Multi-sectoral Rapid Assessment Report

*Timbuktu*

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Acknowledgements

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International Medical Corps’ Emergency Response Team would like to thank all the actors that facilitated the collection of information in this rapid assessment.

In particular, thank you to the Acting Head of the Regional Health Department, partners and NGOs involved in the Timbuktu region: MSF, Solidarités, Handicap International, AVSF, the ICRC; and investigators who provided data collection at the household level as well as key informants and community volunteers who participated in the focus groups.
Summary

In the current crisis in northern Mali, International Medical Corps conducted a multi-sectoral assessment in the Timbuktu region between February 1\textsuperscript{st} and February 4\textsuperscript{th}, 2013, the main points are summarized below:

Health

Serious failures of the health system have occurred during the period when the Northern district was controlled by rebel groups, for the following reasons:

- The Regional Health Department was looted and health personnel and members of communities health associations (ASACOs) have fled;
- Disruption of the supply chain for medication, nutritional inputs, and fuel;
- Disruption of the cold chain;
- Pillaging of buildings and equipment (ambulances, solar panels)

The access to health services was deeply compromised for the inhabitants of the districts of Timbuktu, Goundam, Gourma-Rharous, and Niafunké. Three partners support the health services: MSF (since February 2012), Alima (mainly for the district of Diré) and the ICRC. However, they do not cover all the needs, and the access to health care remains a problem for the populations given the distances and difficulty of access.

Recommendations:

1. Support the health centers that are no longer receiving any assistance from the partners in the districts of Timbuktu, Niafunké, Goundam, and Gourma-Rharous: restore the facilities (buildings, WASH equipment); restore the supply chain for medication and nutritional input; restore the cold chain; recruit/reassign qualified personnel; pay the wages of active health employees (who haven’t received their wages); train and monitor the employees;
2. Strengthen the ASACOs and reassign the community health workers;
3. Provide mobile policies for the health posts;
4. Restore and replace the equipment at the Regional Directorate of Health; reassign the personnel;
   Restore the epidemiological surveillance capacities;
5. Restore the epidemiological response capabilities (surveillance, personnel training, inventory pre-
   positioning).

Food Security and Nutrition
Malnutrition screening - available in the structures supported by the partners - is not always provided at
all the health centers. Care is also available in the centers supported by the partners. Severe
malnutrition care is available in the Intensive Nutritional Education and Healing Units (URENIs) at the
Reference Health Centers (CSREFs) of Goundam, Niafunké, Diré, and at Timbuktu's hospital, or through
mobile teams (thanks to the NGO “Agronomes et Vétérinaires Sans Frontières” (AVSF) at three sites in
the towns of Ber and Salam).

In the five districts of Timbuktu, the families
identified based on vulnerability criteria have
received assistance with commodities from several
stakeholders (PAM, ICRC, Handicap International,
AVSF) during the crisis: the last distributions
occurred in December 2012 and other distributions
are scheduled in February. The distributions were
specifically for children under five years old
(Plumpy'Sup for malnutrition prevention for
children aged 6 months to 59 months) and pregnant
and nursing women.

Recommendations:
1. Plan and implement a nutritional survey in five districts to get a complete picture of the nutritional
   situation in the district of Timbuktu;
2. Provide the systematic screening of malnutrition at the Community Health Centers (CSCOMs) and at
   the mobile clinics;
3. Provide moderate malnutrition care at the CSCOMs and URENAS (Severe Ambulatory Nutritional
   Education and Healing Units);
4. Strengthen the training of personnel and the quality of malnutrition care.

Education
During the period when rebel groups controlled the area, all the public schools of the district were
closed and some buildings were destroyed or looted. Teachers fled and students accumulated a one
year disruption in their schooling. An urgent intervention is required to restore the school activities in the district of Timbuktu.

No outside partner was active in the education sector at the time of the evaluation.

**Recommendations:**
1. Restore and re-equip the school facilities (buildings, WASH facilities);
2. Reassign teachers and professors;
3. Evaluate the adjusting requirements for the courses, and the need for support and remediation programs for children whose schooling was disrupted.

**Protection**
The Timbuktu district was used as a battle field and explosives and weapons are still hidden in some living areas and on main roads. The populations also endured several types of traumas (physical violence, sexual assaults, enlisting of children in armed forces). Important needs for psycho-social support have been identified during the assessment. No support from partners was identified during the evaluation.

**Recommendations:**
1. Lead awareness campaigns on explosives and behavior to adopt in the areas that were used as battle fields;
2. Identify the psychosocial support mechanisms at the community level;
3. Train and strengthen the role of key stakeholders in the communities (for example, community health workers);
4. Implement psychosocial support interventions for the victims of violence based on gender, physical assaults, or for the rehabilitation of children soldiers.

**Water, Sanitation and Hygiene (WASH)**
This rapid assessment exposed a situation of vulnerability for the inhabitants of Timbuktu in terms of water and sanitation. Improving water and sanitation is vital especially since the Timbuktu region experienced a cholera epidemic between July and September 2011. The health sector partners are able to respond to epidemics in the districts that they cover (Alima, MSF, and Solidarités for cholera emergencies).

**Recommendations:**
1. Diffuse the results of the WASH study conducted by Handicap International in December 2012 (facilities and practices status report);
2. Restore the destroyed water and sanitation facilities at schools and health centers;
3. Restore the water supply for the city of Timbuktu;
4. Plan and lead hygiene promotion campaigns;
5. Restore the health facilities' ability to respond to cholera emergencies.

**Shelters**

This assessment has identified two specific points:

- The population movements from the outskirt to the center of Timbuktu - families occupying the houses left empty by those who fled the district (displaced, refugees);
- A phenomenon of looting and destruction during the period of uncertainties in the last weeks.

This situation induces a conflict potential at the local level, including when refugees and displaced individuals will return (rent payment, reclaiming of houses).

**Recommendations:**

1. Estimate the number of families who left their huts in the outskirts and move them to occupy houses in Timbuktu;
2. Evaluate the potential risks of conflicts and establish an intelligence system;
3. Accompany the local authorities and the crisis management unit in case of disputes regarding housing and property disputes.
Introduction

On January 10, 2013, the armed groups in control of the North of Mali moved towards the south to conquer the strategic town of Konna. In response to the appeal by the Malian President, the French army has been intervening since January 11, 2013 (Operation Serval). Using air support from the French Army, the Malian army were able to regain Konna.

Following the French Intervention, the Economic Community of West African States (ECOWAS) began to deploy troops consisting of soldiers from Senegal, Niger, Togo, Benin, Burkina Faso and Nigeria. Chad equally participated in the operation. The intervention was initially designed to stop the progression of the armed groups to the south past Mopti, the de facto border between the north, under the control of the Islamists, and the south, controlled by the Malian governmental authorities. The Interim president of Mali, Dioncounda Traore, declared a state of emergency across the whole country on January 11 and called for a “general mobilization” to defend against the progress of the radical Islamists.

On January 16, ECOWAS regrouped at Bamako to start discussions to speed up the deployment of the International Mission for Mali Assistance (MISMA), the force authorized under resolution 2085 to support the Malian authorities.

On January 18, the Malian army regained control of Konna and Diabaly. Certain neighboring countries of Mali have taken precautionary measures – including closing or reinforcing the borders with Algeria and Niger.

The city of Timbuktu, following 10 months under the control of the Islamists was regained on January 28, 2013. The period under the control of Islamists was marked by disruption of public services (schools were closed, difficulty in maintaining minimal health services), the imposition of strict interpretation of Sharia Law by the fundamentalists (executions, amputations, wearing of the hijab/veil, banning of music), the recruitment of child soldiers, the reinforcement of ethnic tensions (Bambaras versus the Arabs/Touaregs).

