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I – INTRODUCTION

MSF’s mission in Somalia is in many ways unique in its history. As it unfolded, and long afterwards as well, it fuelled debates—many of them heated—in the field, in Nairobi, and at headquarters. It stirred up old demons, and raised fresh questions worth revisiting after the emergency had passed. Behind the net positives of the mission in Somalia were processes and failures that need to be assessed and understood. The features that drove the Somalia crisis placed aid workers in new circumstances with respect to security on one hand and, on the other, the UN’s armed intervention, forcing MSF to obliged to better define its position.

For this reason MSF has decided to take stock of MSF-France’s mission in Somalia so that the experience gained in the course of this mission may be of use in subsequent missions of a comparable nature.

Rather than present a detailed, chronologically ordered summary of this mission we thought it would be more useful to present this evaluation thematically. Those aspects most likely to arouse debate and controversy were given conscious priority. This initial decision led us to favor a critical perspective to the neglect of activities carried out successfully.

GOALS
This document does not claim to offer definitive answers to the issues it raises, but rather to set forth the facts, debates, and circumstances that led to a given decision or favored a given form of conduct, in as objective a way as possible. The reader may then reach his or her own conclusions.

For this purpose a panel and discussion forum has been planned to accompany the release of this report. We hope this will allow everyone, and especially those who were involved in the Somalia mission, to respond and enrich these reflections further.

METHOD
Three instruments were used in combination:

A questionnaire was distributed to identify the main issues the persons we contacted wished to see covered in this document;
Those centrally involved in the mission were interviewed;
Available reports and documents were studied.

Due to insufficient time or unavailability, some persons were not invited to contribute their observations. We understand their frustration and keenly regret it, as well. We wish to assure them that this was indeed a matter of constraints as to time and/or accessibility, and not of any deliberate choice on our part.

This method also came up against another obstacle: the unavailability of certain data (especially statistics) and mission reports at headquarters in Paris. This fragmentary data may have led us to be over-simplistic—even inaccurate—in our analysis, particularly with respect to the technical aspects of programs. We hope this will to some extent be rectified in the discussions and debates forthcoming.
As the persons who raised them have pointed out, a number of issues mentioned in the questionnaire we distributed have not been dealt with here. With due respect to any frustration this may have caused, our selections were influenced by the need to be as concise as possible. Actually, we exceeded our intended limit of 30 pages—at the risk of deterring some of our readers. But as our investigations progressed it became apparent that it would be impossible to be any more concise, given the specificity, variety, and subtlety of the responses we received. Shortening the volume by deliberately omitting certain facts would have further oversimplified an already too simplistic analysis and excluded issues vital to the discussion.

In conclusion, we would like to thank everyone who gave us their time, as well as those who were good enough to review the manuscript of this document. Their accounts, criticisms, and comments were of inestimable valuable.
1. Chronology of Key Events

**1991**

**January 1991:** Mogadishu
USC (Hawiye clan) forces clash with those of the dictator Siad Barre (Darod clan). Fierce fighting in Mogadishu.

**January 5:** The last remaining foreign nationals are evacuated: A joint MSF team (French, Belgian and Dutch) arrives at government-controlled Digfer hospital. 30 to 50 wounded per day.

**January 16:** MSF, the only foreign group in Mogadishu, is forced to evacuate as fighting intensifies. The tally: surgery performed on fewer than 40 wounded.

**January 23:** MSF returns to Mogadishu after negotiations with the USC, and begins operating out of the SOS hospital in the zone controlled by the insurgents.

**January 27:** Siad Barre flees Mogadishu. Ali Mahdi (Abgal sub-clan) is elected interim president by the Hawiye clan but receives no other recognition as such. With the city in chaos, the MSF team evacuates on 1/30. The ICRC is frequently present.

**February 1991:**
The Hawiye divide into sub-clans: the city is at the mercy of looters. MSF runs a surgical program and supplies several health facilities with medicines.

February 2: MSF returns to Mogadishu with a team of four at Medina Hospital (after the program director visits on mission).

**March 1991:** The USC pursues Darod clan-members to Kismayu, tensions ease in Mogadishu; Darod clan-members flood into Kenya.

March 21: MSF France again heads up European coordination team in Somalia.

**April 1991:** Aidid and his forces return to Mogadishu. Fresh tensions between the Hawiye sub-clans. Hospital admissions are on the rise. Security conditions at the hospital remain suspect. The Hawiye sub-clans unite to push back a Darod (Morgan-led) offensive, and the USC recaptures Kismayu. Exploratory mission to Kismayu. MSF Belgium considers a mission. MSF supplies hospitals in Mogadishu: SOS, Digfer, Benadir, Medina, Military, and Martini, as well as local health facilities: water is supplied to some neighborhoods (and displaced persons). The ICRC and the SCF are present as well. Dilemma with respect to orthopedic cases.

**May 1991:** The SNM (Isaaq clan) declares Somaliland independent. 300,000 people are displaced by the fighting across the country. Aidid and Mahdi fall into open conflict.

Problem of cohesion within the MSF team.
June 91: Aidid is elected USC president and seeks to oust Ali Mahdi from power; the Abgal and the Habir Gidir split apart. The USC leaves Kismayu with O. Jess (Ogaden-Darod)—an ally of Aidid’s—in control. MSF increases supplies for hospitals and decides to launch an orthopedic surgery program capable of treating 250 of the 600 cases registered.

July 91: Relations improve between Aidid and Mahdi: the crisis recedes. Orthopedic program is launched (a new operating room at Medina, post-op care at Benadir).

July 18: An MSF guard is killed by looters in the presence of an MSF nurse. The decision is made to have the unarmed MSF vehicle escorted by an armed vehicle.

July 27: A new coordinator for three months. MSF moves out of its quarters in Medina and over to a zone controlled by Aidid/Osman Ato.

August 91: The problem of neutrality: MSF is too much identified with the Saad, a sub-clan of Aidid and Ato’s Habir-Gedir clan. The orthopedic program encounters difficulties. A training program for anesthetists is launched at Digfer. New distributions of supplies outside of Mogadishu in the central region (local health facility).

September 91: Tensions in Mogadishu; MSF proceeds with its orthopedic program while also accepting emergency cases. The problem of MSF “clan-branding” and neutrality is all the more acute now that the city is divided in two.

September 5: Violent clashes between Abgal and Hebrir Gedir. MSF copes with the emergency, but is forced to evacuate one night and join the ICRC in a neutral district of the city. Its team is reduced from 10 to 6.

October 91: Tensions persist. MSF increases its contacts with clans opposed to Aidid. The orthopedic program comes under criticism, particularly after the Lortat-Jacob evaluation. Supplies of medicines and equipment to other regions are expanded. The Belgians discontinue the Kismayo mission.

November 91: War begins again, carving the city in half (Abgal to the north/Hebrir Gedir to the south). Nearly 800 wounded on each side per day; orthopedic and anesthetist’s training programs are suspended. Delivering water and supplying local hospitals and facilities go on as before. MSF is rapidly overwhelmed (over 300 post-op patients without shelter after 8 days of fighting; high post-op mortality rates). In the northern sector there are no hospital facilities for 3,000 wounded persons; MSF crosses the front line and organizes the first aid delivery across the lines following an accord reached between the two warring parties. The clashes will last 4 months, leaving 30,000 wounded and roughly 10,000 dead.

December 91: The ICRC begins renovations to turn a former prison into a hospital 10 km north of Mogadishu. Plagued by looting, the ICRC is forced to cut back on its medical activities and food distribution. MSF proceeds with its surgical program and continues supplying the Abgal-controlled zone with medicines and equipment. The ICRC speaks of an alarming nutrition situation.

December 14: The president, medical director, program director and the head of the Nairobi office arrive to negotiate demilitarizing the hospitals, also to assess MSF’s neutrality and evaluate the running of the surgical program.
December 15: An ICRC worker is shot point blank.

1991- THE TALLY:
9,386 admitted, 2,250 operated on. 110 MSF personnel worked in Mogadishu, 350 tons of equipment delivered. 2.5 million dollars spent.

1992

January 92: Tensions resume after UN/OAU-led negotiations fail. Fighting between forces led by Jess (Darod-Ogaden) and Morgan (Darod-Harti).
A second ICRC worker is shot.
MSF secures a commitment to demilitarize the hospitals.
Nutrition situation is troubling; Two ICRC ships distribute 1,700 tons of supplies and medicines to the northern and southern sections of Mogadishu.

January 23: UN resolution 733 is adopted: an arms embargo and call for a cease-fire. January 1991: Mogadishu [sic]

February 92: Fighting continues as representatives of the two parties negotiate terms for a cease-fire, which will be signed March 3 and observed. Deeply alarming nutrition situation—particularly so for 400,00 displaced persons south and southwest of Mogadishu. MSF Belgium conducts an exploratory mission in Merca-Qorioley (100 km south): emergency conditions…MSF continues to supply fuel to hospitals (dangerous).

March 92: UN mission arrives to supervise the cease-fire and transport food aid. The ICRC advocates massive food contributions to ease tensions; estimates vast needs in region of Merca. MSF exploratory mission at the time of arrival of a new MSF coordinator; MSF office in Mogadishu prepares to move location.

April 92: Epicentre conducts a study of the Merca region: 78.6% malnutrition is verified out of a population of 110,000. MSF decides to intervene quickly.
NGO’s are alerted: 1.5 million Somalis are in immediate danger of dying; 3.5 million people in peril if aid doesn’t arrive rapidly.
Aidid pushes Darod clan members out of the Bay and Gedo regions, triggering a new flood of displaced persons and refugees into Kenya.

May 92: Fifty UN cease-fire observers arrive.
Results of Epicentre study of the Merca region are published.
Coordinators’ week and the board of directors: “Does humanitarian aid perpetuate conflicts”?

Medical-nutrition program established in the Merca region.
Extreme tension in Kismayo.
Coordinator conducts exploratory missions between Merca and Kismayu; recommends expanding programs to Brava.

July 92:
Numerous NGO’s arrive on the scene. MSF attempts to transfer responsibility for delivering medicines to UNICEF and the WHO, and recommends opening a central pharmacy. Plans to withdraw
from Medina and discontinue surgical services. Media presence continues to grow. Fifteen therapeutic feeding centers open in Merca at the end of July.

**August 92:** Kouchner visits. Decision to establish an airlift to transport food; intensive media coverage of the famine.

Aidid accepts a deployment of 500 blue helmets to provide security for aid conveys, which are being looted on a regular basis. The NGO’s are hostages of their own security forces.

Sahnoun learns through the BBC of the UN’s decision to send an additional 3,000 blue helmets; this will jeopardize negotiations with Aidid.


**September 92:** Mogadishu: fighting in Medina Village; port reopens, in the presence of 50 of a planned 500 blue helmets.

Increased aid from the international community is expected. Grave nutritional situation for 60,000 displaced persons in Baidoba. Looting is more and more frequent.

A measles epidemic breaks out among the displaced population; MSF belatedly begins vaccinating.

MSF opens in Hoddur and Wajit under a decentralized, regional coordination team.

MSF France and MSF Spain conduct an exploratory mission in the Abgal-controlled zone in northern Mogadishu.

MSF and the ICRC declare that the Somali problem exceeds the capacities of NGO’s and appeal to political authorities to assume responsibility.

Number of displaced persons: around 1.5 million

**October 92:** MSF opens in Kansardere, discontinues services at Benadir [Hospital] in Mogadishu.

In Geneva as a representative for NGO’s, the MSF coordinator participates in the preparation of an accelerated, 100-day plan for the UN. A conference follows during which funding for the plan is sought.

Darod clan members re-take Bardere; there are heavy tensions in the region of Kansardere and the team is evacuated. Twenty thousand displaced persons in Bardere; 300 deaths daily.

“Rice for Somalia” program in French schools.

Aidid’s Foreign Minister declares MSF France’s coordinator “persona non grata, as the USC adopts a more radical position towards the UN and NGO’s.

Resignation of Sahnoun, criticized by Boutros Gali for his criticism of UN fecklessness [in Somalia].

**November 92:** Tensions exist between the UN and Aidid. Still not possible to deploy the 500 blue helmets. A USC campaign against foreigners begins, with numerous instances of looting. The Americans announce they are ready to provide the UN with 30,000 troops. Debate begins over humanitarian intervention in Somalia.

MSF Spain opens in the region north of Mogadishu.

MSF France’s coordinator leaves the country after receiving threats.

French rice arrives in Mogadishu.

**December 92:**

**December 4:** The Security Council passes Resolution 794 calling for action under Chapter VIII of the UN Charter to establish a secure environment for humanitarian relief operations in Somalia as speedily as possible.

**December 9:** UNITAF forces land in Mogadishu. Operation Restore Hope begins.
Fearing the reactions of armed bands, MSF reduces its staff on a preventive basis, as do all other NGO’s.

**December 18:** Aidid and Mahdi shake hands publicly.

**December 19:** American troops occupy Baidoba and, on the 23rd of the month, Bardere.

**December 27:** Peace accord between Aidid and Mahdi is signed in Mogadishu.

1993

**January 93:** Between 150,00 and 200,00 people are still malnourished in Somalia, according to the ICRC. An MSF France car is ambushed in Mogadishu. Several bullet holes (American?) in the car.

**January 2:** UNICEF representative murdered in Kismayu.

**January 4:** UN sponsored conference bringing together the various factions opens in Addis Ababa. Pharmacists Without Borders again assumes charge of distributing medicines in Mogadishu.

**January 14:** ICRC worker shot in Bardera.

**January 15:** Accord is signed establishing a cease-fire and the immediate disarming of all factions. A planning committee is formed for a Conference on National Reconciliation in Addis Ababa on April 15. The multinational force command sets a deadline of February 1st for a return to normal in Mogadishu.

**January 20:** Ad hoc planning committee for the Conference on National Reconciliation meets in Addis Ababa. MSF activities in Brava suspended for security reasons.

**January 23:** First food aid ship since October 13 enters Kismayu.

**February 93:** Growing number of hostile demonstrations by Mogadishu residents against the United Nations. Negotiations between the factions are at a standstill. Highly unsafe environment in the Merca region: looting, assaults, theft.

**February 5:** Operation to distribute supplies in Mogadishu begins. Lasts 6 days instead of the 90 days planned. Agreement reached between a consortium of NGO’s and the United Nations to establish a pay scale for Somali employees.

**February 12:** An MSF car is caught in an ambush between Mogadishu and Naidoa, then comes under gunfire on the way to Merca. MSF is forced more and more to work in military security zones. MSF considers launching small projects in Dusa Mareb. Epicentre evaluation mission in Hoddur: emergency conditions continue. Day centers open in Hoddur and Wajit. Broad reorganization of the Somali mission.

**February 16:** UNICEF headquarters in Mogadishu is robbed.

**February 22:** Concern nurse dies.
February 23: Attacks on Action Humanitaire Française, the Egyptian embassy, UNICEF, and the WFP.

February 27: MSF Holland “mad max” guards turn against the team and steal 35,000 USD from them.

March 93: UNITAF has lost its neutral image completely. More frequent instances of attacks and looting. Groups and sub-clans will do anything to obtain foodstuffs. Alliances are continuously shifting.

March 9-14: MSF director and program director undertake an evaluation mission to decide the future of the Somalia mission. Decision to close the mission made in Nairobi together with the team.

March 16: Fierce fighting in Kismayu.

March 21: The ICRC withdraws from northern Mogadishu. Major meeting on security planned involving all the parties present in Mogadishu (UN, USA, NGO’s). Kansardere is evacuated again.

