted.

Yet the humanitarian imperative should not be made subservient to security concerns. It is our responsibility to do our utmost to provide life saving relief.

As you can imagine, given the humanitarian needs, C.A.R. is one of the top ranking operational priorities for MSF. For this reason, MSF is making significant efforts to maintain regular projects and to scale up assistance, including through the opening of four additional emergency projects and dispatching experienced international staff to the country.

For MSF, it is not only essential to deploy international staff given the lack of skilled medical personnel available in C.A.R., but also to avoid further exposing our national staff to complex inter-communal violence. In some rural locations, we have observed that the presence of international personnel provides a measure of re-assurance for the terrified civilian populations.

Funding and other reported challenges for deployment of humanitarian assistance

The levels of funding for humanitarian activities reflect the lack of attention given to the country.

As of December 6, 2013, the two major donors for humanitarian funding were the European Commission ($26.9 million) and the United States Government ($24.6 million)[4]. Notably, MSF's total 2013 operational budget for C.A.R. amounts to $37 million. All of these figures do not reflect the additional expenditures required to deploy immediate and significantly increased humanitarian assistance.

However, the lack of experienced relief agency staff on the ground, and what in our view are security assessments disproportionate to field realities, present further, yet avoidable, obstacles to deploying much needed aid. As MSF has demonstrated, these are surmountable challenges. There is space to work.

CONCLUSION

The Central African Republic today finds itself in a state of chronic medical emergency compounded by unprecedented levels of violence. While the world has been looking elsewhere, Central Africans are suffering and dying in unacceptable numbers. Today, as the world turns its attention to C.A.R., longstanding needs should not be forgotten, and acute needs throughout the country must be addressed.

It is imperative to improve humanitarian aid across the areas where fighting has erupted since August 2013. Existing levels of assistance are plainly insufficient given the scale of needs. The country requires more aid organizations conducting larger operations. We acknowledge the dilemmas faced by humanitarian actors, including over security. Yet these must be balanced against the massive needs observed across the country, which demand action.

Given the chronic challenges facing C.A.R., a long-term perspective and strategy is required. The basic services of a country cannot be run by humanitarian assistance alone. It is simply not sustainable.

The international community, donors, and major development actors, must double their efforts. The long-term prognosis is bleak, and unacceptable. Without profound external assistance, C.A.R.'s health system—among other sectors—will simply not function.

RECOMMENDATIONS

Humanitarian agencies must scale up interventions in remote areas in response to increasing needs

Difficult and volatile security conditions cannot justify a limited humanitarian presence outside the capital and the absence of proper monitoring and response mechanisms to the emergency.

The continuous presence of MSF teams in remote areas demonstrates that it is indeed possible to run regular aid programs, despite the instability. Context and security analyses must be improved. Additionally, a larger presence of emergency teams supported by experienced international staff is required to run operations and to protect national staff in a context of growing inter-communal tensions.

[4] Funding figures are as of December 6, 2013. All international figures are according to OCHA's Financial Tracking Service and based on international commitments during the current calendar year, while USG figures are according to the USG and reflect the most recent USG commitments based on the associated fiscal years, which began on October 1 of 2012 and 2013. Figured quoted from USAID, Central African Republic – Complex Emergency, Fact Sheet #1, FY 2014. (December 6, 2013) http://www.usaid.gov/sites/default/files/documents/1866/car_ce_fs01_09-30-2013.pdf

Humanitarian assistance to displaced populations must be enhanced and must respond to the enormous needs throughout the country

The situation for roughly 40,000 IDPs in Bossangoa and tens of thousands of others in Bangui, have rightly caught the attention of the international community. But the broader reality is much worse. All around the country, an estimated 400,000 displaced persons are neglected, most of them exposed to daily violence, deprived of any dignified living conditions. They are exposed to the most common and treatable diseases, yet they have no access to medical assistance.

The public health system is severely disrupted and desperately needs immediate support

Ministry of Health facilities have been robbed and looted of drugs, diagnostic tools, patient records and even furniture. Most medical staff have fled their posts, especially those working outside the capital. Health surveillance systems have stopped, as well as routine vaccination activities. The risk of epidemics is high, particularly in IDP sites, while the annual malaria peak is ongoing. Moreover, widespread insecurity is preventing the population from accessing the few remaining health facilities. The national health system, already dysfunctional before the crisis, is now severely disrupted.

Humanitarian funds must be raised and adapted to both the short- and long-term needs of the country

For years, the country has been trapped between emergency and chronic needs. While it is urgent to mobilize significant humanitarian funding to save lives today, longer-term and resource intensive programs to restore the country's basic services must be implemented.

UN agencies must increase their operations

All international agencies and NGOs must increase their activities in C.A.R. United Nations agencies in particular must increase their capacities on the ground, since many aid agencies rely on them to provide an umbrella under which they operate. Humanitarian and development agencies must scale up and maintain their commitments.

Thank you Mr. Chairman, I'm happy to answer your questions.