The region of Timbuktu, an area of 497,926 KM², represents 40% of the national territory and is the biggest region in Mali. It is divided into 5 districts: Timbuktu, Goundam, Gourma, Rharous, Niafunké and Diré. The main ethnicities are the Sonrhaïs (35%), the Tamashq and Arabs (30%), the Peuls (20%) and the Bambaras (15%). The main industries are agriculture, herding, fishing, trade and craft.

It is difficult to estimate the number of current inhabitants at the time of the evaluation due to the number of the displaced population, and the nomadic lifestyles of certain groups who are only occasionally in town. Some of outlying households are also inhabitants of Timbuktu city. The key informants interviewed during the evaluation estimated that the number of inhabitants of Timbuktu city is 60,000, and that 20% of the population (12,000 people) has left the area.
Methodology

International Medical Corps’ Emergency Response Team lead a multi-sectoral rapid assessment in Timbuktu between February 1 and February 4, 2013. The information was collected using qualitative and quantitative methods.

The qualitative data was collected through:

- Focus groups with key informers from Timbuktu: one group of men composed of nine individuals and one group of women composed of five individuals, took part in these discussions
- A focus group with the community health workers from Ballafarandi (Timbuktu district)
- The visit of 4 CSCOM, 1 CSREF, and the Regional Hospital of Timbuktu,
- The meeting with partners operating in Timbuktu such as MSF, Handicap International
- Phone conversations with Alima, Solidarité, ICRC, AVSF.

The information collected in the health sector also came from a study led by Dr. Ibrahim Maiga, the only representative of Timbuktu’s Regional Health Administration who remained on site.

The quantitative data come from a study of 120 households, organized by the International Medical Corps’ team. The information was gathered in 9 neighborhoods in Timbuktu: Djingareiber, Sareïkeina, Hamabargou, Abaradjou, Badjinde, Bellafarandi, Koyerataywa, Kabara, Sankore. Based on the questionnaire developed by OCHA, International Medical Corps’ team developed a questionnaire covering the following sectors: health, nutrition, food security, protection, WASH and shelters. A Mid-Upper Arm Circumference (MUAC) screening of children aged under 5 was also performed within the families interviewed. Twelve team members (9 men and 3 women), speaking French and Sonrhai, were recruited to gather the information and were trained on the questionnaire and the use of the MUAC tape. The data collection was executed on Sunday, February 3rd, and Monday, February 4th, 2013. The data analysis was executed under "Numbers" (Mac OS X).

Limitations: The quantitative data collected does not provide an overview of the situation outside of the city of Timbuktu. However, the geographical and service access conditions make it more difficult to access this service in the outskirts. International Medical Corps’ team was not able to interview key informants residing outside of Timbuktu.

1 See annex for the list of focus groups participants
2 The CSCOM that were visited are: Bellafarandi, Kabaya, Toya, Houndobomo Koina
3 The Acting Head of the Regional Health Department was present throughout the crisis in Timbuktu and followed the situation and gathered information on the status of the sanitary system in the Northern districts. The hereby report is based on several data shared by the Acting Head of the Regional Health Department.
4 International Medical Corps’ team carried out two studies (in Konna and Duentza) using the information collection tool offered by OCHA. Based on these experiences, the tool was revised to adjust the collection of data. See annex for the questionnaire used during the study.
Health Sector

Key Stakeholders: Acting Head of the Regional Health Department, MSF, Alima.

Active Partners: MSF, Alima, ICRC

Timbuktu's area is divided into 5 health districts: Timbuktu, Diré, Niafunké, Goundam, and Gourma-Rharous. The area possesses a regional hospital in Timbuktu, 5 CSREFs and 94 CSCOMs. Diré's district is completely supported by Alima (16 CSCOMs and 1 CSREF).

The resumption of armed conflict did not cause an influx of the wounded: since mid-January 2013, MSF counted about forty wounded at the Regional Hospital of Timbuktu. However, the regional health system was deeply and negatively affected by:

- The fleeing of health personnel, of ASACO members, and of community health workers;
- The disruption of supply chains of medication and vaccines;
- The destruction of facilities;
- The looting of material resources and equipment;

The collection of epidemiological data was scarce during the period of crisis, and the information remain incomplete throughout the area. However, the main reasons for medical consultation remain: malaria, severe respiratory infections, and diarrhea. Over the year 2012, a peak of malaria was observed in the district of Diré in December 2012, and an epidemic of measles occurred in May 2012, for which a vaccination campaign was organized.

Regional Health Administration Status

The Regional Health Administration is not functional: buildings were pillaged, and the key personnel, including the regional health director, left town. Dr. Maïga temporarily replaced the Health Administration during the crisis.

Recommendations:

1. Restore and re-equip the Regional Health Administration, reassign the personnel;
2. Redistribute the capabilities in terms of epidemiological surveillance and epidemics and natural disasters response.

Health structures status (CSCOMs, CSREFs, regional hospital)

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5 Data extracted from the information collected by the Acting Head of the Regional Health Department. See annex "Status of the sanitary conditions in the Northern regions of Mali"

6 Information extracted from a conversation with MSF in Bamako, on February 7th, 2013
Basic services remain available thanks to the support of different NGOs (MSF, Alima) and of the ICRC, as well as within some structures thanks to the health structures' personnel who did not leave the town. However, the coverage is insufficient and access to health care remains difficult, mainly for the populations living outside of the city of Timbuktu.

Mobile clinics are provided by Alima and MSF: although appreciated by their users, they nevertheless remain insufficient. The key informers report the absence of epidemiological response capacity (cholera 7, malaria 8) in public structures. Only MSF and Alima can respond in the areas they cover, and Solidarités for cholera emergencies in the district of Gourma-Rharous 9. The fleeing of the personnel trained to epidemiological surveillance also weakened the system. Inventory shortages of medication and vaccines vary from one structure to the other.

*Timbuktu’s Regional Hospital status*
MSF has supported Timbuktu’s regional hospital since February 2012 where: outpatient consultations, pediatrics, surgery, emergency services are available. However, specialty services are not available. Hospital capacity is 80 beds. MSF's team is composed of 7 expatriates (regional).

Over the last year, the hospital registered 50,000 outpatients, 1,600 hospitalized patients, and 400 surgeries.

*CSREF Status*
MSF supports 2 CSREFs: Niafunké’s CSREF on URENI activities and pediatrics hospitalizations, and Gourma-Rharous' CSREF (but only on CSCOM-level activities). Timbuktu's CSREF is not functional. The building is new, but has not been delivered formally. Consequently, no activities have been implemented yet. CSREF-level activities are provided at the Regional Hospital supported by MSF. Alima supports Goundam’s and Diré's CSREF, including URENI activities on these two sites. The cold chain is functional for the CSREFs.

*CSCOM Status*
Information gathered show a critical situation for the CSCOMs, which cannot operate at full capacity without the support from external partners due to issues identified above.

According to information collected by the Acting Head of the Regional Health Department, the absence of health professionals 10 is a critical issue. The data below show the status of districts of Timbuktu, Niafunké, Goundam, and Gourma-Rharous only (Diré’s district being covered by Alima).