March 26: An MSF Holland guard is accidentally killed by Australian soldiers.
March 27: The fifteen factions present at Addis Ababa sign a peace accord that calls for establishing transitional mechanisms.

March 31: Renewed fighting in Kismayo. MSF Belgium is forced to evacuate. They are robbed upon their return.

April 93: Growing number of attacks and propaganda efforts by General Aidid against the Americans.

April 14: MSF announces its departure from Qorioley before the end of the month. SCF (US) to provide follow-up care.

April 15: MSF begins to evacuate in the Lower Shebelle [region]. Entire evacuation occurs without incident. MDM Greece resumes activity in Wajit.

June 6, 93: Mogadishu mission closes.
Pie Chart 1

Pie Chart 2
Pie Chart 3

Pie Chart 4
SECURITY/NEUTRALITY

The facts:

- January 1991: enormous security problems for the MSF from the moment of its arrival in Mogadishu (vehicle attacked; arms inside the hospital; personnel pressured at gunpoint; theft, stray bullets).
- February-March-April: repeated requests for protection addressed to General Aidid and ali Mahdi; inadequate response. Acceptance of Osman Ato’s offer of guards at the hospital entrance and, later, for transit (in the MSF vehicle—later in jeeps converted into “mad-max”-type vehicles.
- April-May 91: MSF begins to pay its guards.
- July 91: an MSF guard is killed; the security system is strengthened (40 armed guards). Mad max units are deployed on a continuous basis.
- November 91: war between the USC factions (Ali Mahdi/General Aidid) in Mogadishu. In addition to the issue of security there is now an issue of neutrality because the guards MSF employs belong to the Hebir Gedir Saad clan, i.e. the clan of Osman Ato, General Aidid’s right hand man. Ato becomes MSF’s “logistical” supplier in Mogadishu.
- January 92: the mission’s administrative system is restructured; difficult negotiations begin over establishing contracts with the local personnel.
- March-June 92 – free food distribution is blocked for security reasons (convoys looted; ships blocked off the coast of Mogadishu).
- Autumn 92: numerous NGO’s “land” in Mogadishu; wages are driven up; blackmail and racketeering impact the opening and setting up of missions across the country.
- December 92: UNITAF lands. The status quo established by the NGO’s to provide their security comes under attack. NGO’s become hostages of their own guards and of United Nations forces.
- Spring 93: attacks on convoys create a number of victims among expatriate workers representing humanitarian organizations.
- May ’93: MSF withdrawal takes place without security difficulties

Problems encountered:

- Warlords lack the wherewithal to control the situation in Mogadishu (looting, attacks); requests for their protection are rejected.
- Rapid growth and bloating of the security system (number of guards) owing to a lack of continuity in the coordinating team both in terms of assessing security problems and of responding to them: lack of a larger perspective in Mogadishu and of broad-scale vision in Paris.
- MSF is “clan-branded” due to a relative lack of vigilance and foresight with respect to the evolving Somali political context; a lack of internal transparency at MSF (particularly with respect to how relations with Osman Ato were managed). Flaws in administration and management of local personnel.
- MSF has insufficient leverage to control how the process is evolving—a process it had itself set in motion. MSF is dependent on its guards to carry out its programs and gradually becomes “hostage” to its own guards for its security.

Discussion points:

- MSF activities in Somalia are heavily dependent on security constraints, on the process MSF sets up to cope with them, and on the machinery of events this creates. How could MSF have reversed this and gained better control over the perverse effects of the process?

By establishing criteria for abstention? Better cost/benefit evaluation? Enhanced supervision? By more emphasis on the larger perspective, on analysis and foresight, and by further disengaging itself from operational emergencies? By improving transparency, and better circulation of information? By broadening the operations sector?

III – SECURITY / NEUTRALITY
INTRODUCTION

Opting to use armed guards, and then to pay them, were not the products of a decision at the operations level but, instead, of a process under varying degrees of control at different stages of the Somalia mission. For this reason the debate never presented itself as “Is it ethically acceptable to employ armed guards?”—not at the operations level, in any case. What we should explore, then, is how the process was controlled and how the system of security was evaluated.

The question of whether or not MSF was financing the war economy, mainly by paying the armed guards, arose late in the debate (spring 92) via Stephen Smith and Mario Goethals. If we wish to go beyond the mere data and keep our analysis relevant from the point of view of MSF internally, the question must be placed in context, i.e. within the logic of operations. We will examine the evolution of that logic—which itself was under varying degrees of control.

Finally, MSF’s ties with Osman Ato during the mission posed a problem not only in terms of financing the war, but also of the dependence they created between MSF and General Aidid’s clan. In the end these ties raise the question of how relevant neutrality is in political circumstances as unstable as these were.

These aspects of MSF’s mission in Somalia constituted steps in a machinery of events which we would do well to break down and analyze in order to find out whether the process might have been avoided, circumvented, or brought under control—and if so, how?

1 – PRESENCE OF ARMED GUARDS

MSF is not the first organization to use armed guards, or to pay them. The precedent for it already existed in Somalia.

1.1 – During the war in Somaliland...

- Humanitarian organizations used armed guards in Somalia before the war in Mogadishu (In the HCR compound during the war in Somaliland; the “mad-max” units used by Care). The Somalis were using this system for their own security before the war. They did not “impose” the system—they lived under it themselves.
- The organizations also accepted police protection at the time. Realizing that the government was not paying these police, the organizations gradually began to do so. From that point forward they were, in fact, paid armed guards.

In the case of Somaliland, also, there was no decision made at any particular given moment. And in that case, as well, the circumstances created the precedent. Nevertheless, when MSF came to Mogadishu in January 1991 this precedent was not an influential factor. Although similarities did exist, the process that began with the fall of the Siad Barre regime was entirely different.

January 1991. When MSF arrives, without any particular protection, in Mogadishu on the eve of Siad Barre’s fall there is no longer any government-based legitimacy or control. Two members of the team are shot at in the first few days—the reason for the first evacuation.

A second team sets itself up on the USC side (armed USC escort) but very quickly evacuates amidst the panic that ensues after the dictator’s fall (Note: no coordinator). In these two scenarios, who should
have been considered in charge of security on the Somali side? Who to turn to? A situation in which the population is heavily armed and under no effective control.

A security system is established to meet a threat. The nature of the threat evolves throughout the time MSF is there. What adjustments were made? What kind of supervision was there?

### 1.2 Threats posed to the hospital

When MSF set up operations it was the only western organization present; it was also the only one able to perform a high volume of operations on the war-wounded. The patients are armed; armed vehicles (“mad-max” vehicles) enter the hospital premises—right up to the operating room. The MSF team is pressured, sometimes at the point of a gun, to operate on a given wounded patient rather than another, especially during days of major fighting such as February 13 (USC vs. SPM). From that day onward, if MSF decides to stay a security system will be essential to keep the team working, one that will monitor entry to the hospital. General Aidid and Ali Mahdi are approached and a police force is deployed thereafter (USC men at the hospital entrance). The system rapidly proves to be either ineffective or inadequate. The second solution, adopted on an emergency basis, was to accept Osman Oto’s offer and hire (end of February –beginning of March 91) a few armed men to provide hospital security. This decision was made with the approval of the two principal heads of the USC who were, once again, approached and consulted on the issue.

These men belong to Osman Ato, whom Thierry Durand had met in Nairobi. He had made it possible for MSF to come back come back to Mogadishu, and then to set up operations once again. Exactly what his position in the conflict was, and his role in it, was not understood in its early months. At the time the man seemed to be the only one in a position to respond—respond quickly and well, that is—to MSF’s logistical and security needs.

### 1.3 – Second threat: armed attacks while in transit around Mogadishu.

When MSF obtains its first vehicle it is feared the MSF car will be stolen (April 91). A method of deterrence is needed. From then on armed guards escort the team as it delivers supplies of medicines in the city; also when it moves quarters in April.

Later on, utilizing the “mad max” units Somalis themselves have used since the beginning of the fighting is seen as a logical step in the process of adjusting to the situation and the security constraints it imposes. Because the statements we gathered are not consistent on the point, it wasn’t possible to determine either the precise date or the circumstances in which MSF first used them. In fact they would be used intermittently, depending both on the degree of insecurity in Mogadishu and the coordinator’s assessment of what system to choose in response. They would be employed on a continuous basis from July 1991 onward.

### 1.4 – Security for MSF’s mandate

Were other solutions available to MSF? Didn’t the head of the SOS hospital (who had been in Mogadishu a long time) move about without armed guards? But what value did he really represent? ICRC also tried to move through the city without armed guards. But it very soon gave up (attacks and numerous instances of looting) and rapidly came to use armed guards and mad max units.

Well then, wouldn’t it have been possible to withhold MSF’s presence against guarantees of security (using blackmail from the very start)—to demand that the Somali community itself take over MSF’s security. Was this point pushed as forcefully as it might have been during negotiations with Aidid and Mahdi? In order to respond to this question in February 91 another question would have needed answering (and to be asked as well?): was there a strong enough desire in the Somali community for MSF to stay? If not, what leverage did MSF have…Actually, the reasoning went as follows:

- MSF is practically the sole western presence in Mogadishu; the country is now completely cut off from the world. MSF therefore wants—it chooses—to be there and bear witness.
The situation is one of extreme emergency, with many victims and virtually no surgical facility to deal with them. The civil authorities have been dispersed. Who are the Somalis to turn to? This gap instills a very strong determination to stay.

In Mogadishu, MSF is fulfilling its mandate to the very letter. The issue therefore is whether the system of security will make it possible to honor this choice—not whether MSF is going to agree to work under critical security conditions. Gradually, under emergency conditions, the system of security will take shape on a pragmatic basis, with no ethical debate. It consists of armed guards and mad max units.

Conversely, didn’t the Somalis to some extent gauge MSF’s desire to be there—“at any price” (Note: Osman Ato—always there at just the right moment, though he doesn’t really need to offer his services…) And, indeed, once the system was in place it became all the more impossible to work without armed guards. From then on a piece of the process slips from MSF’s control. When it comes to using armed guards, the only real leverage MSF has is that it knows whether the organization is ready to leave. The question is never really framed in these terms, not by the operations team, in any event. The criteria for abstention are never specified. The “ethical” drawback that would incline us to weigh the use of armed guards is mentioned, but not factored in as criteria for abstention. An operational logic prevails, even though it gives us less room for maneuver. In any case, for MSF abstention brings with it a threat of another kind.

1.5 – Stray bullets; A number of major “incidents” (mortar fire on the hospital, shells passing through the operating room). The tension between security and MSF’s presence is now at its most extreme. This is the moment when discontinuing activities is the most seriously considered. Paris has confidence in the program director, who leaves the team quite free to decide for themselves. With the exception of a very few individual cases, the team decides to stay every time.

Once the system is in place (armed guards, mad max units), what kind of supervision was there over the process and how it evolved?

1.6- Less vigilance The choice has been made. It will not be called into question again. The armed guards are there; the mad max units are there; it is the “normal” status quo. The debate over “the use of force to deliver humanitarian aid” will not surface until much later and, even then, not at the operations level.

June 1991. The war comes to a halt. The situation is “calm” in Mogadishu. But some twenty bullet wound cases per day are still recorded at the hospital. In addition, because of a major incidence of looting the team feels it is necessary to retain visible forms of deterrence. An MSF guard is shot at the beginning of July 91; travel is thereafter protected by mad-max units along with twenty or so armed guards. Nevertheless, many believe this period was the only moment it was possible to get control over the proliferation of guards, or at least to re-evaluate what the exact needs were in terms of guards and mad-max units. According to Frédéric Vigneau in his June report, “It is clear that if such-and-such a clan decides for whatever reason to shoot at us, 1, 2, or 3 mad maxes are not going to stop them, either”. In the end the inclination is to keep the guards that had been hired up to that point.

At the beginning of July an MSF driver is shot in the presence of a nurse. Yet two armed MSF guards are present in the MSF vehicle. The team is stunned. The coordinator is backed up by Paris’ confidence in him/her and its reflexive reaction: “Security must be enhanced”. So there will be no more consideration given to trimming back the system of armed guards. General Aidid pays a visit, reiterating his pledges to “clean up” the city; nothing happens. Once again, the logic of operations legitimizes the use of mad max units and the retention of a large number of armed guards. This period, in fact, brings up the issue of what the right balance is between the real needs and our response,
because the coordinator is using few if any objective criteria for assessment, only his/her own system of evaluation. The needs are beyond dispute, but how do we ensure that the response is adequate to meet the needs—no less...and no more? In this respect, regular visits by the program director make it possible to keep perspective and consistency in our assessments. But there is inconsistency on this point, as well.

1.7 – The bigger picture
No visits, no evaluation for nearly two months (June, July)—neither from Paris nor Nairobi. But monitoring the process and keeping the process in perspective is very difficult to do from Mogadishu. Evaluations of the risks, the threat, and decisions made in terms of security are increasingly the province of the coordinator alone, who at the time appeared somewhat inclined to heavy handed solutions. So the system is self-reinforcing. Until Francois Jean visits in August and finds an “MSF army”, bloated out of all proportion to the circumstances. A few days later in September a new clash causes tensions in the city, which continue to mount until fighting breaks out again in November. Control over the process of armed guards is again difficult—no longer at issue, even.

2 – MSF AND THE WAR ECONOMY
The ethical debate over paying the armed guards didn’t emerge until the moment the cost of the guards, and more generally of security, was discovered, and when Stephen Smith demonstrated its connection with financing the war. Our own figures don’t allow us to deal with the second issue, only to chart the amounts MSF spent on its security comparatively (See Main Economic Chart) and the relative portion that went to Osman Atoto. However, it is possible to assess the perverse effects of turning security into cash by identifying the major steps that led MSF to be caught up in this machinery of events.

2.1 – Paying the armed guards
When it was decided in February to accept Osman’s offer to place guards at the entrance of the hospital, it was clear that it was up to MSF to oversee them. The decision to pay them, not to simply compensate them in kind, was MSF’s responsibility alone, therefore. Paris was not really consulted on the question, except to sign off on a choice the coordinator’s office in Mogadishu had made.

The factors that logically led to paying the guards were as follows:

- They provided a service and were steadily growing in number, like the rest of the local staff. But these were not volunteers, or USC men. This was a professional context.

- Since we didn’t have the option of demanding that the Somali community take over security, this became a service context. And, if we were to be able to depend on the guards in every eventuality, it made sense to pay them.

- All the guards, or nearly all, were “supplied”, once again, by Osman Oto, whose influence on the war, and on MSF’s activities as well, we were now beginning to appreciate. Paying them, it was believed, meant freeing ourselves somewhat from this influence, this dependence.

Therefore the guards were to be paid, and in local currency. The number of guards grew and they were “employed” for longer periods and for higher wages, so the armed guards became professionalized (end of spring 91).

Nor, once again, was there any reflection given beforehand in Paris as to the principal, as such, of paying guards, or to provide for another solution. But then again, what other operational solution, what room for maneuver was there, given that we had decided to remain come what may? Was it possible in
March 91 to gauge that we were generating another form of dependence—that of guards upon the NGO’s, a system that could eventually present problems when it came time to withdraw? The question for MSF, once again, was expressed more in terms of monitoring, of controlling the spiraling costs of the guards and their perverse effects, not in terms of a policy principle.

2.2 – Obstacles to monitoring the process
In the beginning, wages were insignificant and there were a negligible number of employees. Little economic investment involved. But MSF did not set any limits, either. Where did we want to end up? What would the cost be? What would the terms be? In reality, MSF did very little planning on this subject. And indeed, from the beginning of the second war (when security issues were vital to its preservation) MSF was at a disadvantage with respect to its guards because it had no protection against pressure over wages, or coerced hiring...Because of the process described above, on the one hand. And on the other, because hiring only happened through one man who had secured a monopoly for himself. And, finally, because there was no contract.

2.2.1 – Osman Ato
When MSF came back to Mogadishu in February 91, it was Osman Ato who helped the team to move back, then to find a house; then jeeps (converted into mad maxes; 2 X $85 per day), and a generator ($120 per day), and a water tanker ($200 per day), and the occasional crane, etc. To give some indication, Osman Ato’s bill for the months of October, November, and December 91 came to $60,000 dollars. And, while he did not raise prices for MSF on his “services”, it would be reasonable to say, simply by doing the multiplication, that over the entire period MSF was in Somalia it spent nearly $400,000 on Osman Ato.

Because he was virtually the only individual with the resources for it, Osman Ato became a key factor in the MSF mission in Somalia. And since it was an emergency situation, and Osman Ato was the only one able to respond immediately to MSF’s every need, and it was understood that we had no choice, there was not enough—or even no—negotiation done over the prices of various rental needs.

The lack of organization (management-administration) and follow up which resulted from having one coordinator after another and, thus, different counterparts dealing with Osman Ato, worked to his advantage. As an example, the figures quoted for renting Osman’s equipment fluctuated depending on each coordinator, according to their statements. And when MSF tried to do without his services and organize a convoy itself, the risks of being looted by Osman Ato’s own men caused it to give up very quickly. From then on security depended on him, so it became difficult to use competition as a lever.

So: an absence of limits or points of reference—to some degree even a loss of the notion of relative costs, and of criteria for intervention or abstention. Example: compensation in the amount of $7,000 for the family of the MSF guard who was shot (problem of setting a precedent…); the first planes were chartered for over $6,000 (today around $3,000); a water tanker was rented for $200 per day with no negotiation or formal agreement (only to discover later that, in addition, the water tank had vanished…). Actually the invoices were sent directly to and paid by the Nairobi office, which further diluted financial responsibility among Nairobi, Paris, and Mogadishu (where the guards were paid); in any case this left the coordinator’s office in Mogadishu with little financial oversight over the amounts spent on Osman, and in fact gave Ato a chance to play the different parties off against one another.

2.2.2 – Absence of a work contract
The lack of an administrator and the heavy duties of the coordinator explain, for the most part, why no work contract was agreed on between the guards and MSF before the very beginning of 1992. Yet, again and again, “incidents” with the guards pointed up the lack of coordination and organization when it came to managing local personnel.
In fact, with a few exceptions in February 91, there was no employment contract prepared for local personnel, which means there was: no job description, and therefore little way to discipline an employee if there was a problem; no amount set in advance for compensation in case of injury or being wounded, overtime, or dismissal.

As a result the door was left ajar for blackmail…to which the mission was more or less subjected, again and again, in the autumn of 91 whenever dismissals occurred. These “incidents” led one coordinator after another to draw up contracts (in spring 92), but it wasn’t easy to do so: negotiations on the basis of blackmail, strikes and even threats from the guards, and later by the entire local staff; passive demands, etc. In the end MSF yielded in the disguised form of a bonus prorated on the basis of seniority (total cost for the operation: $7,000 shared out among the guards).

2.2.3 - Racketeering
Autumn, 1992: The rapidly increasing number of NGO’s is accompanied by a rapid increase in the number of armed guards. The Somalis realize they have discovered a goose that lays golden eggs. In the end, a lack of transparency and coordination between the organizations as to wages, amplified by their dependence on armed guards for their security, leads to serious wage inflation. Security becomes a virtual industry. The balance shifts. Where once the Somalis were dependent on NGO assistance, now there is a system in which organizations are dependent, for their presence, on Somali guards (pressures from donors, the media), with no room whatever for maneuver.

This situation therefore left the door ajar for racketeering of every sort—especially because there were no “legitimate” civilian counterparts—when nutritional centers were opened, vehicles rented, etc. Although MSF was relatively protected by the contracts it had signed several months before as well as its experience and seniority on the ground (counter-example: MSF Holland), there are records of salary increases at this same time (even correcting for inflation of the SSH).

(see: table chart)

And, indeed, the Somalis realized they held the advantage over the NGO’s, especially after the media arrived. NGO’s no longer had the option of swapping their work for their security—it was up to them, instead, to leave if they couldn’t accept the conditions the Somalis had set. The problem was deciding exactly how much pressure was acceptable. In November 92 Medina Hospital authorities attempted to blackmail MSF into taking over renovations at the hospital and paying the wages of the hospital’s entire staff. They had been encouraged by the earlier experience of Digfer Hospital, where the IRC team had yielded to the Somalis’ demands. The blackmail failed, despite USAID’s offer of financial support to MSF, mainly because the surgical emergency in Mogadishu had passed and MSF’s mission was then in its nutritional phase. MSF withdrew from Medina Hospital.

2.3 – MSF becomes hostage to its own security system
The final perverse effect associated with paying the guards emerged at the moment MSF withdrew. As UNITAF, and later UNOSOM forces arrived the pressure mounted. To begin with, because security
risks (attacks on convoys, looting) soared, putting NGO’s in a highly precarious position. Some NGO’s were under threat from their own armed guards (theft), as well. Another reason was that the NGO’s represented (due to the looting) the primary means of support available (which then led to coerced hiring of personnel). NGO’s had, essentially, turned into a major source of economic gain, which the UN’s arrival threatened to disrupt with no immediate alternative to offer. The facts have been recounted a number of times, but this was how NGO’s became hostages of their own security systems. So, when MSF decided to discontinue, the security risk lay in how the more than 800 employees would react, especially the armed guards, to their dismissal.

This time around the debate occurred in a number of venues inside MSF: in the field, at meetings of program directors, within the board of directors, in Nairobi, etc. Although MSF’s disengagement was not primarily motivated by security issues the debate centered, for the most part, around this topic. The debate over closing the mission lacked somewhat in clarity, actually, as a result of so many participants. Everyone agreed, in fact, that withdrawal was necessary—but for different reasons. Consensus eventually coalesced around the issue of security and the anxiety it was creating at MSF in Somalia, but this was only one of the variables that led to closing the mission. The decision was hastened by the death of an Irish nurse, and plans for a phased but rapid departure were adopted when the team met in Nairobi March 3. The perception at the time was that major risks were present, without knowing exactly what kind or what degree of severity would justify a reaction.

Probably because MSF had been there since January 91 and was able navigate a variety of potential hazards (clans, wages, etc.) thus allowing it to depart in stages, not in flight, MSF encountered no difficulties as it withdrew from Somalia. This was all the more remarkable because other NGO’s were having major troubles at the time, whether they were attempting to leave or to stay. The same was true, it must be noted, with respect to theft and looting; MSF was very much spared compared to most of the other organizations.

3 – NEUTRALITY AND THE “CLAN-BRANDING’ OF MSF

When MSF arrived in Mogadishu in January 91 it worked in government-controlled territory. The second team, which came back with the aid protection of the USC, set up operations in the insurgent-controlled zone at the SOS hospital, apparently the only facility that was readily operational at the time. While neutrality was already an issue in both instances with respect to access to victims, conditions of work and security made it impossible from the very start to position two teams in the same city. When the team began operations in Mogadishu for the third time, at Medina Hospital, the city was, for the time, being unified under the USC flag. The problem that confronted MSF was not so much one of neutrality as one of dependence or, at minimum, being “branded” with a particular clan identity. So once again it found itself in a problematic scenario connected to that of the armed guards and MSF’s control over its security system.

3.1 – MSF Saad

When the Nairobi coordinator met Osman Ato in Nairobi he was not aware that this individual was General Aidid’s right-hand man, or that he belonged to the Hebir Gedir Saad clan. MSF returned on USC territory, but had made no decision to work with the members of one clan, if only because it was not yet familiar with the Somali clan system in all its complexity. MSF did, on the other hand, accept the protection of the USC, which by every indication had assumed “authority’ in circumstances that remained quite chaotic, as the war unfolded at the city’s gates. The USC was then the party of the Hawiye clan, which had defeated Siad Barre, and the city where MSF was operating was united, at the time, under this banner. When Osman Ato helped MSF to set up operations again, at Medina Hospital, Omar Arte Jelib (Ali Mahdi’s Prime Minister) acted as his guarantor. The guard’s clan affiliation (Hebir Gedir—mostly Saab, like Ato) therefore had no repercussions, and there were none when in
April the team moved to a house located across from Ato’s “workshop”. On the contrary, the affiliation tended to reinforce the deterrence aspect of the security system:

- It meant the group was close-knit, and this had been reinforced by its victory over Siad Barre;
- Osman Ato was already known among Somalis as a very powerful man, and therefore “feared”;
- The Saad themselves enjoyed a reputation among the other clan that enhanced deterrence.

But it was this very understanding of Ato’s influence that motivated MSF to assert its independence—thus the decision to pay the armed guards. Even then the impact of the decision was negligible because MSF still had to go through Ato, alone, for its recruiting, albeit indirectly (recruiting via other guards). MSF “clan branding” was quickly reinforced a few weeks later by a combination of factors:

- The rapid increase in the number of guards and their professionalization, as described above;
- The split within the USC between Ali Mahdi’s Abgal sub-clan and the Hebir Gedir sub-clan of General Aidid (who had returned to Mogadishu in April). Reports in May had forecast clashes but didn’t discuss the security implications of MSF’s being branded as Hebir Gedir. The split was made permanent in June when the first clashes began inside the city. A lack of perspective and political insight: the coordinator’s office made no attempt to re-align its position; Paris was clearly insufficiently aware of the issue.
- The mission turns inward in the absence of visits/evaluations from Paris.

In the eyes of the Somalis MSF was clearly branded as Saad. Osman’s guards were posted at the entrance to the street, screening not only arms but the wounded, as well, according to clan membership. Although they were not screening, they were nevertheless intimidating to the wounded who are Abgal or Murusade-affiliated.

It was only when a new coordinator arrived and François Jean visited in August 91 that the problem of MSF’s alignment was truly pushed and debated in Paris. It had, in fact, never actually been discussed at the operations level. MSF had to re-right the balance—by moving, by remedying the recruitment process, by making the hospital more accessible... Even when MSF began to supply health clinics throughout the entire Hawiye zone, or made tentative approaches to the various clans, the coordinator’s initiatives were thwarted by Ato’s decisions, and still more so by the fact of the deteriorating situation after the clash in September that led to the second period of war, creating emergency conditions in Mogadishu. In view of operational priorities the problem was deferred—even as the earliest warning of the full import of MSF’s clan alignment occurred: on September 10, 91 the team had to evacuate Medina Hospital during the night to escape Abgal shelling of the Hawiye zone and place itself under the protection of the (neutral) Suleiman clan at the ICRC.

3.2 – Mogadishu: the limits of neutrality
Within a few months, therefore, MSF had accepted a house and the protection of Osman Ato only to find itself, due to its lack of vigilance, at the center of a clan war that would make it increasingly difficult to remain operationally neutral. MSF is a humanitarian organization; this and the various conventions and charters meant that it was not incumbent on MSF to observe the division being established in the city, or to negotiate its way amidst the clan war. In theory, the opposite was true, as was repeatedly made clear to the major players, Aidid and Mahdi. As it turned out, it became one of the coordinator’s primary responsibilities to understand this arena of politics and clans and factor it into MSF’s activities—just as it was the coordinator’s
responsibility to assess MSF’s neutrality, especially in the performance of its duties. Was it a question of being “actively” neutral by setting up operations on both sides—or of being neutral on the basis of transparency, i.e. by keeping the two major players informed of its activities on either side?

3.21 – Active neutrality
The “obvious” response was to set up a second team in the city’s northern sector. But this solution also presented a number of difficulties and obstacles:

- It meant yielding to attempts at blackmailing MSF on the part of Ali Mahdi, who had an equal if not greater problem with the fact that MSF was on Aidid’s side than with the idea that it was not helping the Abgal side. On the other hand General Aidid, who was more concerned with his image, which was enhanced by the presence of NGO’s on his side of the city, demonstrated little if any reluctance with respect to the work MSF did with the enemy.
- In the context of a country completely cut off from the rest of the world (the airport was frequently shut down), highly precarious security conditions, and the nearly continual possibility of having to evacuate, a team of eight people seemed to be the maximum acceptable size (there were more, nevertheless, in repeated instances).
- During the winter of 91-92 managing and coordinating one team alone already presented enormous difficulties in terms of organization, logistics, and managing human resources (serious tensions within the team). Expanding the number of expatriate workers therefore meant multiplying these risks and difficulties—not proportionately, but exponentially.
- If such a solution were considered, problems of recruitment and rotation would come back into play.

By coincidence rather than deliberate choice, an agreement to “divide” the city was signed with the ICRC at about the same time. The ICRC, which was renovating a hospital in the northern sector of the city, was to provide surgical care there, while MSF would continue to send medical supplies. Ali Mahdi gave his approval to the project…which was dropped a few weeks later when the ICRC evacuated and discontinued its presence in the northern sector of the city.

3.32 – Neutrality via transparency
This was the option that was selected and explained whenever someone from Nairobi or Paris came through Mogadishu, or when paying visits to General Aidid or President Ali Mahdi to reaffirm MSF’s neutrality, etc. In any case, conducting its operations on the Hebir Gedir side gave MSF political leverage with General Aidid (but was it usable—and was it used?) In addition, two representative incidents highlighted the weakness of this reasoning and the limits of this “politics of transparency”.

When war broke out again the team decided to organize a joint convoy of surgical and medical supplies to the city’s northern sector with the ICRC and the SCF, crossing the front line. Although Aidid had given it the green light when consulted beforehand the team was taken hostage at the line by the general’s men, either due to crossed signals or malice. The situation was critical, although the convoy was indeed able to cross the line the first thing next day, and continued to do so throughout the remainder of the conflict—despite the very hostile reactions of Ali Mahdi early on. And, even when possible, the weekly trip of the MSF vehicle from one side of the city to the other ran enormous security risks.

In December the team decided to organize a convoy to an Abgal-Murusade enclave in the middle of the Hebir Gedir zone; due to a wish to cover the entire city, but also because they had
identified this as the source of a good deal of shellfire, some of which had hit the hospital (one shell had passed through the operating room). For purposes of transparency Aidid was informed, but he vetoed the operation. The team then bypassed his security and organized the convoy in secret. Heavy security risks were involved. Paris reacted sharply, dreading Aidid’s response (he had no doubt been informed). The program director then went into the field to reaffirm MSF’s neutrality and implicitly offer excuses to the General for this “secret” trip.

In fact, another handicap of this option might be pointed out, one that relates more to monitoring the activity and to its effectiveness. Although the convoys were organized nearly every week they remained unpredictable and, more to the point, did not permit of any kind of supervision/maintenance of equipment used (fuel, generator). Real needs could not be precisely evaluated; in particular, it was impossible to monitor the use of medical equipment and medical supplies being delivered, because we know that for a long time there was no suitable facility capable of responding properly to surgical emergencies on the Abgal side.

To conclude, none of the solutions had been completely satisfactory on the operational level or from a political point of view. Although the point is debatable, the chosen option to limit the numbers of expatriate workers was probably the best compromise in such an environment. This was certainly the case in light of the work the teams accomplished (2,203 operations between mid-November and the end of March).