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7 The last cholera epidemic stroke in 5 regions in Mali: Mopti, Timbuktu, Gao, Kayes, and Ségou between July and September 2011. A total of 1,308 cases and 57 deaths were reported overall. In Timbuktu, 413 cases and 20 deaths were reported.
8 In December 2012, a peak of malaria was confirmed in the district of Diré, and the response was provided through the NGO Alima in partnership with the National Health Administration, WHO, and Unicef.
9 Solidarités has a response capacity to cholera emergencies in the district of Gourma-Rharous, with two pinasse boats equipped with water treatment stations.
10 See annex for the types of qualified personnel on site providing services. Information provided by district and by health structure.
<table>
<thead>
<tr>
<th>District</th>
<th>Health Professionals</th>
<th>Partners (number of CSCOMs supported)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timbuktu</td>
<td>Present in 11 of the 21 CSCOMs</td>
<td>MSF (3), ICRC (3)</td>
</tr>
<tr>
<td>Niafunké</td>
<td>Present in 4 of the 20 CSCOMs</td>
<td>MSF (2)</td>
</tr>
<tr>
<td>Goundam</td>
<td>Present in 5 of the 22 CSCOMs</td>
<td>MSF (1), Alima (2)</td>
</tr>
<tr>
<td>Gourma Rharous</td>
<td>Present in 6 of the 15 CSCOMs</td>
<td>MSF (3)</td>
</tr>
</tbody>
</table>

Moreover, personnel available at the health centers have not received any wage over the last months, or have only received a modest premium from ASACOs.

Summary of CSCOMs supported by external partners in the district of Timbuktu:

<table>
<thead>
<tr>
<th>District</th>
<th>CSCOM</th>
<th>Partners / Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timbuktu</td>
<td>Bellafarandi</td>
<td>MSF: Primary Health, URENAS</td>
</tr>
<tr>
<td></td>
<td>Sankoré</td>
<td>MSF: Primary Health, URENAS</td>
</tr>
<tr>
<td></td>
<td>Bourem-Inaly</td>
<td>MSF: Primary Health, URENAS</td>
</tr>
<tr>
<td></td>
<td>Beregoungou</td>
<td>ICRC : Primary Health</td>
</tr>
<tr>
<td></td>
<td>Teherdjé</td>
<td>ICRC : Primary Health</td>
</tr>
<tr>
<td></td>
<td>Ber</td>
<td>ICRC : Primary Health</td>
</tr>
<tr>
<td>Gourma Rharous</td>
<td>Gourma Rharous town</td>
<td>Primary Health, URENAS</td>
</tr>
<tr>
<td></td>
<td>(site CSREF)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Madiakoye</td>
<td>MSF: Primary Health, URENAS</td>
</tr>
<tr>
<td></td>
<td>Banikane</td>
<td>MSF : Primary Health, URENAS</td>
</tr>
<tr>
<td></td>
<td>Benguel</td>
<td>MSF: Primary Health, URENAS</td>
</tr>
<tr>
<td>Goundam</td>
<td>Tonka</td>
<td>MSF: Primary Health, URENAS</td>
</tr>
<tr>
<td></td>
<td>Goundam central</td>
<td>Alima: Primary Health, URENAS</td>
</tr>
<tr>
<td></td>
<td>Zouera</td>
<td>Alima: Primary Health, URENAS</td>
</tr>
<tr>
<td>Niafunké</td>
<td>Niafunké ville</td>
<td>MSF: Primary Health, URENAS</td>
</tr>
<tr>
<td></td>
<td>Léré</td>
<td>MSF: Primary Health, URENAS</td>
</tr>
<tr>
<td>Diré</td>
<td>The district is entirely covered by Alima</td>
<td>Alima: Primary Health, URENAS and URENI level CSREF</td>
</tr>
</tbody>
</table>
Outside of sites supported by external partners, the cold chain could not be preserved in most of CSCOMs. In Niafunké, at least 9 CSCOMs had to stop their EPI (Expanded Program on Immunization) activity because the cold chain was broken by fuel shortage since April 2012. In Goundam, all CSCOMs without external support have also the vaccination activities due to fuel shortage.

**Mobile clinics**

MSF organizes a support by mobile clinics within the CSCOMs of Doro, Gossi, and Elkat since October 2012. However, since January 10th, 2013, the activities have been interrupted due to the security and access conditions. These activities will resume as soon as possible. Alima operates 5 mobile clinics in the district of Goundam, once a week, at 4 health care posts (Fatankara, Hangabera, Bougoumera, Tondigame) and 1 CSCOM (Douekhire). AVSF supports three health care posts in the communities of Ber and Salam through mobile intervention.

In the district of Diré, the cold chain is preserved thanks to the support from Alima.

In annex of this report, the health structures needs are based on the internal evaluation conducted by the Acting Head of the Regional Health Department as well as visits of the health centers executed by International Medical Corps.

**Recommendations:**

1. Support the CSREFs and CSCOMs which currently receive no support from partners in the districts of Timbuktu, Niafunké, Goundam, and Gourma-Rharous; restore the facilities (buildings, WASH equipment); restore the supply chain for medication and nutritional input; restore the cold chain; recruit/reassign qualified personnel; pay the wages of active health personnel (who haven't received their wages); train and monitor personnel;
2. Strengthen the ASACOs and reassign the community health workers;
3. Enforce mobile policies at the health care posts.

**State of Community-Based Interventions**

*Community health associations (ASACOs)*

The ASACOs are in charge of managing the CSCOMs. The Ministry of Health provides the initial equipment and supply in medication and basic medical equipment, and provides the training and monitoring of health professionals. The ASACOs are in charge of recruiting the personnel and managing the funds provided by CSCOMs for the payment of the wages of CSCOM's teams, of renewing the inventory of medications and medical equipment, and maintaining the health center. The ASACOs provide the day-to-day management of the CSCOMs, as well as the recruitment and monitoring of community health workers.

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11 The CSCOMs quoted in the Regional Health Department report are: Aradébé, Nounou, Gayé Maoundé, Konkobougou, N’Gorkou, Koumaïra, Sumpi, Attara, and Dofana.
The ASACOs are officially set up, but several members fled from towns, and they are currently dysfunctional. Meetings are not regularly scheduled, and only small activities are maintained. It is critical to consider that these dysfunctions occurred prior to the crisis situation. The household survey shows that the ASACOs members are not known by most of the households. When asked "What do you do if you discover an issue at the health center", only 11 persons (9% of surveyed individuals) answer that they report to the ASACOs or discuss it with ASACOs members or the NGOs supporting the health structure.

Some ASACOs continue to manage the services in most of health structures in which users pay. These user contributions are considered critical for the operation of the CSCOMs, although they have an impact on the access to health care in a context of limited access to financial resources for the populations. The information extracted from focus groups has actually shown that households still have important financial difficulties due to the rise of unemployment and slow-down of commercial and handicraft activities.

Some complementary health systems or health area subscription systems are in place at some centers. For example, the cost of a subscriber card covering 5 family members is FCFA 1,000 at the CSCOM of Ballafarandi. This subscription gives access to health care at a cost of FCFA 250 (valid for 5 individuals per subscriber). Non-subscribers pay the medical consultation FCFA 500.

If some structures organize the community health workers per association (example of Ballafarandi’s RC association), the activities within the communities are minimal due to the fleeing of community health workers and shortage of material supplies (for example: inventory shortage of contraceptives). However, the community health workers received a financial compensation partly thanks to the sale of these products. The remaining community health workers guarantee that they can provide a minimal activity in the sectors of pre-natal and post-natal consultations, sanitation, water treatment (promotion of Aquatab), malaria prevention (promotion of the use of mosquito nets), information and awareness campaigns regarding HIV. They also provide the referencing of pregnant women and children to the CSCOMs for the vaccination and monitoring of the children.
The main issues voiced by the community health workers are the inventory shortage of contraceptives, isolation of the families, the reluctance of some men regarding their messages, the lack of sanitation material (shovels, rakes). They also expressed their worries regarding the return of refugees, representing a potential increase of the numbers of families to cover, in a context of limited resources. The community health workers also mentioned that they need continuous training on psycho-social assistance in preparation of the role that they will play during this period of crisis.