3.3 – Somalia: Flaws in communicating neutrality

While in Mogadishu there was a problem with respect to neutrality, a shift in scale reveals that when one considers the various MSF sections, the criteria of neutrality were indeed met in Somalia as a whole, albeit late in the conflict.

- MSF Holland was present in the north very early on, working with the SNM.
- MSF France then came to Mogadishu and worked with the USC (SNA and AM)
- MSF Belgium, after much beating-about-the-bush, set up operations in Kismayu in April 92 (the decision was made following an exploratory mission a year earlier, during the Morgan period), on the SPM (SNA, APF) side.
- MSF Holland was in Baidoba in August 92 working in the SDM and SSDF zone
- Finally, MSF Spain set up operations in northern Mogadishu in October 92

The lack of coordination between the sections—in the field at any rate—(the first meeting of the field coordinators wasn’t until February 92) probably explains why MSF did not use this set of facts more systematically to showcase its neutrality, which was steadily disputed throughout the entire conflict and even afterwards, when the city of Mogadishu remained divided in two.

CONCLUSION

As we have seen, these security issues had an operational as well as a political dimension. In like manner, they give rise to two conclusions: one a diagnosis internal to MSF, the other a reflection on the role of humanitarian action in conflicts.

MSF AND SECURITY

Security issues are among the topics that generate the most concern at MSF, probably because they depend on shifting assessments and perceptions: of the risks one could be taking; of the acts that make it worthwhile to take them; of the compromises one should make… In Somalia as elsewhere, decisions associated with security and neutrality quickly made it impossible to stick to rigid principles.
Nevertheless, the impact these decisions had could, perhaps, have called for:

- more criteria to better characterize the process; setting more limits on order to better control and remedy perverse effects;
- More consistent use of, and more precise, cost/benefit evaluations—because when all is said and done, the object is to balance out perverse effects and positive outcomes.

It follows from this that looking at matters from a broader perspective in order to maintain a clear vision represents a necessary part of assessing and monitoring activities in the field.

*What kind of assessment, what kind of clarity, what form of evaluation should there be, then, at MSF?*

**The coordinator’s evaluations**
The first level of evaluation is that of the coordinators. But their assessment criteria with respect to security stem from a number of factors such as experience, seniority of presence onsite, personality, the team they oversee, knowledge of the country, etc. These are variable factors. This is why the coordinators’ evaluations and attitudes were partially inconsistent, and that contributed to a relative loss of control over how the process evolved. Coordinators are the individuals who know the situation and its constraints best. But no matter how competent they are or how high the quality of their analyses may be, they tend to have middle-term vision. They are handicapped by the lack of a broader perspective on their environment, on the one hand, and by the very brief time reaction time available to them, on the other. This is not specific to Somalia, of course, but it was amplified there by the severity of the emergency at the time of the fighting in Mogadishu. This is what made regular visits by outside individuals (Paris, Nairobi) important—not so much to supply answers as to ask questions and bring a fresh eye to the situation. It enhances the quality of information available to Paris, as well.

**Information in Paris**
Indeed, the geographic spread of MSF programs makes information more fragmented. Furthermore, as in any company, each program director organizes his/her own “territory”. And when information is supplied at an operations meeting, it is done in an incomplete way (it is incomplete, in any case, because it is being delivered by the field). Further, the complexities of the clan system and the political situation in Somalia accentuated the mission’s lack of transparency. Little by little, information came to be possessed and exchanged only by, and among, insiders, considerably narrowing the margin for criticism or simple, outside evaluation.

**The operations meeting**
This lack of information and transparency make it very unlikely that issues such as the armed guards would be submitted for debate at an operations meeting. Particularly so, because the mission of an operations meeting is, by definition, highly operational in nature. For all these reasons it was difficult (and in addition, delicate) for program directors to problematize or assess how that process was spiraling—or even to question the running of the program.

**Emergency decision-making**
Efficiency in decision-making is diluted as the number of participants grows. In the Somalia mission in particular, the need for a high degree of operational efficiency in the midst of an emergency, and the very strong emotions the mission generated, probably also made it difficult to have an ongoing, objective view of the choices that were being made. Very likely it was for all these reasons combined that the spiral of events was not really dealt with except when the sheer number of guards, and the sums of money involved, in particular, became an issue.
Other arenas of debate
The discussion took place in a number of forums at that time: at the board of directors’ meetings, at the coordinators’ weeks, and in the media. As relevant and interesting as these reflections truly were, they were nevertheless often rhetorical in nature, detached from the field and its constraints. Too “political” in this instance, or in any event not operationally-oriented enough to influence the unfolding MSF intervention.

Consequently, it would useful to reflect on what evaluation process MSF should adopt in this type of situation so that problems of an operational nature, but with significant political repercussions, can be debated in a way that bridges the gap between the concrete and the theoretical.

THE POLITICAL FAILURE OF THE SYSTEM OF ARMED GUARDS

From a more comprehensive, political perspective, the history of MSF security in Somalia consisted of the following simplified sequence of events: the fall of Mogadishu, followed by war between the USC factions, plunges Somalia into crisis in an atmosphere of chaos and violence. Because there are a great many victims and Somalia is isolated from the world without the resources to cope with the emergency, MSF recognizes its duty to provide assistance. But, in order to have the capacity to act it equips itself with armed guards meant to allow it to protect itself and deliver humanitarian aid…even if these guards are known to be associated with the men in charge of the fighting which has victimized many of the people MSF is treating. Famine then arrives, on top of these circumstances. It demands massive amounts of aid. Convoys are looted on a regular basis and aid cannot be delivered. The system of armed guards now reveals its limitations, is even declared a failure by the clans to whom MSF has turned for its own security. And it is these very limitations that lead to the American military intervention.

If MSF should be led to intervene in a comparable context, how can it plan for such a chain of events, and what stance should it take; how should it position itself”
THE ORTHOPEDIC SURGERY PROGRAM
(Reconstructive traumatology)

The facts:

June 1991:
- Survey of 600 cases for diagnosed for orthopedic surgery, feasibility study as an MSF program
- Operating room opens at Medina Hospital; new and European-standard
- Relative calm in the city of Mogadishu
- Change of coordinator; O. Lortat-Jacob, who is to supervise the program, is unavailable to conduct a field evaluation until September 91

July 1991:
- MSF program for a population of 200 cases is launched

September 91:
- Clash in Mogadishu; emergency cases rise again; elective surgery program suspended
- Highly negative evaluation by Lortat-Jacob in the field

November 91:
- Elective surgery program is permanently discontinued as fighting breaks out in mid-November 91

Problems encountered:
- Inadequate evaluation of program’s constraints (post-op; multiple operations) and of its unsuitability for the Somali context (emergency conditions begin again)
- Program fails (incompetence; technological “bubble”, criteria for operations and protocols are too sophisticated)
- Patients reject therapy; return to traditional medicine
- Lack of outpatient follow-up

Discussion points:
- Does the failure of the plastic surgery program in Mogadishu rule out this type of program for the future? Is there an alternative?
- How can MSF avoid the failures that resulted, associated with its aggressive attitude to intervention in its choice of programs?


INTRODUCTION

The program for reconstructive traumatology—improperly labeled orthopedic surgery—launched by MSF in Mogadishu in July 91 had a negative overall outcome. What problems lay behind the failure of a program that O. Lortat-Jacob characterized as “seductive, on paper”?

Three successive stages of the project: evaluation, decision to proceed, and the setting up of the program.

1 – Evaluation of the program’s feasibility

The following factors were available at the time of the evaluation:

- June 1991: About 600 cases diagnosed for orthopedic surgery are being deferred at the hospitals in Mogadishu (there are, in fact, many more throughout the city); they present a major public health problem: protesting patients jamming the hospitals. Between 200 and 300 orthopedic cases are designated are selected from the various hospitals in Mogadishu for priority treatment.

- The team discovers a brand new operating room at Medina Hospital which not only offers sanitary conditions close to European standards, but also would allow the MSF team to remain on site should the fighting break out again. The operating infrastructure is immediately functional and suitable for complex surgery, such as orthopedic. Equipment is available.

- Energy and enthusiasm on the team for the project run high, while programs for emergency surgery and delivering medical supplies subside in intensity. The surgeon and anesthetist in charge of evaluation are available to stay on site for three months.

- Relative calm in Mogadishu. It is believed the situation is normalizing and that the program will make it possible to start the hospital up again. It is also hoped that an intermediary can quickly be found. However the evaluation report cites political –military instability that is creating around 200 surgical cases a day. Serious clashes in Mogadishu June 18 and 19. Launching the orthopedic surgery program obliges a long-term presence (repeated operations; lengthy post-op period). For this program, MSF is committed to operate for a year without taking on new patients.

- The experience of wartime surgery at Medina Hospital and the numerous mission reports all conclude that there are serious inadequacies and difficulties there in post-op treatment: logistical costs and insufficient sites; personnel vary in degree of reliability and qualifications; difficult patients (refusing amputation; rejecting therapy; families continuously present and tricky to deal with; threats made to nursing staff). An orthopedic surgery program, however, relies heavily on the quality of post-op care.
From the moment MSF begins doing orthopedic surgery, it becomes difficult to refuse the emergency cases that arrive. During the summer of 91, 20 to 30 bullet-wound cases arrive each day at the same hospital (Medina). Are two programs that conflict with each other in real time compatible for the same team in circumstances like those in Somalia, where the likelihood of clashes and thus emergencies is high, making post-op supervision difficult?

Just as the program is launched, the medical coordinator (doctor/anesthetist) replaces the mission coordinator. He is the original creator of the project. The second author of the evaluation is a vascular surgeon. The evaluation is not re-examined by a separate coordination team in the capital. In addition, O. Lortat-Jacob will not be available to conduct a field evaluation until September 91. There is no specialist in orthopedic surgery available, therefore, to supervise the launching of the project.

2- The decision is made
This conjunction of several factors leads to failures in the process of decision-making in June 91, as the evaluation is being submitted to headquarters.

The medical coordinator, back in Mogadishu at the time, was never really debriefed on the question, and it is not clear therefore that he opposes the project;

Absence of a prior study by the medical director;

Absence of the program director at the meeting where the final decision was made;

Inadequate evaluation of the complexity of the surgery in this type of program (50% of the patients return) and of post-op (minimum hospitalization of four to five months);

The specialist in orthopedic surgery is not familiar with circumstances in Mogadishu (risks of fighting), or of the cultural atmosphere, which is particularly resistant to this type of program (rejecting therapy);

No visits to Mogadishu from either the medical technology division or the program director as the program is launched. Paris’ decision therefore rests solely on the report of the project’s authors.

3 – Implementing the program
Other factors predispose the program to collapse.

Little or no monitoring as the program proceeds. The program soon begins to operate in a closed circuit (the Diprivan “affair” is symptomatic). Little monitoring of consequences of the operations: the surgery practiced is more sophisticated than foreseen (elbows re-broken to reduce angles), aggressive (applying high-dose fixatives) and not always well done (huge problems with respect to competence). The consumption of supplies and equipment for surgery and post-op becomes ever more important in conditions where re-supply is difficult.

Very large disparity between the traditional treatments practiced up to now; MSF’s orthopedic surgery program has become a veritable “tech-bubble” in the Somali context (bone grafts, arthrodesis...). The protocols are too sophisticated. The gap is poorly accepted by the local surgeons and also by the patients themselves, who remove the fixatives and, in some cases, go back to traditional medicine.

In August 91 the program director comes to Somalia for an evaluation in Kismayu. He/She stops for just a few hours in Mogadishu and visits Benadir Hospital, but has no time to conduct an evaluation (this wasn’t the purpose of the visit to Somalia). Hardly
mentions the program upon returning and asks Lortat-Jacob to get there sooner. But the near-silence of the program director is interpreted as support for the program on his/her part. Similarly, it is hard for non-experts to conduct a reliable evaluation of such a sophisticated program. “To the eye of a non-expert it was a smoothly-functioning program”. Everyone knows that Lortat-Jacob is on his way, and leaves it up to his evaluation.

In reality the period covering July-August 91 was a time when communications were poor between Paris and Nairobi and between the field and logistics, which does nothing but follow orders. A certain remoteness sets in between the medical technology division and the coordinator. Paris is nevertheless somewhat troubled by bad news coming from the field. But they wait for Lortat-Jacob.

Lortat-Jacob was unavailable when the program was launched and only conducted an evaluation in September 91. He outlines highly negative conclusions with respect to the program and its evolution. He stresses the gap between the original evaluation on paper and the reality: complexity of treatments; numerous superinfections; impossibility of sending patients with fixatives back home; very long hospitalization, and, especially, inadequate results after the fixative is applied (excision, reconstruction, lack of adequately qualified personnel); protocols that are too sophisticated. He also mentions the incomprehension and resistance of the patients.

The program is interrupted when fighting breaks out anew (clashes in September, then war in September). Nevertheless, despite the complexity of post-op care, the patients already operated on will continue in MSF’s care until the end of their treatment.

4 – A few figures
The absence of any systematic gathering of reliable data makes it possible to present only a very incomplete picture of the surgical program in Mogadishu.

| Chart |

Orthopedic surgery: Between July 27 and October 10 91
163 interventions (26% of patients have two operations)
117 patients operated on (51% within 0 and 10 days after being wounded)
54% of patients require treatment for longer than 5 months
82 external fixatives

CONCLUSION:
The fact that serious needs were identified at a time when MSF was already on-site and its programs were easing up encouraged the rapid launching of a program whose costs (in every sense of the word) were poorly evaluated. To what extent does the failure of this program indicate the limits of MSF’s aggressive approach to intervention in a context such as Somalia?
MSF’S RESPONSE TO THE FAMINE

The facts:
- December 91, rumors of famine south of Mogadishu
- Security constraints amidst civil war; internal difficulties on the team; complexity of surgical programs and delivering medical supplies. The MSF team (reduced to the minimum number) then-present in Mogadishu does not leave the city until February 92
- February 22 92: first exploratory mission to Merca-Qorioley conducted by MSF Belgium along with MSF France’s coordinator (report not released). March 3: a second exploratory mission conducted by the new coordinator: the famine is very severe and there is an immediate need for action on a large scale.
- April 18-29 92: Nutrition and sanitation study conducted by Epicentre in Merca-Qorioley (results released May 9).

Over five months have already gone by since the first rumors
- June 92: food aid is released; ICRC oversees free food distribution in Merca.
- July 92: first MSF nutritional feeding centers open in Merca (followed by another in Brava in August).
- September 92: centers open in Hoddur-Wadjit.
- October: center opens in Kansardere.

Problems encountered:
- Complexity of surgical program.
- Security problems virtually shut down travel in Mogadishu until January.
- Tensions inside the team and between the team and the guards.
- Headquarters is focused on problems in Mogadishu cited above; difficult to circumvent these and conduct an exploratory mission—also to resolve war-surgery issues and embark on a nutrition program. Dependence vis-à-vis ICRC’s free food distribution.
- Recruitment is difficult.
- Absence of “management” continuity in the Somalia mission: transition between program directors and simultaneous opening of then Kenya mission.

Discussion points:
- To what extent would a more timely resolution of MSF’s internal problems have allowed it to respond more quickly to the famine?
- How would MSF have responded if the ICRC’s free food distribution had begun later than it did?
INTRODUCTION:
Beginning in December 1991, rumors appeared of famine in the vicinity of Mogadishu. They were confirmed by an ICRC nurse present in the Merca region. Operations in Paris asked the coordination team in Mogadishu to conduct an exploratory mission to evaluate the situation. In the end it wasn’t until the arrival, in due form, of Epicentre’s nutritional survey in April 92 that MSF began to issue communications on a massive scale about the famine that had gripped the Merca region for several months, and launch a supplementary nutrition program.

The first nutritional centers opened in June 92—two months after the survey results. A total of six months passed, therefore, between the time MSF was alerted of a possible famine and the time it began to act. The task, then, is to explore what factors contributed to the delay in detecting the famine and justified the delay in implementing the nutrition program.

1 – DELAYED DETECTION OF THE FAMINE

1.1 – Demands of the surgical program
The rumors of famine reached MSF at a time when it was caught in the middle of the battle between the Abgal and the Hebir Gedir in Mogadishu. The rumors were confirmed when wounded people with malnutrition began to arrive at the hospital. The surgery was highly intensive (1,500 interventions between the start of the conflict in mid-November and the end of January 92). The program was highly demanding and post-op supervision presented numerous problems such as the distribution of medicines in Mogadishu and the continuing obligations of the orthopedic program, which was interrupted when the fighting started (roughly a hundred patients had already been operated on at Benadir Hospital). Security problems were especially acute in the city, and inside the hospital as well. The ICRC reduced its team and then temporarily suspended its activities due to the intensity of the fighting. The MSF team, which had to stay as small as possible, was flooded with work (reduced team since January 8, no medical coordination team. From Mogadishu, therefore, it was difficult for the coordinator to envisage undertaking another program.

1.2 – Security issues
In December 91 fighting intensified and spread across the entire south and west of the country. Security concerns allowed of no margin for travel. It was only beginning in January 92 that a certain calm emerged, and security conditions would allow a potential exploratory mission. Moreover, as the conflict spread most of the clans, including some that had hitherto been neutral, would become involved. In addition, leaving Mogadishu to explore the region would have required organizing an ad hoc security system and, thus, other guards, as the “neutrality” issues
encountered in Mogadishu during this same period underline. Here it should be noted, however, that one lone expatriate ICRC nurse had been in Merca since November 91.

1.3 – Internal problems on the team
From the coordinator’s point of view it was still more difficult to conduct an exploratory mission because the team was going through a difficult period in terms of management. The team was in a state of continual tension (shelling and stray bullets at the hospital; the instance of the nurse who went back and forth over the front line several times, alone, against the advice of the coordinator’s team); there was a good deal of agitation and a lack of cohesion and internal communication. It was also a critical phase with respect to managing the local personnel (blackmail by guards who had been dismissed; diverse instances of desertion; conflicts of authority). It therefore appeared difficult to leave the mission and let it run without a coordinator. Besides, the coordinator was attempting to reorganize the mission, restructure the entire staff, and change the team’s quarters.

1.4 – Lack of aggressiveness at headquarters
Paris was troubled by the insecure working conditions of the team in Mogadishu (stray bullets; weapons in the hospital; three non-MSF expatriates killed between mid-December and mid-January), not to mention the questions regarding MSF’s neutrality to which these conditions were related. These questions, along with evaluating the surgical program and the team’s internal problems, were the main subjects of a number of visits from Paris at the end of December and in mid-January, as well as various reports that as yet made no mention of the famine. As the fighting gave way to relative calm in January 92 there was fresh talk of the need for an exploratory mission. Was it possible to be more aggressive at that point and push more openly for the team to leave Mogadishu, especially from the end of January onward, when the rumors became increasingly persistent? Or even to circumvent the problems the team and the coordinator were experiencing by sending an exploratory mission directly from Paris to Mogadishu? In any case the fighting picked up in intensity again around mid-January and efforts focused on mobilizing public awareness of the country’s situation and appealing to the international community to find a political solution to the war in Somalia (plans for a campaign at the United Nations; press conference in New York).

1.5 – Surgery/Mogadishu dominate
In addition to the intensity and difficulty of the programs in Mogadishu (surgery, distribution of medicines, supplying water), there was the nature of the mission. Performing emergency surgery amidst civil war for a forgotten people (this was the period of the Gulf War)—MSF was fulfilling its mandate to the very letter. As a result there was a heavy focus within the MSF-Somalia mission on the work in Mogadishu. Both the team and headquarters were preoccupied by the programs in Mogadishu and the security of the team. The famine presented a different set of issues and was not directly affecting the city of Mogadishu, although there was already an influx of people into the capital hoping to access the food aid CARE and the ICRC were struggling to deliver.

Beginning in mid-February 92, several factors would rapidly propel the situation forward: the decision to reorganize the team (adding a medical coordinator), Mario Goethals’ trip between February 22 and March 2 (an exploratory mission in Qorioley which verified the seriousness and urgency of the situation and the need to open a mission in coordination with MSF France); the arrival of a new coordinator whom Paris pushed energetically, from the moment he/she arrived, to leave Mogadishu; the signing of a cease-fire, finally, on March 3, 1992.
2 – DELAYED IMPLEMENTATION OF THE NUTRITION PROGRAM

MSF Belgium’s exploratory mission (together with MSF France’s coordinator in Mogadishu) to Merca-Qorioley generated no mobilization in response in Mogadishu (absence of communication). A second exploratory mission was conducted April 1 and 2 in Merca, Qorioley, and Audegle by the new coordinator in Mogadishu. Everything pointed to the absolute urgency of intervening; but given the scope of the problem, the coordinator agreed there should be a supplementary mission by Epicentre to evaluate the situation with greater precision as a basis for planning an initiative. An in-depth study was conducted a few days later under difficult conditions; two weeks later it again confirmed the broad scale of the disaster. At that very time the results of an ICRC nutritional study that had been ongoing since January 20 reached MSF on April 7—the day before the Epicentre study was to be released.

The communications team acted straight away to mobilize for humanitarian aid at the international level and to push the MSF operations team to intervene immediately and on a massive scale. Two people were sent to New York and Washington to communicate with the press and conduct meetings at the United Nations and before Congress. For its part the coordination team in Mogadishu and the sanitation engineer stayed in Merca mobilizing efforts there—and losing patience with the trouble Paris was having reacting quickly. Tensions mounted until the coordinator’s week May 18-27 92, during which the mission coordinator and the operations team clashed over MSF’s inertia.

On June 6 five nutritional feeding centers opened in Merca. But the decision to keep the number of expatriates to the strictest minimum for security reasons meant the program could not be stepped up until July, and this despite the aggressive support for intervention within the communications team. Beginning in August events began to move quickly. Centers were created in Hoddur and later Wadjit in September, and Kansadere in October. To assess the respective responsibilities for the delay in treatment we would need to be able to appraise the relative impact of each of the following factors

2.1 – The absence of free food distribution
The results of the Epicentre study were clear: it is pointless to launch a supplementary nutrition program if free food distribution isn’t also taking place. The ICRC was already on the ground and was ready to lunch free food distribution, but was waiting for aid to reach Somalia’s shores. In addition, foodstuffs were highly coveted and convoys were being looted on a regular basis. They made it possible to stock a few kitchens, anyway, however difficult the process. Also, in the presence of widespread inertia the question arose: while it is waiting for other organizations, should MSF grab the baton and launch a program of free food distribution?

In July the board of directors debated the advisability of MSF’s launching free food distribution. But the sheer scale of the task prevented it from taking the plunge. It doesn’t fall within MSF’s mission or skill set—not to mention the security problems and logistical difficulties the lack of security and the severity of the famine impose. The risks of failure and accident were judged to be too high.

2.2 – Recruiting and financing
The importance of local and expatriate personnel and the specificity of the skills required, in addition to security concerns, made recruiting difficult and slow, especially at a time when the Somali famine had little media exposure and when Kenya was also recruiting heavily. Finally, it was still more difficult to give added priority to Somalia recruitment while MSF was marking
time waiting to launch the program. Increased media coverage supplied the answer to the problems of recruitment and financing—although in the latter case a first round could have been drawn from MSF’s own funds.

2.3 – Nairobi
At this same time, Nairobi was opening several missions in northern Kenya in the Somali refugee camps at the border; the Nairobi office “lost focus” on the Somali problem, which already had the benefit of seniority and Paris’ undivided attention. But, more importantly, the scale of the work involved in opening the missions in Kenya placed a considerable added burden on Nairobi’s mandate, despite the creation of a new post.

2.4 – Yalta – changes in program directors
For a few weeks the Somalia mission drifted while missions were being redistributed geographically among the program directors. After more than 14 months, Somalia was handed over to a new program director. In the absence of the new occupant of the post (just after the transfer) Somalia was placed under an interim director. The fact that emotions had already been running high inside the mission made the succession no easier. In June the mission was once more given another program director. Each change, of necessity, brought another period of transition and even readjustment. This comparative lack of continuity occurred at the same time the decision to intervene was made and, then, the opening of the program in Merca, i.e. a period that required especially sustained oversight. Moreover, during the same period—and this was a related issue—the flow of information on MSF’s activities in Somalia was poor at headquarters, between the sectors, and even within each sector.

2.5 Security /Mogadishu dominate
The question has already been raised as to the compatibility of two such different programs in the same country under the same coordination team. In addition, this focus on Mogadishu and the surgical program was probably reinforced, if only implicitly, by two factors: The MSF mandate with respect to free food distribution is far less clear than it is for war surgery. The security problems that had been encountered for over a year in the city of Mogadishu were projected onto the rest of the country. Although real security problems did exist in the field, we may nevertheless speculate whether the fear of “accidents” that lay behind Paris’ choice to keep teams reduced to the barest minimum was not exaggerated, as certain of the teams on-site would have agreed (except for Kansardere, of course).

CONCLUSION
Clearly there was significant delay in detecting the famine. But even if this deserves to be pointed out, security problems and the absence of free food distribution would probably have prevented any action, at the time. Besides, when the Epicentre mission was conducted we were still operating within “reasonable” time frames.

The foregoing account instructs us that, in hindsight, we could have brought forward by one month the openings of the first centers in Merca, when the first ships arrived and the ICRC kitchens opened. And in circumstances such as these, a month is a significant period of time. In addition, we could have counted on the fact that launching the program would have had the effect of pulling the other NGO’s along in our direction. But in order to gain this month, the problems associated with security, the succession of program directors, and recruitment would have to have been brought under control. Moreover, this would not have resolved the problem of MSF’s dependence with respect to the absence of free food distribution that the ICRC was planning.
History can’t be undone, but we might nevertheless reflect on the question of what MSF’s reaction would have been, and what it would have done, if the ships had arrived several weeks or months later. In short, what do we do next time?

2 - DELAY IN THE IMPLEMENTATION OF THE FEEDING PROGRAM

The exploratory mission of MSF Belgium to Merca-Qorioley (in coordinator with MSF France in Mogadishu) led to no mobilization on the part of Paris (lack of communication). On April 1st and 2nd the new coordinator of Mogadishu led a second exploratory mission to Merca, Qorioley, Audegle. Everything pointed to the utterly urgent need for an intervention. However, given the magnitude of the problem, and with the agreement of the coordinator, a complementary Epicentre mission was to assess the situation with greater precision in order to organize the intervention to be undertaken. A detailed survey was carried out a few days later in difficult conditions. Two weeks later, it confirmed the magnitude of the disaster. At the same time, the results of a nutritional survey conducted by the ICRC since January 20 reached MSF on April 7, the day before the start of the Epicentre survey.

The Communications Department reacted immediately with a media plan to mobilize international humanitarian aid and to induce the MSF Operations Department to intervene immediately and on a massive scale. Two people were sent to New York and Washington to communicate with the press and to conduct interviews at the United Nations and the U.S. Congress. For its part, the leadership in Mogadishu and the WATSAN engineer remaining in Merca mobilized and grew impatient with Paris’s struggle to react in a rapid manner. The tension mounted until the Coordinators Week of May 18 to 27, 1992, during which the head of mission and the Operations Department came into conflict with the MSF’s inertia.

On June 6, five feeding centers were opened in Merca. But the decision to maintain the number of expatriates at a bare minimum for security reasons only helped to accelerate the Merca program in July, in spite of the Communications Department’s intervention. Starting in August, things quickly came together. Centers were created in Hoddur, then in Wadjit in September, and then Kansardere in October. In order to assign respective responsibilities for the delay in taking care of the situation, the relative weight of each of the following factors should be measured.

2.1 - The absence of general distribution

The Epicentre survey results were clear: it was futile to embark on a supplemental feeding program when there was no general distribution being provided. The ICRC was already prepared to launch the general distribution, but it expected that assistance would reach the Somali coast. Moreover, foodstuffs were highly coveted and convoys were regularly looted. However, these convoys did allow a few meals to be provided, albeit with difficulty. Also, in light of the general state of inertia, the question was asked: Should MSF take over, while waiting for other agencies, and launch a general distribution program? In July, the Board of Directors debated this opportunity for MSF to launch a general distribution program. But the magnitude of the task prevented this task from being undertaken. This was neither the calling nor the competency of MSF, not to mention the problems of security and the logistical difficulties that the insecurity and the seriousness of the famine were causing. The risks of failure and accident were considered too great.

2.2 - Recruitment and financing
The importance of local and expatriate staff and the specific skills required, as well as the security issues, all made recruitment difficult and slow, particularly at a time when the Somali famine was not being publicized and when Kenya was also conducting a significant recruiting drive. Finally, it was all the more difficult to give greater priority to recruitment in Somalia when the program’s launch was being significantly delayed due to foot-dragging. Getting the famine in the news is what would solve the problems of recruitment and funding, even if – in the case of the latter – the first step could doubtless be taken on the basis of existing funds.

2.3 - Nairobi

At the same time, Nairobi was managing the opening of several missions in northern Kenya among the Somali refugee camps at the border. The Nairobi office was "shifting attention away" from the Somali problem, which was already benefiting from its seniority and sustained attention from Paris. But most importantly, the amount of work necessary to open the Kenyan missions significantly encumbered Nairobi’s mandate. This occurred in spite of the creation of a new position.

2.4 - Yalta: changes in program managers

For a few weeks, the Somalia mission would suffer from floating around during the geographical redistribution of missions among program managers. After more than 14 months, Somalia was entrusted to a new manager. During the absence of this manager (just after the transfer), Somalia was placed under interim management. Furthermore, this mission was already one of significant influence, which did not exactly facilitate succession.

In June, the mission was once again assigned a third program manager. However, every change necessarily corresponded to a period of adaptation – even readjustment. And this lack of continuity coincided in time with the decision to intervene, then with the opening of the Merca program, that is, a period that required particularly sustained monitoring. Observed during the same period – and this is related – was a poor flow of information at headquarters regarding the MSF’s work in Somalia, between departments and even within each department.

2.5 - The Mogadishu security trope

The compatibility of the two such diverse programs in one single country and under the same leadership has already been questioned. Furthermore, this polarization regarding Mogadishu and the surgical program was undoubtedly accentuated, even induced, by two factors:

- MSF's mandate for a general distribution of food was much less clear than for war surgery.
- The spread of the security problems was encountered for more than a year in the city of Mogadishu throughout Somalia. Even though there were quite real security problems in the field, one might have wondered, however, whether the fear of accidents behind Paris’s decision to reduce teams to a bare minimum was in fact exaggerated, as certain teams on site might have said (except for Kansardere of course).

CONCLUSION

Clearly, there was some delay in the detection of the famine. But even if this should be stressed, security concerns and the lack of a general distribution of food would doubtless have hindered any action at the time. Furthermore, when the Epicentre mission was carried out, they were still within a "reasonable" delay.