**Recommendations:**
1. Strengthen the Community Health Associations (ASACOs) and reassign the community health workers;
2. Provide training to the community health workers on psycho-social support;
3. Equip the community posts with material for the promotion of hygiene and sanitation.

**References**
The community health workers and the Acting Head of the Regional Health Department highlighted the difficulties in referring their patients: Timbuktu's CSREF ambulance is out of service due to engine failure.

In 2011, Handicap International gave pinasse boats and ambulances to the CSCOMs located on the river in the districts of Timbuktu and Gourma-Rharous.

Two ambulances are available and operational in the CSREF of Goundam and Diré, as well as two pinasse boats supplying the CSCOMs located by the river.

**Recommendations:**
1. Establish the status of the operational ambulances/pinasse boats
2. Support the costs of repair of the non operational ambulances

**Household status (results of the household survey)**
The results of the household survey in the city of Timbuktu are analyzed below. Again, it is critical to remember that the key informers insisted on the existence of real differences between the city of Timbuktu and the outskirts, the latter suffering from great difficulty of access to health services because of the distances.

Seventy-nine percent of the households surveyed (95 individuals) declare that they required health services over the last year, for themselves or for a family member. Eighty per cent of the households surveyed prefer using CSCOMs' services and Timbuktu's Regional hospital.
Among the households using CSCOMs and the hospital, 87% of households (76 individuals) declare that they had access to free health care and medication and 83% of the households (72 individuals) declare that they are satisfied with the quality of the health care. Twenty-nine percent of the individuals surveyed (35 individuals) declare that women do not feel safe going to the CSCOM or to the hospital.

Eighty-five per cent of the individuals surveyed (102 individuals) declare that the children possess a vaccination card. Seventy-four per cent of the individuals surveyed (86 individuals) declared that they slept under a mosquito net, and 63% (74 individuals) declared that they were informed about HIV.

**Conclusion**

The health system in the district of Timbuktu is going through serious difficulties with the crisis situation. The qualified personnel is absent in 52 out of 78 CSCOMs in the districts of Timbuktu, Niafunké, Gourma-Rharous, and Goundam. The ASACOs are dysfunctional; the policies established are interrupted; the cold chain is broken at many sites and the minimum activity package cannot be delivered to all the sites. The CSCOMs also face inventory shortages of critical medication due to the disruption of the supply chain. Some buildings were pillaged and require restoration work. Over the year 2012, several alerts were triggered (malaria in Diré in December 2012, measles in May 2012): the health system's response capacities are inexistent outside of the teams supported by the partners. Despite this support and the implementation of mobile strategies, the response capacity remain insufficient to cover the whole district and to ensure health care access to the populations of the district of Timbuktu.
**WASH Sector:**

**Key Stakeholders:** Handicap international, Solidarités, AVSF

**Active Partners:** Handicap International in the district of Gourma-Rharous, Solidarités in the district of Diré, Goundam and Niafunké

The discussions started with the key informers (men and women) and the household study made it possible to identify the main sources of supply of drinkable water: drinking water conveyance system for 84% of individuals surveyed, handpumps (4% of surveyed households), surface water (river) for 3% of surveyed individuals, and water sellers (3% of surveyed individuals). Two per cent of the individuals surveyed declare that they buy water bottles for their own consumption. Eighty-six percent of the individuals surveyed declare that they do not treat the water because it is already treated at the source of the conveyance system (chlorine). The individuals using water from the river declare that they treat their water before consumption, by boiling it.

The female key informers participating to the focus group highlighted that handpumps are usually out of service because of maintenance problems prior to the crisis. The two groups acknowledged that the quantity of water per household is insufficient due to the shortage of fuel to feed the pumping station. Electricity comes 4 hours per day and water is available from 8am to 4pm everyday in the city of Timbuktu. Both groups declared that the households have water storage capacities, which remain insufficient. This was confirmed by the household study showing that 93% of the surveyed individuals (111 individuals) declared that they had storage recipients (buckets, pots, containers).

The schools, markets, and health centers are equipped with latrines but they are not in good condition according to the focus groups. For the households, the groups of key informers guaranteed that there was a good cover of latrines in the city of Timbuktu and the quantitative data of the household survey confirm that 81% of the surveyed individuals have latrines at home. The key informers estimate that the situation is different in the outskirts. Sixty-nine percent of the individuals surveyed (83 individuals) in the city of Timbuktu declare that they wash their hands with soap, and among them, 65% (54 individuals) declare that they wash their hands more than three times a day.

In the outskirts, the use of soap remains scarce due to its cost, and the latrine coverage at the family level remains an issue. Women also expressed needs in terms of sanitation and waste water management inside the city of Timbuktu, where there is no sewing and waste management system.

At the time of the evaluation, Handicap International has implemented hygiene promotional activities and distribution of hygiene kits (Aquatab, soap, cans) at the health areas of Gourma-Rharous that are also endemic areas for cholera. Handicap International also conducted an evaluation of the WASH facilities at the community, school, health center level, and a household study on WASH practices in December 2012, whose results will be distributed and shared by the end of February with the WASH cluster.

In the districts of Diré, Goundam, and Niafunké, Solidarité works on the restoration of WASH facilities in the health centers where Alima operates, on waste management, on hygiene promotion, and on training of community health workers. A diagnostic is also pending in the districts of Diré and Niafunké.
Solidarités plans to extend this WASH intervention to 5 new CSCOMs of the district of Goundam with WASH activities and training, as well as to the MSF intervention sites in the districts of Niafunké and to 3 CSCOMs in Timbuktu.

AVSF is active in the communities of Der and Salam in northern Timbuktu through mobile teams for the distribution of family hygiene kits (Aquatab, soap) to families with kids suffering from severe malnutrition, and of NFI to displaced families. AVSF also works on wells and drilling projects (16 sites).

**Conclusion:**
The data collected highlight a situation of vulnerability regarding the water supply and hygiene practices. The city of Timbuktu, which is supplied mainly by a drinkable water conveyance system, is going through a limited supply of water between 8am and 4pm only. This vulnerability is judged more important by the key informers for the areas outside of the city of Timbuktu. The data provided by Handicap International will give a complete picture of the situation in the district regarding the facilities and practices.

**Recommendations**
1. Diffuse the results of the study conducted by Handicap International in December 2012 (status of the facilities and practices);
2. Restore the destroyed water and sanitation facilities at schools and health centers;
3. Restore the water supply for the city of Timbuktu;
4. Plan and lead hygiene promotion campaigns;
5. Restore the health facilities’ ability to respond to cholera emergencies.
Food Security and Nutrition Sector

Key Stakeholders: Acting Head of the Regional Health Department, MSF, Alima, Handicap International, ICRC Mopti, AVSF, Solidarités.

Active Partners: MSF, Alima, ICRC / Red Cross Mali, PAM, Handicap International, AVSF, Solidarités

The information collected from the groups of male and female key informers and the household study are similar and show the difficulties of the families to find foodstuffs on the markets.

Fifty-eight percent of the surveyed individuals (70 individuals) declare that the quantity of foodstuffs on the market is not enough. The main limitations identified are described in the following diagram:
The key informers highlighted that massive purchases of foodstuffs by rebel groups and limited road access caused disruption of the supply chain.

Eighty-three percent of the individuals surveyed (99 individuals) declare that they have difficulties to feed their family due to a lack of resources (47%), high prices (27%), low-level of family inventories (15%), lack of access to the market (10%), and lack of kitchen utensils (1%).

Sixty-one percent of the surveyed individuals (73 individuals) declare that they own a family inventory of foodstuffs. Sixty-four percent of the families owning an inventory estimate that their family reserves can feed the household for a few days, 21% for a few weeks, and 15% for a few months.

The key informants surveyed mentioned that the price of basic foodstuffs has increased over the last year, including that of millet, which became very expensive. The survey revealed that 34% of the households rely on purchases, 14% on their own production, and 14% on family donations.
The households in Timbuktu received food support from ICRC/Red Cross Mali: two food distributions were organized last year, the last in November 2012. The families received rice, oil, millet, beans, and small peas. The key informers also declared that the use of credits and loans were more and more common due to the lack of resources of the households.

The surveyors also screened children using the MUAC tape. Three hundred and fourteen children were screened. The two children suffering from severe acute malnutrition and the 18 children suffering from moderate acute malnutrition were referred to the health center to receive appropriate care.

MSF and Alima provide health care to malnutrition cases referred to the centers they support. Moderate acute malnutrition care is provided at the CSCOM level (URENAS) and severe acute malnutrition at the CSREF level (URENI). Alima also provides malnutrition screening and health care at two health posts in Goundam: Zouera and N’bounan.

Handicap International operates in the districts of Gourma-Rharous and Timbuktu. They provide malnutrition screening at the community level, referring to the appropriate centers supported by MSF for adapted treatment, and organize food distributions based on vulnerability criteria (25% of the population in the district of Timbuktu). The latest distribution of Plumpy’Sup for children from 6 to 59 months was organized at the end of December 2012, together with a distribution of general food for pregnant women. The next distribution was scheduled for the months of January and February, but it was canceled for security reasons. It was rescheduled for the week of February 17th for the district of Timbuktu, subject to the stability of the security conditions. Handicap International also has a support program for agricultural inputs and fuel, and provides advice and support to the owners of small arable surfaces.

ICRC and PAM organized food distributions for all the 5 districts of Timbuktu. The latest distribution dates back to December 2012, and the next one is scheduled for March 2013. The products distributed are: rice, semolina (for some communities depending on their food habits), beans, oil, and salt. ICRC also organized the distribution of seeds to vulnerable families in the district of Timbuktu and has a breading program in the northern districts (cattle feeding, vaccination, and livestock wells).

AVSF works in the livestock areas of the northern districts of Timbuktu and provides screening of the severe and moderate malnutrition cases through mobile teams, as well as health care at 3 health outposts: 2 health posts in Ber and one in Salam. AVSF provides direct on site health care since the populations (of Moorish and Tuareg origin) refuse to move to Timbuktu. To date, the activities have been interrupted for security reasons, among others. The mobile teams are composed of personnel of Tuareg and Bambara origin. The Bambaras refuse to go to the livestock areas, and the Tuaregs refuse to go to Timbuktu. A new team is being constituted for the activities to resume. AVSF organized a food distribution based on vulnerability criteria (very poor families with displaced individuals) at the end of December 2012, with a donation covering a period of two to three months. They are planning another distribution for the month of May 2013, for a period covering three months.

Solidarités and PAM plan food distributions in the district of Diré in the towns of Diré, Dengha, Garbakoira, Tienkour, Haibongo, Binga, Sareyamou, and Tindirma, starting on the week of February 17th, 2013. Five thousand and one hundred and forty-five households (5,145) will benefit from this
distribution (PAM ration: cereals, oil, legumes, salt, and super-cereals), and 1,286 pregnant and lactating women will benefit from a general food distribution (oil and super-cereals). Finally, 4,630 children aged from 6 to 59 months will receive Plumpy’Sup for malnutrition prevention (1/2 pack per day per child).

Conclusion:
The families and key informers highlighted their difficulties to guarantee the food consumption of their family due to the disruption of the supply chain, shortage of some foodstuffs, and also lack of resources. During the crisis, vulnerable families from the 5 districts of Timbuktu received food support from several stakeholders: PAM, ICRC/Red-Cross Mali, Handicap International. The latest distribution dates back to December 2012, and other distributions are scheduled for the weeks/months to come.

Recommendations
1. Plan and implement a nutritional study in the five districts to get a complete picture of the situation in the district of Timbuktu;
2. Provide systematic malnutrition screening at the Community Health Centers (CSCOMs) and at the mobile clinics;
3. Provide moderate acute malnutrition care at the CSCOMs (URENAS);
4. Strengthen the training of personnel and the quality of malnutrition care.
Education Sector
No active partner has been identified in the education sector.

Timbuktu has 12 primary schools, 8 second education schools, 3 high schools, 5 vocational high schools, and several private schools. The exact number of private schools has not been disclosed by the key informers.

The education sector was heavily hit by the crisis and is a critical preoccupation for the leaders and households in Timbuktu. The fleeing of teachers, partial destruction of buildings, pillaging, closing and occupation of schools are the issues quoted that led to the interruption of education for a majority of Timbuktu's children. Public schools are all closed since April 2012. Some schools, including a high school, were occupied by armed groups. The leaders consider that it is the State's responsibility to ensure that teachers return to their position. School equipment and school material are also on the priority list regarding rebuilding and restoration of sites.

Part of the Koranic schools are operational. However, several of them closed with the fleeing of marabouts during the crisis. Women expressed their worries regarding the education of the children, but also their lack of understanding of the situation: no explanation was given to the children regarding the closing of schools.

The household study revealed that, of all the households surveyed, 93% of the households (111 households) had school-age children. Twenty-two percent of the households (24 households) with school-age children educate their daughters in a Koranic school and 36% of the households (40 households) with school-age children send their boys to the Koranic school. Children sent to public schools have stopped their education because their school was closed and/or occupied by armed groups.

Conclusion
The education sector suffered heavily in this crisis, with the closing of all public schools. Leaders organized a symbolic ceremony to inform about the reopening of schools, but this will only be effective with the return of teachers and professors, restoration of buildings, and equipment in school materials.

Recommendations
1. Restore and re-equip the school facilities (buildings, WASH facilities);
2. Reassign teachers and professors;
3. Evaluate the adjusting requirements for the courses, and the need for support and remediation programs for children whose scholarship was disrupted;
**Protection Sector**

Both groups of informers interviewed acknowledged that the protection sector is important since land mines have been reported in the city, including the mosque, where the presence of land mines is confirmed, and the Ministry of Culture, where it is unconfirmed, and in the outskirts. The case of a child wounded by a grenade was also reported by the community health workers in Bellafarandi.

Leaders also expressed their worries regarding the children and the traumas caused by the crisis. In fact, the leaders report the enlistment of children into armed groups, especially for Tamashek families who had to pay the armed groups, take up arms themselves, or to give their children.

Violences and traumas caused to women should also be noted. One case of rape was reported to the crisis management committee, and the convict was beaten by the Islamists in Timbuktu. But women state that various assaults against women are known outside of the city, and perpetrated by MNLA fighters. Women also experience living in fear. At the time of the interview, they still expressed this fear and the uncertainty regarding their future (“Will they come back?”). Women especially expressed traumas linked to confinement, miscellaneous prohibitions (to group, to talk to men of their family in public), and wearing the veil. Women were beaten up in front of their husband if they were not covered enough by their veil.

Women also highlighted they young women and teenagers especially suffered outside of the city, where there are rumors of rape.

No psychosocial support system is implemented in Timbuktu, and only medical care is available as part of the services offered by MSF.

No case of lost children was reported.

Telecom Sans Frontières (TSF) implemented a telecommunication service at the city hall to facilitate the restoring of family links in the case when some family members have left the town. These services are operational since February 14th, 2013.

The household survey reports the following items: on 120 households surveyed, 40% (48 individuals) declare that they had issues linked to insecurity. Among them, 50% (24 individuals) declared that endured physical assaults.