History teaches us after the fact that the opening of the first centers in Merca could have been anticipated by a month, starting with the arrival of the first boats and the opening of the ICRC
kitchens. And in a situation of such gravity, one month is a considerable delay. Furthermore, the foot-dragging that other NGOs would engage in over the program launch could well have been anticipated. But to make up for this delay, it would have been necessary to curtail those problems related to security, the succession of program managers, and recruitment. Furthermore, even this would not have resolved the problem of MSF’s dependency vis-à-vis the lack of a general distribution that the ICRC was to have ensured.

History can not be remade, but the question can still be asked as to what would have been the reaction of MSF and its mission if the boats had only come a few weeks or months later. In sum, what would we do next time?

FEEDING PROGRAM

The facts:

- Feeding program from June 1992 to April 1993
- Average of 18 feeding centers (24 from September 1992 to February 1993)
- From June to December 1992, more than 500 children / center
- Over 35,000 children admitted from June 1992 to April 1993
- Very high proportion (30%) of severely malnourished children
- High proportion (30% to 40%) of children over 5 (including many "medical cases")
- 30% to 50% of work devoted to non-nutritional causes
- Opening of day care starting January 1993

The problems:

- Inadequate and irregular general distribution of food
  Unused MSF expatriate / number of feedings (and number of admissions) ratio
- Children poorly individually monitored because of too much work
- Discharge criteria not respected – feeding congestion
- Irregular attendance
- Low average kg/day weight gain
- Long average length of stay in the centers (3 months)
- Few nutritional surveys carried out
- Unimix ration poorly accepted

Points and discussion:

- More means for the same target?
- The same means for a more curtailed target
  For a single region, a full range of activities: general distribution, feeding centers, water supply, immunization, curative activities
VI - FEEDING PROGRAM

**INTRODUCTION:**

A few concepts to re-frame the situation in Somalia:

MSF can only start feeding program (therapeutic feeding centers) if a general distribution of food is ensured. The notion of intensive centers or supplementary feeding centers, which is aimed at children severe and moderate malnutrition, is senseless if the entire population has trouble eating regularly.

The Somali nutritional problem goes far beyond the framework of refugee camps or at-risk areas familiar to MSF: half or even 2/3 of the country's territory should be "covered".

For an idea of the magnitude of the existing general population, on average, in the sites where MSF has established missions, the following figures (estimates) are offered:

- Merca and surrounding area (Qorioley, Bulo Marer, Golweyn, Shalambot, Kurtum Warey): 190,000
- Brava - Sablale: 40,000
- Hoddur: 20,000
- Kansardere and surrounding area (Ufurow, Habel Barbar, Korunbod): 42,000

The program established by MSF was on an unprecedented scale: 26 feeding centers (October-November 1992) and more than 35,000 children admitted to the centers from June 1992 to March 1993. The lack of security forced the staff (local and expatriate) to stop all activities daily at 5:00 PM; the operation of the intensive feeding center was prohibited 24 hours a day.

The system of general food distribution was irregular, chaotic, and poorly coordinated. In Hoddur, for example, the ICRC opened 5 "kitchens" with the distribution of 2 meals per day – representing 2,100 kcal/day. In January 1993, the number of beneficiaries was 2,300 (12% of the population), while theoretically these were intended for 7,500 people. CONCERN distributed dry rations to about 2/3 of the population, but these rations were inadequate (250 g/person/day instead of the theoretical 500 g). In addition to the cooked rations, MSF provided around 170 grams of dry rations/person/day. Because of this, there was involuntary competition, and families were forced to choose one system or the other. The distribution schedules and admissions criteria made it difficult to maintain synergy between the systems. Half the population used a single system, 40% two systems, and 10% used 3 systems to cover their needs.

**Some figures / indicators:**

- The admission and discharge criteria were not those that MSF practiced in general; in December 1992, in Hoddur, approximately 1/3 of children were under 5 years of age; in February 1993, in Merca/Brava, 73% of children under care were no longer malnourished (W/H > 80%).

- From June to December 1992, there was an average of 525 children present per feeding center (ranging from 435 to 600); this was significantly higher than the 150 to 300 children to whom MSF was accustomed.

- Among the children present in the feedings centers, the percentage of severely malnourished
was approximately 1/3; again, well above the usual 5-10%.

- In January 1993, The MSF expatriate/local staff ratio per feeding center in Hoddur is 1:105 (MSF standards 1:30).

1 - How did MSF arrive at such a bastardized program?

By "bastardized", we mean that the feeding program that was established—at least for most of the time—did not look like what MSF was used to, meaning a program with standardized organization (supplemental feeding centers or intensive centers, for children under 5 years of age).

The answer to this question is partly found in the points discussed in the introduction. The magnitude of the nutritional disaster, associated with an inadequate or poorly-coordinated general distribution, led MSF to try to feed a maximum number of malnourished children (including those over 5 years of age). The number of malnourished children, combined with the low availability of general rations, led MSF to focus its feeding programs on only moderately malnourished children. The choice was difficult: malnourished children were of course admitted to feeding centers, even if the treatment was inadequate.

When the children recovered, they were discharged according to the usual criteria, leading to them being condemned anew since the general food distribution channels were inadequate. The high proportion of orphans augmented this phenomenon.

A significant proportion of children in the feeding centers, particularly those older than 5 years, were "medical cases" requiring treatment to fight off the most common diseases (diarrhea, measles, and respiratory infections). Due to the absence or inadequacy of curative centers (this problem will be addressed in the “Curative Activities” chapter), the feeding centers took on the significant role of a pharmacy, going far beyond the care usually provided to malnourished children and sick.

The question was raised of MSF launching a general distribution of food program, notably during a board meeting. Some were rather in favor, but the majority was against and this alternative was rejected. Just as in the past when this issue had been addressed (the famine in Ethiopia), there were numerous reasons for not going down this path: others did it (ICRC); no experience in this type of aid that used specific networks with which MSF was not familiar; a separate structure would be required since this type of procurement exceeded the capacity of MSF-Logistics. In Somalia, add to this security problems, since the delivery of food was a coveted prey.

The very high number of children per nutritional center in 1992 (average of 525) fell sharply from January to April 1993 (average of 161). This high number was at the expense of the proper functioning of the centers, with the local staff getting trained on the job, supervised by a nurse who oversaw MSF feedings—often several at a time (up to 5). The alternative of opening more centers in order to reduce their size (or to increase the coverage) was hard to contemplate given the MSF strategy of using few expatriates for security reasons.

Operating centers with no supervision could not be contemplated either, due to the variable quality of the local staff (the Kansardere experience where the team had to evacuate on a number of occasions, including once for a month).
2 - What was the impact and effectiveness of the feeding program?

Number of MSF-F feeding centers
in Somalia, June 1992 - April 1993

Total number of children recorded as admitted and discharged in all the feeding centers:
Total admissions: 35,356 (June 1992 to March 1993)

Admissions/month, feeding centers

Total discharges: 9,933 (July 1992 to April 1993)
--> only 28% were monitored from admission to discharge (9,933/35,356)

Starting from January 1993, there is an inadequate number of feedings compared to the number of children in the centers.

Ratio # of children present / # of feedings
MSF-F, Somalia, June 1992 – April 1993
Proportion of severely malnourished children per month in all the MSF feedings:
- June 1992: 32.4%
- January 1993: 19.8%

Proportion of severely malnourished children per month per mission:
-- Merca:  
  - June 1992: 32.4%
  - October 1992: 11.6%
  - February 1993: 5.8%
-- Hoddur:  
  - September 1992: 29%
  - October 1992: 36%
-- Wajit:  
  - October 1992: 26.5%

Attendance:
- Merca (Sep-Oct-Dec): 74%
- Hoddur (Oct-Dec-Fev-Mars-Apr): 58%
- Wajit (Feb 1993): 73%

Average length of stay: (standard = 30 to 45 days)
- Merca (Dec): 111 jours
- Hoddur (Feb-March-Apr): 82 jours

Average weight gain (g/kg/day) (intensive center standard = 10)
- Qorioley (Oct): 1.9
- Merca (Dec): 2.4
- Hoddur (Jan-Feb-Mars-Apr): 6.7

Development of the average cost per child (U.S. $) in nutritional centers, September 1992 - February 1993:

The increase in costs, from late January 1993, is due to a decrease in the number of children per center associated with still elevated number of centers and personal.

Coverage:
Impossible to assess because there were very few nutritional surveys. In January 1993 to Hoddur, it was estimated that 50% of severely malnourished children (MUAC < 110mm) had not been admitted to feeding centers. The coverage of moderately malnourished children was probably higher.

Mortality in the feeding centers:
calculated using the number of deaths / number of children present:

- Merca-Brava: June: 11.6%, July: 10.6%, August: 7.5%, September: 4.8%, October: 4%, November: 4.5%, January: 2.8%
Trying to answer the question of impact is a crapshoot. The indicators mentioned above (notably the rather encouraging mortality indicators in Merca and the decreasing percentages of severely malnourished children) doubtless associate a real improvement in the situation with a very high number of children dead over the course of the months, reducing the most at risk group through the same. Which of these two factors played the largest role is impossible to determine. They are at opposite ends of the spectrum but they came together to establish an improvement calculated on the basis of the situation.

The lack of nutritional surveys repeated in the same area is an important gap which, in hindsight, seems incomprehensible during the conduct of the feeding program. The only survey results which MSF had for its missions are those of Merca (April 1992) before the establishment of the mission and those of Hoddur (January 1993) 3 months after the establishment of the mission. Without excusing it, this gap can be explained by the overwhelming amount of work, the magnitude of the program, the limited number of expatriate MSF staff per team, and – of course – the insecurity (except in Hoddur and Wajit).

The attendance data cited above are the same data as contained in the monthly reports. They should be interpreted with caution since the method for calculating attendance was variable. These data were generally over-estimated because they were frequently calculated on the basis of the dry rations distributed at the end of the day, which attracted many children. For example, in February 1993, the attendance rate in Wajit is 73% but this actually corresponds with the children who came to a single meal. The rate drops to 38% if those who came to 3 daily meals are considered.

The pessimistic coverage figures cited above for Hoddur should be moderated. During a mortality survey conducted in Merca-Qorioley at the end of November 1992, 6 months after the program was established, a very small number of malnourished children were detected outside of the feeding centers, demonstrating – in plain view – that the coverage of the feeding centers was excellent.

The nutritional effectiveness of the centers themselves is mediocre if one refers to the results obtained during the analysis of the Merca and Qorioley records. This is confirmed by the average length of stay, which is about 3 times longer than the normal length of stay. This relative effectiveness can doubtless be explained in several ways: 1) the theoretical distributed ration, consisting of 3 times 100 g of cooked Unimix, in the form of porridge (3 x 450 Kcal and 10 g of protein = 1350 Kcal) combined with 200 g of Unimix in the form of dry rations (900 Kcal), was not appreciated children, 2) a part of this ration was consumed by the accompanying person or by the family (dry rations), 3) attendance, for which the above figures are only averages, was irregular, 4) the size of the centers did not allow sufficient individual surveillance of the children by a single MSF nurse.

Starting in October 1992 in Merca-Qorioley, the Unimix ration, boiled or in the form of cakes (better appreciated), is diversified to include camel milk, a banana and a traditional rice-based meal. Unfortunately, we have no data that would allow us to evaluate this diet. Similarly, in Hodddur, a biscuit (250 Kcal) was added to Unimix.

Starting is January 1993 in Hoddur and Wajit and in February in Kansardere and Merca-Brava, MSF redirected its nutritional strategy by opening a daycare care in each site. These daycare
centers, for the most severely malnourished children (<70% or <110 mm), provide 5 meals per day of enriched milk, Unimix, and hypercaloric biscuits, which make up a ration of 1400 to 1600 Kcal. A dry ration of 200 g of Unimix (900 Kcal) is then added to this ration. The accompanying person receives a meal consisting of rice, oil and beans. These centers, even though for security reasons they can not replace the intensive centers open 24/7, do get very good results: in Hoddur, where attendance from February to April 1993 was 86%, the average weight gain is 9.4 g / kg / day (average from January to April) and the average length of stay of 36 days (average from February to April).

The reasons for this success can probably be explained by:
- Better dividing up of meals.
- Better attendance.
- Smaller number of children (50 to 100), allowing closer individual supervision.

**Conclusion:**
The MSF feeding program in Somalia is unique in the history of the organization because of its magnitude and originality. Limited experience in managing feeding centers with more than 500 children (a portion of whom were older than 5 years) coupled with an environment that was hostile toward any assistance, made the task difficult.

The coordination of a feeding program, whether regional or in the capital, was disrupted by lack of time that could be spent on it. Given the Somali environment, overseeing the 12 feeding centers in Wajit, Hoddur, and Kansardere was a difficult task for one single person. Likewise, the medical leadership in Mogadishu was overwhelmed by the influx of new NGOs seeking information, the many weekly meetings, and by the management problems encountered with UNITAF and UNOSOM. Leadership in Mogadishu could not go out in the field as often as they wanted. Analysis of monthly data was delayed. It was not until February 1993 that these data would be analyzed. We then realized that “cooking” was no longer done except in the therapeutic feeding centers: of the 12,000 children present in the centers at that time, only 3,000 were still really part of the feeding programme, as it had been designed.

If the various mortality surveys conducted in Somalia are consulted, it is clear that the situation was improving by late January 1993, since the international forces had arrived 2 months ago and the general food distributions were more regular since that time. But the improvement had no doubt started before the arrival of the United Nations troops, who were able to boost this phenomenon.

It appears that opening daycare centers was a success. Could we have started this strategy earlier?

One can always wonder if the choice to open 4 missions outside of Mogadishu was the best or whether it would not have been better to focus our aid on a single region (Merca-Brava?) with more means, even if the objective of decentralization (Baïdoba for example) was a good choice.

In fact, a quantitative evaluation of such a program is nearly impossible given the available data. Evaluating coverage and impact requires fairly reliable population data, which is almost never the case. Furthermore, frequent population movements, which are associated with excess mortality, are rarely taken into account. This results in to rapid changes of the denominators, which are all too rarely updated.
MEASLES

The facts:

- Measles epidemic in all the MSF missions (especially in October-November 1992)
- Total number of recorded cases: 4,160
- Very high proportion of cases > 5 years: 67% in Hoddur and Wajit in October 1992
- Total number of measles deaths: unknown; 20 to 50% of all deaths among children under 5 years are attributable to measles (Merca, Hoddur)
- Approximately 50,000 doses of vaccine administered by MSF
- Vaccine coverage among the target population: 54% to 57% according to the mothers and 14% to 27% according to the cards (in Hoddur and Merca, respectively).
- Immunization coverage in the feeding centers: varies from 7% to 76%

Problems encountered:

- Three missions established at the same time (Hoddur, Wajit, and Kansardere)
- Immunization following the start of the epidemic
- Immunization 3 weeks after the feeding centers were established
- Lack of vaccines and cold chain equipment when the missions were established
- Very small team size, teams were already overburdened with the feeding activities
- Lack of responsiveness from the reduced leadership staff: field, Mogadishu, Paris

Items for discussion:

- Strategy of few expatriates / establishing 4 missions outside of Mogadishu
- More resources per mission or even less resources with less missions
- Operational sequence adopted: Nutrition / Water – Immunization – Curative activities
VII - MEASLES

INTRODUCTION

Immunization against measles is an emergency in situations involving IDPs / refugees according to MSF intervention strategies. The lack of continuous monthly data for each site prevents an accurate reconstruction of the history of the epidemic and the action conducted against it.