**Conclusion**

The evaluation exposed important needs in terms of protection. Whether it is about raising awareness on explosive devices or health care and support in cases of crisis-related traumas, it is important to answer to the specific needs of children, teenagers, and women. An intervention in the management of the conflict regarding the nature of the conflicts based on ethnicity (Tuareg/Arabs vs. Bambaras) is also to be considered.
**Recommendations**

1. Lead awareness campaigns on explosives and behavior to adopt in the areas that were used as battle fields;
2. Identify the psycho-social support mechanisms at the community level;
3. Train and strengthen the role of key stakeholders in the communities, especially community health workers;
4. Implement psycho-social support interventions for the victims of violence based on gender, physical assaults, and for the rehabilitation of children soldiers.
Shelter Sector
No active partner has been identified in this sector.

The households are accommodated in tents, huts, or in houses.

In the Household survey, 22% of the surveyed households declare that part of their housing was destroyed, and 17% declare that they were pillaged. The destructions mainly seem to have touched households located in the districts of Djingareiber, Sorekeima, and Ballafarandi. Discussions with the groups of key informers provide more insight on this data. These destructions and pillaging could come from individuals taking advantage of the crisis situation to wreck and pillage some houses. In fact, there hasn't been any combat leading to massive destructions in Timbuktu.

Interviews with groups of leaders and key informers also highlighted the dynamics during the crisis: some families from the outskirts left their housing to occupy houses in the city center. This generally occurred with the approbation of the city neighbors, several families occupying the same house. Therefore, some housings are overpopulated. This also leads to thinking that the return of refugees and displaced individuals might create tensions when the property owners will try to retake their house.

The question of rents has also raised. Due to the crisis situation, unemployment, slow-down of commercial and handicraft activities, the families have difficulties to pay their rent. When the property owners come back, this might create tensions and critical situations for some households.

Recommendations
1. Evaluation the amount of families who left their huts in the outskirts and occupy houses in the city of Timbuktu;
2. Evaluate the potential risks of conflicts and establish an intelligence system;
3. Accompany the local authorities and the crisis management unit in case of disputes regarding housing and property disputes;
4. Facilitate the supply of materials to the city for the required restoration and reconstruction works.
ANNEX 1

CSCOMs visited in Timbuktu Region
February 3, 2013

Kabara CSCOM
Looted in April 2012 by the MNLA: equipment and medication
Destroyed doors
Destroyed pump
The staff works on a voluntary basis with incentives from the ASACO to maintain a minimum service. A midwife reportedly supported by the municipality.
ASACO and ministry ensure the supply of drugs.
The doctor left the structure to work with MSF in Niafunké.
A nurse fled to the South
Patients pay for the services they receive
No nutrition program in place
Latrines functional

Houndoubomo Koina CSCOM
Looted in April 2012 by MNLA
Motorcycles, solar panels and tents for cholera treatment were stolen
No housing available for health personal
Water system available
Incinerator destroyed
Patients pay for services: 500 FCFA for consultations, deliveries for 1000 FCFA
Stock out for some drugs such as anti-malarial medication
No nutrition program in place
Latrines functional

Toya CSCOM
Has not been looted and functions normally
Membership and mutual health insurance in place
Non-members pay for services
The cold chain is not working due to lack of fuel
Latrines and water pumps are functional
All staff work as volunteers receiving a premium from the ASACOs
# ANNEX 2
*Extract from the Acting Head of the Regional Health Department’s report on the state of the health system in Timbuktu Region*

<table>
<thead>
<tr>
<th>Districts/Regional Health Directorate (RHD/DRS)</th>
<th>Health Facility</th>
<th>Human Resources</th>
<th>Material Resources (Logistics)</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ransacked</td>
<td>Not Ransacked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rharous (13 CSCOM)</td>
<td>3 CSCOM</td>
<td>10 CSCOM and 1 CSREF are intact</td>
<td>Displaced</td>
<td>Functional</td>
</tr>
<tr>
<td>Diré (14 CSCOM)</td>
<td>14 CSCOM + CSRef are intact</td>
<td>Displaced</td>
<td>Functional</td>
<td>Medication warehouse functional</td>
</tr>
<tr>
<td>Niafunké (20 CSCOM)</td>
<td>4 CSCOM</td>
<td>16 CSCOM + CSREF</td>
<td>Displaced</td>
<td>Functional</td>
</tr>
<tr>
<td>Goundam (15 CSCOM)</td>
<td>CSREF + 3 CSCOM</td>
<td>12 CSCOM intact</td>
<td>Displaced</td>
<td>Functional</td>
</tr>
<tr>
<td>Timbuktu (17 CSCOM)</td>
<td>CSREF + 4 CSCOM</td>
<td>13 CSCOM</td>
<td>Displaced</td>
<td>2 ambulances, 2 4X4 vehicles stolen</td>
</tr>
<tr>
<td>RHD/DRS</td>
<td>Completely</td>
<td>Regional Cold Chain</td>
<td>Displaced</td>
<td>All vehicles</td>
</tr>
<tr>
<td></td>
<td>Functional</td>
<td>3 doctors (2 recruited by MSF and ALIMA) + 2 nurses (recruited by MSF and ALIMA)</td>
<td>1 ambulance, 1 4x4 vehicle stolen</td>
<td>Medication Warehouse functional</td>
</tr>
<tr>
<td>HRT</td>
<td>Functional</td>
<td>3 doctors (2 recruited by MSF and ALIMA) + 2 nurses (recruited by MSF and ALIMA)</td>
<td>1 ambulance, 1 4x4 vehicle stolen</td>
<td>Medication Warehouse functional</td>
</tr>
</tbody>
</table>
## ANNEX 3

*Extract from Acting Head of the Regional Health’s report on the Districts of in Timbuktu Region, April 2012*

**Gourma Rharous**  
Situation du personnel et des infrastructures en date du mois d’Avril 2012

<table>
<thead>
<tr>
<th>STRUCTURES</th>
<th>Staff Present</th>
<th>Absent Staff</th>
<th>Infrastructure and Logistics</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADIORA CSCOM</td>
<td>DT (TS)</td>
<td>Care Giver</td>
<td>Buildings and equipment intact; drugs and vehicles in place;</td>
<td>Curative consultation center fixed</td>
</tr>
<tr>
<td>BAMBARA-MAOUDE CSCOM</td>
<td>IO. ; Traditional birth attendants; Manager/Care Giver</td>
<td>DT (Doctor); TS</td>
<td>Buildings, drugs and equipment ransacked; motorcycle and ambulance secured.</td>
<td>None</td>
</tr>
<tr>
<td>BANIKANE CSCOM</td>
<td>DT (TS) ; Traditional birth attendants, Manager/Care Giver</td>
<td>None</td>
<td>Buildings and equipment intact; drugs and vehicles in place;</td>
<td>Curative consultation center fixed</td>
</tr>
<tr>
<td>BENGUEL CSCOM</td>
<td>Traditional birth attendants, Manager/Care Giver; ATR; 1 Community Health Worker</td>
<td>DT(TS) ; DT(TS)</td>
<td>Buildings and equipment intact; drugs in place; The motorbike was stolen by armed men.</td>
<td>Consultation and curative activities in SR center fixed.</td>
</tr>
<tr>
<td>EGACHAR CSCOM</td>
<td>None</td>
<td>DT(TS); Traditional birth attendants; Manager/ Care Giver</td>
<td>Buildings and equipment intact; Drugs in place; Motorbike secure</td>
<td>None</td>
</tr>
<tr>
<td>GOSSI CSCOM</td>
<td>Traditional birth attendants ; ATR</td>
<td>DT (Doctor); TS; I.O.; Care Giver</td>
<td>Buildings, drugs and equipment ransacked;</td>
<td>None</td>
</tr>
<tr>
<td>Location</td>
<td>Staff Description</td>
<td>Team Size</td>
<td>Equipment/Drugs/Motorbike</td>
<td>Consultation and Curative Activities</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------------</td>
<td>-----------</td>
<td>---------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>HAMZAKOMMA CSCOM</td>
<td>Traditional birth attendants; Care Giver</td>
<td>DT (TS) DT (TS)</td>
<td>Buildings and equipment intact; Drugs in place; Motorbike secure</td>
<td>Curative consultation center fixed</td>
</tr>
<tr>
<td>HARIBOMO CSCOM</td>
<td>Traditional birth attendants; Manager/Care Giver</td>
<td>DT (TS) DT (TS)</td>
<td>Buildings and equipment intact; Drugs in place; Motorbike secure</td>
<td>Curative consultation center fixed</td>
</tr>
<tr>
<td>INADIATAFANE CSCOM</td>
<td>Traditional birth attendants; Manager/Care Giver</td>
<td>DT(TS); Traditional birth attendants</td>
<td>Buildings and equipment intact; Drugs in place; Motorbike secure</td>
<td>Curative consultation center fixed</td>
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<tr>
<td>KORO-BELLA CSCOM</td>
<td>None</td>
<td>DT(TS); Traditional birth attendants</td>
<td>Buildings and equipment intact; Drugs in place; Motorbike secure</td>
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<tr>
<td>MADIAKOYE CSCOM</td>
<td>Traditional birth attendants; Manager/Care Giver</td>
<td>DT (TS) DT (TS)</td>
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<td>Consultation and curative activities in SR center fixed</td>
</tr>
<tr>
<td>TINTADENIT CSCOM</td>
<td>DT (TS) DT (TS)</td>
<td>None</td>
<td>Buildings and equipment intact; Drugs in place; Motorbike secure</td>
<td>Curative consultation center fixed</td>
</tr>
<tr>
<td>RHAROUS CSREF</td>
<td>Loaded SIS (TSLP) Manager DV, 1 Traditional birth attendants, two aides, 1 LPN, 2 TS, 1 keeper, 2 drivers, 2 assistants archivists, 1 cleaner</td>
<td>Doctors; 3 I.O ; 3 Midwives; 1 Sanitation Technician; 2 TSS; 3 TS; 2 Accountants</td>
<td>Buildings and equipment intact; Drugs in place; Vehicles safeguarded; Stores and equipment found ransacked</td>
<td>Consultation and curative activities in SR center fixed</td>
</tr>
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</table>
### Goundam Health Center Staff Situation, April 2012

<table>
<thead>
<tr>
<th>CSCOM</th>
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<th>Absent</th>
<th>Onsite</th>
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</tr>
<tr>
<td>Central</td>
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<td>3</td>
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<td>Kanaye</td>
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<tr>
<td>Echell</td>
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<td>1</td>
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<td>M’Bouna</td>
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<td>2</td>
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<td>Tin Aicha</td>
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<td>1</td>
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### Niafunké Health Center Staff Situation, April 2012

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<tr>
<th>No</th>
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<th>Present</th>
<th>Absent</th>
<th>Functionality (F = Functional, NF = Not Functional)</th>
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<td>Head of Post</td>
<td>+</td>
<td></td>
<td>NF</td>
</tr>
<tr>
<td>02</td>
<td>IO</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03</td>
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<tr>
<td>04</td>
<td>Care Giver</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>05</td>
<td>DV Manager</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06</td>
<td>Guardian</td>
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<tr>
<td>ATTARA CSCOM</td>
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<tr>
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</tr>
<tr>
<td>01 Head of Post</td>
<td>+</td>
<td>NF</td>
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<tr>
<td>02 Traditional Birth Attendant</td>
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<tr>
<td>03 Care Giver</td>
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<tr>
<td>04 DV Manager</td>
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<td>NF</td>
</tr>
<tr>
<td>02 Traditional Birth Attendant</td>
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<td></td>
</tr>
<tr>
<td>03 Care Giver</td>
<td>+</td>
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<tr>
<td>04 DV Manager</td>
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ANNEXE 4
Focus group discussions held with leaders in Timbuktu

Women’s Group: 5 participants – Monday, 4 February 2013, Timbuktu

Men’s Group: 8 participants – Monday, 4 February 2013, Timbuktu
Introduction

Bon jour, je m'appelle XX et je suis un enquêteur/enquêtrice pour l'ONG «Corps Medical International». Corps Medical International est une organisation non gouvernementale (ONG) qui travaille dans les domaines de la santé, de la sécurité alimentaire. IMC effectue une mission dans l’ensemble des quartiers de Tombouctou pour connaître les besoins de la population dans différents secteurs tels que la santé, la sécurité alimentaire/nutrition, l’eau et assainissement. Avez-vous du temps à nous accorder (30 minutes) et acceptez-vous de répondre à nos questions?

Les réponses que vous nous apporterez seront compilées et transmises aux Nations unies et aux autres ONG à Bamako. Merci.

A. Nutrition et Sécurité alimentaire

A1. Combien de repas par jour chaque membre de la famille fait-il?

- Hommes
- Femmes
- Enfants

A2. Quelles est la base de l'alimentation dans la famille?

- Mil - Blé - Riz - Autre

A3. Trouvez-vous les denrées alimentaires suffisantes à la consommation de la famille sur le marché? Si non, pourquoi?

- Rupture d’approvisionnement
- Rupture de stock
- Achat massif - Marché fermé
- Autre (citez):

A4. Avez-vous des difficultés à assurer la consommation alimentaire de votre famille? Si oui, pourquoi?

- Peu de réserves familiales- Prix trop élevé
- Manque de ressources
- Pas d'accès physique au marché
- Pas d'ustensiles ou d'installation pour cuisiner
A5. Faites-vous des réserves de denrées alimentaires?

A6. Si oui, combien de temps pouvez-vous assurer la consommation alimentaire de votre famille?
   - Quelques jours
   - Quelques semaines
   - Quelques mois

A7. Comment assurez-vous la nourriture à votre famille?
   - Propre production
   - Assistance alimentaire (date de la dernière distribution)
   - Don par des familles
   - Achat
   - Emprunt à crédit
   - Pêche/cueillette
   - Travaux payés en nature

A8. Nombre d’enfants présents dans la famille et testés (moins de 5 ans)

A9. Nombre d’enfants en malnutrition modérée et âge (MUAC / repère jaune)

A10. Nombre d’enfants en malnutrition sévère et âge (MUAC / repère rouge)

B. Santé
B1. Etes-vous allés au centre de santé pour vous ou l’un des membres de votre famille au cours de cette dernière année?

B2. Où allez-vous pour accéder à des soins?
   - CSCOM
   - CSREF
   - Médecin privé
   - Médecin traditionnel
   - Autre (citez)

B3. Les soins sont-ils gratuits?

B4. Les médicaments sont-ils gratuits?

B5. Etes-vous satisfaits de la qualité des soins?

B6. Le personnel de santé est-il présent?

B7. Les femmes se sentent-elles en sécurité pour se rendre au CSCOM?

B8. Les enfants ont-ils un carnet de vaccination?

B9. Utilisez-vous une moustiquaire?
B10. Connaissez-vous le VIH?

**C. Abris**
C1. Nombre de personnes dans le foyer
C2. Nombre de personnes ayant quitté le foyer
C3. Nombre de personnes accueillies
C4. Le logement a-t-il été détruit?
C5. Le logement a-t-il été pillé?