In Somalia, unlike other missions where MSF programs cover an entire population, the data collected most of the time concerned only the feeding centers, thus under-estimating the magnitude of the epidemic. The immunization companies at the beginning by MSF were targeted at feeding centers then extended to all sites and, in some cases, the surrounding villages in collaboration with other agencies (UNICEF, SCF-US, OXFAM, WHO). Nevertheless, we are trying to identify a few useful tips.

Two different scenarios:

1. In Merca-Brava: the epidemic is minimal; 733 cases were recorded from July to October 1992, which is not much given the average of 14 nutritional centers established during this period. The immunization campaign among children of 9 months to 5 years of age began on August 22, 1992. At the end of October, MSF administered 18,025 doses. Following a survey of immunization coverage conducted in November 1992 in Merca and the surrounding area (excluding Brava), the proportion of children vaccinated was 57% according to the mothers and 27% confirmed with their immunization cards. Given these results, the immunization campaign resumed in December 1992/January 1993 with 6,167 additional doses, for a total of 24,192 doses administered by MSF. In February 1993, SCF-US, OXFAM, and WHO joined MSF to continue the campaign, broadening the target population of 9 months to 12 years. A total of 37,803 doses have been administered in the Merca-Brava region since the campaign began.

We do not have the figures for immunization coverage in the feeding centers. The proportion of deaths due to measles in the feeding centers was 5% and 8% respectively among children under 5 years and over 5 years in July; in October 1992, it was respectively 20% and 23%.

2. In Hoddur, Wajit and Kansardere:

The epidemic began in early October in Hoddur and Wajit and on October 23 in Kansardere. MSF had established these missions on September 4 and 15, respectively. The Kansardere mission was established on October 3.

2.1 - the number of cases and deaths:

In Hoddur, there were 1280 cases, including 871 cases over 5 years of age (68%) in October. The number of cases in November was not known but the last case was reported on November 14. In Wajit, there were 560 cases including 361 cases over 5 years (64%) in October. 198 cases were identified in the feeding centers, including 55 deaths (CFR = 28%). From November 1st through the 21st – the date of the last case – there were 540 cases, including 18 deaths, representing a total 1,100 cases, including 73 deaths. In Kansardere, there were 170 cases from October 23 to 31, 495 cases in November, 382 in December, representing a total of 1,047 cases. The number of deaths in Kansadere is unknown.

2.2 - Immunization:
The immunization campaigns began on October 7 in Hoddur, October 10 in Wajit, and November 9 in Kansardere. In Hoddur, the target population included children from 9 months through 15 years in the feeding centers and 9 months through 5 years outside of the feeding centers (non-malnourished children). Elsewhere (Wajit, Kansardere), the target was represented by children from 9 months to 15 years. Each vaccination campaign lasted about a week. The number of doses administered by MSF was 4,794 in Hoddur, 3958 in Wajit, and 8238 in Kansardere, of which 2286 were administered by MSF and 5952 by UNICEF.

In the feeding centers, immunizations continued theoretically on a daily basis after the campaign, but not in a systematic manner and without precise criteria (e.g. – all new admissions).

In Wajit, 942 more children would be vaccinated in the feeding centers until the end of January 1993.

In total, some 18,000 doses of measles vaccine will be administered in these 3 locations and their surroundings, including 11,980 by MSF. The number of doses per age cohort is not known.

2.3 - immunization coverage:
In January 1993, a survey of immunization coverage in Hoddur among the population of children 9 months through 15 years, gave the following results: 54% of children were vaccinated according to their mothers and 14% were confirmed as being vaccinated by their immunization cards.

The proportion of children vaccinated in the feeding centers Hoddur varied from 7% to 76% (average: 43%) in October 1992 in and 64% in November. The average in Wajit was 73% in October.

2.4 – measles-related mortality;
The figures for measles deaths cited above do not mean much, to the extent that MSF was only working in the feeding centers at the time and had no surveillance system for the deaths that occurred outside the centers. By definition, dead children no longer not attend feedings; the number of deaths reported to the centers only represents a small fraction of the actual deaths. Managing the feeding of more than 500 children did not permit absent children to be individually monitored. Only when a mother had several children in a feeding center could we ask her the reason for the absence of one of them and possibly attribute the death of that child to measles.

A survey conducted by the CDC on October 1992 in Hoddur estimated that of all the deaths recorded in the feeding centers among children under 5 years, the cause of 50% of these could be attributed to measles. This figure is doubtless the most revealing in terms of assessing the devastation caused by the disease during the most severe period of the epidemic. Yet it does not permit us to form any idea of the specific mortality rate due to measles.

During the same month, the proportion of deaths in Wajit due to measles is estimated at 18% for all ages.

How could MSF teams been surprised by this epidemic in Hoddur, Wajit and Kansardere?

3 - Several factors come into play:

3.1 - Seasonality:
Under normal circumstances in Somalia, the seasonal outbreaks of measles begin instead in December. The MSF strategy was to establish feeding centers and a water supply, followed by the measles immunization and the establishment of clinics. This operational sequence was to take place over a period of 4 to 6 weeks, allowing in principle enough time to vaccinate before the onset of an epidemic. But in fact, the population clusters favored the emergence of epidemics regardless of the usual seasonality.
3.2 - **The concomitant establishment of 3 missions:**
The three missions were launched almost simultaneously over a very short period of time. A regional medical coordinating body had been established. The obvious nutritional needs led quite naturally to the establishment of the program through the establishment of the feeding centers. The facility took longer than expected (10 days on average): site selection, choice of armed guards, screening and training of staff, logistics. This accumulation of tasks, in different sites, probably delayed the launch of the immunization campaign.

3.3 - **Teams size:**
In 3 sites, the immunization campaign began about 3 weeks after the feeding centers were launched. This delay was due in large part to the much reduced size of the teams. Besides the logistics/watsan personnel and the regional medical coordinator, only one single MSF nurse was present in each team in Wajit and Hoddur. Tackling the establishment of feeding centers and an immunization campaign starting from the very beginning of a mission exceeds the capacity of a single person, even when helped by the regional coordinator. Mogadishu proposed increasing the number of nurses, but this was not borne out in the field. This is due in part to Hoddur where UNICEF had promised at the outset to quickly take charge of the immunization, but that would never come to pass.

3.4 - **the scaled-down coordinating body:**
This lack of responsiveness was also the result of a scaled-down coordinating body. Locating the medical coordinating body in the region of Hoddur-Wajit-Kansardere – a good idea in itself – had the perverse effect of leading to confusion between the field and the medical coordinating body in Mogadishu regarding their responsibilities. Moreover, Mogadishu was overtaxed at the time due to the arrival of numerous NGOs and the influx of journalists. In Paris, neither the programme manager nor the medical department reacted in time.

3.5 - **Cold chain equipment:**
Was not present when the mission was launched. It was the very elevated number of cases detected that led to the launch of the campaign. A short delay was then necessary to bring the equipment to Hoddur and Wajit.

4 - **The Nutrition / Water - Vaccination - Clinic operational sequence:**
This sequence was adopted when the Merca mission was established, at a time when measles was a secondary priority. Nevertheless, it was expected that immunization would begin quickly once the feeding centers were launched. In Merca, the period between the establishment of the mission (June) and the beginning of the campaign (August 22) did not have any dramatic consequences. This is due to the fact that MSF was working in 8 different sites within this region.

This same scheme was likewise applied to Hoddur and Wajit as quickly as possible, but not quickly enough. It is likely however that the epidemic had already started in Hoddur before the arrival of the team and that the month of October coincided with peak of the epidemic. The immunization, even though delayed, helped to stop the epidemic around mid-November.

**CONCLUSION**
According to available data, the measles epidemic spread over a short period of approximately 6 weeks. The number of cases and deaths reported was greatly underestimated because data collection was focused mainly on the feeding centers. Better data collection of cases, deaths and doses administered would have been desirable.
The proportion of cases over 5 years is unusual, close to 2/3, confirming that there had been low immunization coverage over the past years.

The lack of standardization among the target populations to be vaccinated demonstrates a lack of coordination. Daily and systematic immunization of all the children in the feeding centers would have allowed for better coverage.

Ideally, in this kind of situation, the two activities, feeding and measles immunization, should take place simultaneously.

A campaign of earlier immunization could only be contemplated with more robust teams starting as soon as the missions are established or by bringing in specific reinforcements from Paris. The measles epidemic is a good example of the limitations of MSF’s strategy in Somalia consisting of "reduced number of expatriates on site for security reasons".
CURATIVE ACTIVITIES - CLINICS

The facts:

- There were no more operational medical facilities in Somalia
- The feeding centers were used for medical purposes
- In Merca, oral rehydration centers were opened
- MSF is slow to open clinics compared to how long it took to establish missions (3-month delay in Hoddur, 4-month delay in Wajit, 8-month delay in Merca)

Problems encountered:

- Limited impact from the use of the feeding centers for medical purposes (staff, medicines, target population)
- The medical use of these feeding centers causes an excess of work, is poorly controlled, and is detrimental to the feeding activity
- "Conflict" with the ICRC in Merca, wait-and-see policy in Hoddur and Wajit
- Polarization toward the feeding program
- Significantly reduced team size
- Lack of clarity regarding needs
- Lack of physicians on field missions
- Difficulty in recruiting physicians
- Lack of responsiveness from the field coordinating body, lack of availability from the Mogadishu coordinating body, and lack of clarity from headquarters

Items for discussion:

- Limitations of the strategy of "limited MSF expatriate staff for security reasons"
- Operational sequence was adopted when curative activities were the last part to be implemented (but the sequence was originally planned over a maximum of 6 weeks)
- Loss of contact with reality and lack of hindsight on the part of policymakers in a mission very absorbed with security problems and political developments (internal Somalia, the United Nations, military intervention)
INTRODUCTION
The first part of the MSF mission in Somalia was focused on war surgery, the second, starting in June 1992, was focused on the famine. As such, operational priorities were moving naturally towards the establishment of feeding centers and supplying drinking water. But given its knowledge of the vicious cycle of malnutrition/infection, it is surprising that MSF paid such belated attention to the medical care of the Somali population.

Indeed, practically all the medical facilities in the country had become almost non-operational due to destruction, lack of staff or a very limited supply of drugs. Here, we will only address the sites outside of Mogadishu where MSF intervened, without addressing the supply of drugs provided by MSF in the city of Mogadishu (north and south) and its surroundings. Providing this supply of medicines – though it was limited to a standard distribution and did not involve any curative activities by MSF – suggested a genuine desire to improve access to care. Furthermore, providing these supplies to the clinics represented a major portion of the budget.

The main diseases encountered, worsened by the precarious nutritional status, were diarrhoea and dysentery, often accompanied by dehydration, acute respiratory infections, malaria, skin infections and conjunctivitis, as well as measles during the epidemic period.

A few points of reference:
- In Merca-Brava, MSF opened 3 oral rehydration centers in October 1992 (the mission was established in June 1992 – delay of 4 months), 8 will be opened in December 1992.
- In Qorioley (district of Merca), MSF opened a clinic with a dozen hospital beds in March 1993 (delay = 9 months).
- In Hoddur, MSF opened a clinic on 11/25/1992 (mission was established there in early September – delay = 3 months) and a hospital section at the end of January 1993.
- In Wajit, MSF opened a clinic on the 12/31/1992 (the mission there was established in September – delay = 4 months).

Why were the clinics not opened earlier?

1 - The “medicalized” feeding centers:
Around month after the opening of the feeding centers, the various MSF missions (Merca, Hoddur, Wajit) converted the feeding centers for medical use (plus systematic Vitamin A prophylaxis and mebendazole). This was a response to the obvious needs of malnourished children admitted carrying related diseases. But this medicalization was limited by several factors:
- The variety of available drugs was very small (<10) and intended to treat, along with few resources, diarrhoea and dysentery, malaria, respiratory infections, and conjunctivitis.
- Local staff working in the feeding centers was poorly trained; the MSF nurse did not have enough time to properly supervise this job. In addition, treatments were poorly-monitored.
- The target population was limited to children attending the feeding centers.

This medicalization, though limited, was not negligible. It was largely responsible, one to two months after the opening of feeding centers, for the high proportion of children who were no longer malnourished, but who continued to attend the feeding centers. This side effect was to result in overloading the feeding centers with an additional activity to the detriment of the individual monitoring of malnourished children.
2 - The opening of oral rehydration centers, the case of Merca:
This started in October 1992 in Qorioley (Merca district) and was extended to other sites in the region in November and December. The relative inefficiency of the treatment of diarrhoea in the feeding centers was noted, which led to this decision.

- The "conflict" with the ICRC:
Starting in September 1992, the issue of whether to engage in curative activities, including running clinics, was raised. But in the region of Merca, it was emphatically the ICRC who held the task of running clinics: since November 1991, an ICRC nurse had been distributing monthly medications to a dozen clinics, whose staff had been recruited by the Somali Red Crescent. This activity was rather symbolic, as the ICRC itself recognized, insofar as: staff was considerably unqualified (sometimes without any previous experience), did not undergo any retraining, was unsupervised, and the diagnoses and prescriptions were comical; the clinics were only open a few hours a day.

MSF therefore proposed to the ICRC on a number of occasions that MSF take charge of these clinics (or some of them), including actual supervision, beginning in May 1992. Locally and in Mogadishu, the ICRC's response was quite favorable. However, the ICRC office in Nairobi always refused this proposal, but at the same time failed to improve this facet of their services. And so MSF found itself in a delicate position, not daring to open any dispensaries similar to those of the ICRC, with whom relations had always been good.

Given the lack of curative care, MSF created plans in November 1992 for a project to rehabilitate at least the hospital in Qorioley (around fifteen beds), which was to begin in January 1993 and would open in March with the arrival of a MSF physician. So that only priority patients would be hospitalized, a clinic was to open at the same time in front of the hospital. This activity – integrating not only hospitalization but also outpatient services – would confirm that needs were indeed very real in March and April.

3 - The wait-and-see approach in Hoddur and Wajit:
This involved several factors:
- Polarization regarding the feeding programme, which was the priority and to which everyone’s energy was being devoted.
- The much reduced size of MSF teams, with one nurse per team (until December 1992), who could not possibly be in two places at one time.
- The lack of clarity regarding needs, which should have led to earlier requests to strengthen the team (but the coordinating bodies in Mogadishu and Paris were reluctant for security reasons).
- The delay in the adopted operational sequence: nutrition and water and subsequently immunization followed by the clinic, scheduled to be implemented in about 6 weeks, but which was ended up being carried out over 3 months (see the measles chapter).

4 - The lack of MSF doctors in field missions:
In addition to the regional coordinating body, in charge of overseeing the Hoddur, Wajit, Kansardere missions as well as a physician, who arrived late in Merca (January 1993), the health activities of the field missions were managed on a day to day basis primarily by MSF nurses. Their outstanding work and their skills are not at issue, but near absence of doctors underlined the inadequately curative –and even emergency–orientation typically given to the MSF mission in Somalia (except for the surgical aspect).
From June to November 1992, one single MSF doctor was present on the ground in Somalia before the arrival of a second, who would oversee medical coordination from Mogadishu.
5 - The role of recruitment and coordination:
Before opening the mission in Merca, it was anticipated that a doctor, field coordinator would be recruited. But despite numerous attempts at the time, one was never found. Then, when the nurse coordinator did an excellent job in fulfilling this role, the idea was abandoned. In June 1992, at the very beginning of the media campaign, then during the summer period, there were no applications from experienced doctor kicking around in the Paris office.

The near-exclusive priority given to nutrition by the coordinating bodies in Mogadishu and Paris, also failed to lead to the recruitment of doctors, when it is well-known that experienced nurses are more efficient in the management of feeding centers.