**D. Education**
D1. Y a-t-il des enfants en âge scolaire dans la famille?
D2. Les filles vont-elles à l'école? Si oui,
   - école publique
   - école privée
   - école coranique
D3. Les garçons vont-ils à l'école? Si oui,
   - école publique
   - école privée
   - école coranique
D4. Si les enfants ne vont pas à l'école, pourquoi?
   - Pas de bâtiment/bâtiment détruit
   - Pas de professeur
   - Pas de matériel scolaire
   - Problème de sécurité
   - Interdiction de la part des jihadistes

**E. Eau, hygiène et assainissement**
E1. Quelle est votre source d'alimentation pour l'eau de boisson?
   - Adduction en eau potable
   - Puits bouses
   - Pompe à motricité humaine
   - Eau de surface (lac, fleuve)
   - Vendeurs d'eau
   - Camion citerne
   - EDM/SOMAGEP
   - Achat de bouteille d'eau
E2. Combien de litres d’eau par personne et par jour utilisez-vous? (ou de seau d’eau)

E3. Traitez-vous l’eau de boisson? Si oui, par quel moyen?
   - Pastilles de chlore
   - Filtre
   - Bouillir

E4. Avez-vous des moyens de stockage de l’eau (bidons, seaux, citernes?)

E5. Avez-vous des latrines?

E6. Vous lavez-vous les mains avec du savon?

E7. Si oui, combien de fois par jour?

F. Gouvernance
F1. Y a-t-il une ASACO fonctionnelle au niveau du centre de santé que vous utilisez?

F2. Connaissez-vous les membres des ASACOs?

F3. S’il existe des dysfonctionnements au niveau du centre de santé, que faites-vous?

F4. Y a-t-il un comité d’usagers/comité de gestion fonctionnel au point d’eau que vous utilisez?

F5. Connaissez-vous les membres de ce comité?

F6. S’il existe un problème en regard de l’alimentation en eau, que faites-vous? Que fait le comité? Connaissez-vous son mandat?

G. Protection
G1. Avez-vous fait face à des problèmes liés à l’insécurité dans votre famille? Si oui, quels incidents ou problèmes avez-vous rencontré?
   - Arrivée de personnes déplacées
   - Départ de personnes de la famille
   - Agressions physiques, brimades
   - Agressions sexuelles
   - Tensions familiales
   - Enfants «perdus»
   - Risques de mines et d’engins explosifs

G2. Existe-t-il au sein de votre communauté, un système de support (tontines, groupement ou associations, ONG locale etc.)

G3. Souhaitez-vous souligner une difficulté particulière ou un problème que rencontre votre famille?

Merci de nous avoir accordé du temps.
ANNEX 6

Map of Health Facilities
ANNEX 7
Snapshot of Logistics and Security from January 31, 2013 to February 5, 2013
(Note: 494 CFA is equivalent to $1 USD)

TRANSPORTATION

- Access (doesn’t consider security aspect): Timbuktu was accessible from Douentza by road in 4 hours. The road was correct (2/3rd laterite, compact soil, then 1/3rd of mix soil/sand). 300m sand dune (16°14'57,0"N 2°51'57,2"O to 16°15'7,0"N 2°51'57,8"O) difficult to pass (many cars got stuck here). Recommendation: to travel with 4x4 fitted with sand plates.

- Very few cars on the road, difficult to find assistance in case of a problem. Recommendation: to travel in a 2-car convoy minimum and pulling rope.

- Cargo transport: the road from Douentza to Timbuktu was closed to cargo transport. It seems the road from Diabali to Lere was opened (unconfirmed, a bus leaves Bamako to Timbuktu on Thursdays with goods and passengers). Recommendation: to prefer river transport from Mopti.

- Ferry: 3 ferries that seemed operational (French Army booked the 3 to transport their cars). However, no engine is functional. Ferries are pushed by 40HP pirogue engines in 1 hour going upstream. The cost of ferry crossing is CFA60,000 (to split between number of cars, up to 4). Ferry stations on Timbuktu side. First in first on the ferry. Recommendation: it is possible to transport the vehicle the evening of the day before by ferry with driver sleeping on the other side, and do an early crossing with passengers in pirogue.

- When coming from Douenza, it isn’t possible to call the ferry. Recommendation: One should cross with a pirogue (20min/CFA6,000).
1. **VEHICLES**

   - **Rental:** CFA75,000/day (including driver, excluding fuel) for vehicles with lots of km in a low state of maintenance. Recommendation: rent vehicles in Bamako for Timbuktu.
   
   - **Maintenance:** We experienced problems with our 4x4 system. The driver managed to find a workshop, appropriate spare parts and fixed it. With lots of vehicles passing by Timbuktu in the past, very basic workshops have developed and mechanics skills are pretty good. However, this is far below standard and price of spare parts (when available) is twice the price paid in Bamako. Closest average standard workshop is Mopti. Recommendation: to maintain stock of spare parts for most frequent used spares in Timbuktu. To set up good standard workshop (if vehicles are owned). To undertake emergency repairs in local workshops and drive cars to Mopti for further repairs.
   
   - **Fuel:** Diesel seems to be of low quality, scarce and expensive. 1L= CFA 900 (vs. 650 in Bamako or Mopti). Diesel was found in a small storage in Douentza, good quality at 650CFA (no pump station was operational). Recommendation: to transport fuel from Mopti by river and set up storage units in Timbuktu.

2. **ENERGY & WATER**

   - **Electric supply:** from 6:00 PM to 10:00 PM plus random. Fairly stable. Electricity expected to be restored when fuel supply will resume.
   
   - **Generators:** generators available for rent: single phase / 4.5KVA (CFA 22,000/day), 0.9 KVA (CFA 20,000). Old generators, in medium/bad state. Recommendation: To bring generators from Bamako even for short term missions.
   
   - **Water supply:** totally unstable. Comes and goes any time of the day (surprisingly, didn’t seem related to the electric supply). Good pressure when water was available. Recommendation: water towers/tanks for water storage. Pumps don’t seem necessary as pressure seemed ok.

3. **COMMUNICATION**

   - **Telephone network:** Partially destroyed for Orange (4 down out of the 6 antennas), the network was back on February 3 with maximum congestion and no data transfer option. NGO TSF set up a BGAN for government officials at the mayor office and installed emergency phones for the population’s benefit (closed on February 8).
   
   - Orange is sending equipment to undertake priority repairs. While the network can’t be considered reliable for the moment, Orange is sending large amount of equipment to proceed with emergency repairs and restore networks (again, data isn’t a priority).
   
   - Network is expected not to cover villages for some time (beyond antenna perimeter).
   
   - No information was available about Malitel, which isn’t yet operational.

**Recommendations:**

   - Use a Thuraya as back up telephone option
   - Consider V-Sat as only reliable internet connection for now. However this may soon charge as Orange will make efforts to provide data transfer in a 2nd stage.
   - Equip vehicles with VHF and HF to maintain communication during field trips beyond Timbuktu cell network radius.
4. **PROCUREMENT POSSIBILITIES**
- Retail: There are very few shops opened. Arab merchants left town. Trade routes coming from the north stopped to be used and the town is living on its stocks (no more Coca-cola on day 3, difficult to find wax-candles). Until southern supply routes are permanently restored, only basic procurement activities are possible but unreliable.
- The main shop, GdF (Galerie Doucoure & Fils), is also doing transport and money transfer (via Moneygram). Supplies are however scarce (for example, difficult to find candles).
- Recommendation: to consider transporting most supplies from Mopti by pirogue.

5. **CONSTRUCTION**
- Companies: According to Sane Toure Construction Company, met in Timbuktu, from over 20 companies operating in Timbuktu prior to events, there are only 3 companies that are still operational (Sane Toure, Tombouctou Construction and AlFarouk Construction).
- Constructions/rehabilitations can still be undertaken. This may take more time by chartering large pirogues for supplies, still possible. Labor intensive activities are a priority to provide income and restore livelihoods.
- Price per sqm are likely to be increased by 30% due to the logistics constraints (baseline is CFA85,000/sqm ground floor health center incl. well, tower and solar-panels).