The lack of availability of a medical coordinator in Mogadishu from October-November 1992, who would have gone to visit the MSF missions, was probably also responsible for the delay in starting up a curative program.
Similarly, visits by the programme manager, mostly focused on Mogadishu and directed toward policy, relationship, or safety issues, did not permit a timely readjustment in a curative direction.

The medical department in Paris failed to intervene in this area in Somalia. The other visits from headquarters individuals failed to address medical problems, except for problems in the nutrition and sanitation sectors, whose roles were not directly related to curative activities.

CONCLUSION
In response to the question “why did we not open clinics earlier?”, there are a certain number of common arguments to explain the delay in the immunization against measles; other arguments are specific.

The limitations and consequences were revealed of the strategy consisting of limited the number of MSF expatriates in each team. Opinions are divided regarding whether a more permissive attitude was feasible within the context of Somalia, at least at the start of the missions. In this case, it would have led to a focus on training from the outset, in order to subsequently give more responsibilities to the local staff. Then, at a later time and with reduced teams, it would have been necessary only to ensure a supervisory role.

The medicalization of the feeding centers failed to meet the needs for curative activities. It also contributed toward hindering the management of the feeding centers by adding an additional task that was difficult to do with the limited human resources available.

The vision for MSF’s assistance to the famine in Somalia was pared down over many months to just the nutritional aspect, even though curative needs had been emphasized from the outset. Does this polarization not reflect a lack of responsiveness and clarity at the various decision-making levels involved?

In retrospect, it seems paradoxical to have devoted so much energy and funding to the surgical mission and so little to the medical mission (curative). In terms of public health, the treatment of sick individuals would doubtless have saved many more people, if the resources for this had been provided. At least the debate did not end on the word "security".
MORTALITY

The facts:

- Extreme mortality observed in Somalia, especially in 1992
- Impossible to estimate the number of deaths in Somalia
- Variable mortality among different site and among different periods of time
- Mortality affecting IDPs 2-3 times worse than residents
- Children under age 5 died 2-4 times more than the rest of the population
- The situation improved starting in January 1993, but nevertheless mortality rates remained very high compared to the "norms"
- The surveillance system for mortality established in Hoddur starting in February 1993 is the only one, along with the surveys, that provided interpretable numbers

Problems encountered:

- The surveillance system for mortality was almost impossible to implement, at least at the start of missions
- Data collected by MSF (proportion of deaths in the feeding centers) was limited to the feeding centers and highly under-estimated [true mortality]; interpreting the data was of a sensitive nature
- Retrospective mortality surveys were the only source of information available in spite of the possible biases

Items for discussion:

- In this situation, were repeated retrospectives surveys the only way to evaluate the situation and its development?
- Was it possible to implement a system like the one established in Hoddur at an earlier time and in all the missions?
IX - MORTALITY

INTRODUCTION
Mortality rate is the indicator that is the best way to assess the overall seriousness of a situation. Regular monitoring of these rates, calculated using the same methods, enables the evaluation of those trends that occur as the situation develops.

In Somalia, the mortality data collected by MSF and other agencies were not adequate to estimate the number of deaths occurring on a regional scale or even in the sites where MSF was intervening. This was due to several factors:

- the methods used vary among different site and among different periods of time;
- the absence of reliable denominators, exacerbated by population movements, makes calculating rates a very haphazard activity;
- MSF activity, focusing mainly on feeding centers, covers only a minority of the population – those admitted to these centers; The number of deaths recorded primarily includes this minority (theoretically the most vulnerable);
- deaths recorded by MSF in feeding centers are significantly under-estimated because the method used is usually passive data collection (except in Hoddur from February to April 1993).

Finally, the observed mortality can not summarize the impact of the feeding programmes alone. This general indicator includes all the factors, other than malnutrition, which serve to influence the variations in the number of deaths and their causes.

Some references: the threshold for "normalcy" of the crude mortality (all ages) in the countries of Sub-Saharan Africa is 20 to 24 deaths/1,000/year, or 0.55 to 0.65 /10,000/day. Above 1/10,000/day, the situation is regarded as very serious and above 2/10,000/day, the situation is catastrophic.

Having made these remarks, we present here the primary available data that provide–to some extent–an idea of the seriousness of the situation in Somalia during the period of MSF’s intervention.

1 - Results of surveys conducted during MSF’s intervention:
These retrospective surveys, conducted by Epicentre, use the same methodology. The results given are those regarding mortality over the previous 30 days. Only one mission (Merca) benefited from two surveys in the 6-month interval before and after the opening of the mission.

Results of surveys, crude death rates during the month preceding the survey:
  -- March 1992, Merca: 8.6 / 10,000 / day
  - November 1992, Merca: 7.3 / 10,000 / day
  - January 1993, Hoddur: 15.8 / 10,000 / day

In Merca, the moderate decrease in the rate in November 1992 (5 months after the MSF began its intervention) compared to that of March 1992 may seem surprising. It can be explained by the fact that the mortality rate certainly continued to increase between March and June (beginning of the intervention). The discrepancy between beginning of the intervention and 5 months later
would have been higher if the actual rate had been available right before the mission was established. On the other hand, one can assume that without intervention, the rate on November 1992 would have been higher. One can also imagine that populations, once they recovered, were replaced by populations in a poor general state of health.
The rate from Hoddur in January 1993 reveals a more serious situation. The assistance did not come until September 1992; the situation had more time to break down.

2 - Survey results, mortality rates by residency status and age:

Crude mortality / 10,000 / day:
- Residents; from 3.3 (Merca, March 1992) to 17.3 (Afgoi, Dec. 1992)
- IDPs; 6.3 (Afgoi, Dec. 1992) to 24 (Bardera, Dec. 1992)

Under-five mortality / 10,000 / day:
- Residents; 8.2 (Afgoi, Dec. 1992) to 49 (Bardera, Dec. 1992)
- IDPs; 23.8 (Afgoi, Dec. 1992) to 98 (Bardera, Dec. 1992)

These figures come from surveys conducted by the CDC in Atlanta and Epicentre. The methodology is comparable. A more comprehensive table summarizes the data at the end of this chapter.

These results show a wide variation from one site to another and from one period of time to another. Apart from Merca, there have been no surveys repeated over time that would permit an evaluation of the situation’s development.

On the other hand, these results show that IDPs die 2 to 3 times more than residents, and that children under 5 died 2 to 4 times more than the general population (see Table).

3. Survey results: mortality observed during periods of 4 to 12 months, expressed as a proportion of deaths in the initial population:

If one expresses, more haphazardly, the number of deaths as a fraction that disappeared from the initial population, during varying periods of recall (see table), we get the following results (dates listed are those during which surveys took place):
- Entire population:
  - Residents: 5.7% (Merca, April 1992) to 24.7% (Bardera, Dec. 1992)
  - IDPs: 11.6% (Hoddur, Jan. 1992) to 39.3% (Baïdoa, Nov. 1992)
- Population under 5:
  - Residents: 11.5% (Merca, April 1992) to 52.1% (Bardera, December 1992)
  - IDPs: 19.7% (Merca, April 1992) to 66.9% (Bardera, Dec. 1992)

This staggering proportion of deaths reflects the tragedy that took place in Somalia during this period. The same as above can be made regarding internally displaced persons and children under 5.

4 - The proportion of deaths by feeding center:

Apart from the survey results, we have at our disposal data on deaths in the MSF feeding centers. The raw numbers are not always disclosed and the results are expressed as a percentage of deaths among children in feeding centers. The denominator (children present in feeding centers) is not very clear; how it was calculated is not known. In fact, one can not count a child admitted on 1st or 25th of the month in the same way; what does one of the children who were present irregularly? What should have been counted is the number of children-days present per month. Moreover, the proportion of deaths depends on the admissions criteria, used in a variable manner in Somalia.

Monthly data were not always available. Some results are therefore averaged over several months. Moreover, data by center were never reported; therefore, presented once again are the averages from different feeding centers from the same mission.

5 - Mortality in the feeding centers: % of deaths / children present:
- Merca: June 1992: 11.6%, July: 10.6% August: 7.5% in September, 4.8% in October: 4% in November, 4.5%, Jan 1993: 2.8%
- **Hoddur**: Period from September-December: 847 deaths or 11%. In Hoddur, a survey by the CDC in the feeding centers in October 1992 gives the following results: 43 to 65 / 10,000 / day depending on the feeding center.

- **Wajit**: period from October to December: 2.7%

- **Kansardere**: October: 14 deaths or 1.1%; in November: 80 deaths, or 2.7% (period from October to December 1992: 236 deaths or 6.4%).

These figures are difficult to interpret for the reasons mentioned above. However, since the method remains consistent over time, the downward trend in mortality over the months is clear in Merca. We must temper this analysis due to the fact that as time passes and humanitarian aid improves, the most fragile children die, thereby reducing the proportion of the most vulnerable.

In Hoddur, we have two sources of data for overlapping periods. The "conversion" of the proportion of deaths (11%) to number of deaths / 10,000 / day allows the severity of the malnutrition rates in feeding centers to be fully appreciated.

Finally, as has been said in the chapter on measles, the system of recording the number of deaths in the feeding centers under-estimates reality. More children die at home than at the center and the mother does not necessarily come to declare the death of her child. What became of the children who stopped attending the feeding centers, are they dead or simply missing? It is not possible to estimate the proportion of registered children dead in the feeding centers compared with those not registered. This would have taken two different systems of mortality surveillance (passive and active).

6 - **Results of the surveillance system in Hoddur**:

It was only in Hoddur that a MSF nurse set up a daily mortality surveillance system for the whole city, from February to April 1993. This system was based on a daily tally of the number of graves. This is the only system that allows health status of the total population of the city to be evaluated. The results are as follows:

**Crude mortality rate in Hoddur, February-April 1993**: - February 1993: 2.1 / 10,000 / day; March 1993: 2.4 / 10,000 / day; April 1993: 2.0 / 10,000 / day

It is no coincidence that these are the figures - the only ones providing comprehensive information though limited in space – that were used to argue for the preparation of MSF's withdrawal from Somalia, starting on March 12, 1993 during the visit of the Director General and the Somalia program manager.

7 - **Causes of death in the feeding centers**:

The available data on the causes of death in the feeding centers are very incomplete. As an example, we cite those of Merca and Hoddur, over the course of 2 months:

<table>
<thead>
<tr>
<th></th>
<th>Diarrhoea</th>
<th>Measles</th>
<th>Acute respiratory infection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;5 years</td>
<td>&gt;5 years</td>
<td>&lt;5 years</td>
</tr>
<tr>
<td>July 1992</td>
<td>43%</td>
<td>45%</td>
<td>5%</td>
</tr>
<tr>
<td>Oct. 1992</td>
<td>31%</td>
<td>31%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoddur</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct. 1992</td>
<td>24%</td>
<td>50%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Dec. 1992</td>
<td>56%</td>
<td>0%</td>
<td>12%</td>
</tr>
</tbody>
</table>

These three diseases are responsible for 2/3 to 3/4 of all the deaths that occurred in the feeding centers during these periods.
CONCLUSIONS
Setting aside the surveys and the surveillance data from Hoddur at the end of the mission, the system for gathering the number of deaths in the feeding centers can not comprehensively evaluate the situation. Hence the importance of establishing a comprehensive system for mortality surveillance. The system established in Hoddur is related to one of the methods used by MSF in refugee camps. Perhaps, this system should have been established earlier, and extended to small communities such as Wajit. However, it would have been much more difficult to establish in larger missions such as Merca, where MSF intervened in 5 different sites, including 3 major cities (Merca, Qorioley, Brava) with many cemeteries. Finally, such a system can only be conceived with a somewhat stable population and a team that does not evacuate too often (Kansardere, Brava). The retrospective mortality surveys also have their limits. The validity of the results depends on rigorous protocol and the recall period (the longer the period, the more reliability is poor). Broadly speaking, demographers agree that such surveys underestimate the reality. Finally, all things being equal, a decline in mortality, used as an indicator of an improvement in health status, must be interpreted with caution. The extreme mortality rates observed in Somalia over a long period should not be used solely for comparison. The return to "normal" should rather refer back to the standards cited in the introduction to this chapter.
<table>
<thead>
<tr>
<th>Place/Source/Month of survey</th>
<th>Residency status/ Age group</th>
<th>Sample size</th>
<th>Recall period (in months)</th>
<th>Number of deaths</th>
<th>Deaths/10,000/day</th>
<th>% of deaths during period</th>
<th>Deaths/10,000/30 days preceding the survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merca/ Qorioley MSF/Epicentre April 1992</td>
<td>Residents</td>
<td>391</td>
<td>12</td>
<td>51</td>
<td>3.2</td>
<td>11.5</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>&lt;5</td>
<td>657</td>
<td>12</td>
<td>161</td>
<td>5.4</td>
<td>19.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All ages</td>
<td>1725</td>
<td></td>
<td>105</td>
<td>1.6</td>
<td>5.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IDPs</td>
<td>2444</td>
<td></td>
<td>392</td>
<td>3.8</td>
<td>13.8</td>
<td>2.2</td>
</tr>
<tr>
<td>Merca/MSF/Epicentre Dec. 1992</td>
<td>Total</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>404</td>
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<td>21</td>
<td>16.4</td>
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</tr>
<tr>
<td></td>
<td>All ages</td>
<td>2127</td>
<td>7.5</td>
<td>48</td>
<td>7.3</td>
<td></td>
<td>7.3</td>
</tr>
<tr>
<td>Baidoa/CDC/UNICEF Nov. 1992</td>
<td>IDPs</td>
<td>19</td>
<td></td>
<td>44</td>
<td>30</td>
<td>69.4</td>
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<tr>
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<td>&lt;5</td>
<td>147</td>
<td></td>
<td>28</td>
<td>8.00</td>
<td>16</td>
<td>8.2</td>
</tr>
<tr>
<td></td>
<td>All ages</td>
<td>212</td>
<td>8</td>
<td>137</td>
<td>16.9</td>
<td>39.3</td>
<td>23.4</td>
</tr>
<tr>
<td>Afgoi/CDC/UNICEF Dec. 1992</td>
<td>Residents</td>
<td></td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;5</td>
<td>58</td>
<td></td>
<td>63</td>
<td>3.5</td>
<td>7.6</td>
<td>3.7</td>
</tr>
<tr>
<td></td>
<td>All ages</td>
<td>767</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IDPs</td>
<td>237</td>
<td></td>
<td>31</td>
<td>5.5</td>
<td>11.6</td>
<td>6.3</td>
</tr>
<tr>
<td>Bardera/CDC/UNICEF Dec. 1992</td>
<td>Residents</td>
<td></td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;5</td>
<td>58</td>
<td></td>
<td>63</td>
<td>18.9</td>
<td>52.1</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>All ages</td>
<td>237</td>
<td></td>
<td>31</td>
<td>5.5</td>
<td>11.6</td>
<td>6.3</td>
</tr>
<tr>
<td>Hoddur/MSF/Epicentre Jan. 1993</td>
<td>IDPs</td>
<td></td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;5</td>
<td>101</td>
<td></td>
<td>204</td>
<td>24.3</td>
<td>66.9</td>
<td>97.9</td>
</tr>
<tr>
<td></td>
<td>All ages</td>
<td>1277</td>
<td></td>
<td>716</td>
<td>13.1</td>
<td>35.9</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;5</td>
<td>576</td>
<td></td>
<td>211</td>
<td>19.7</td>
<td>26.8</td>
<td>48.5</td>
</tr>
<tr>
<td></td>
<td>All ages</td>
<td>3323</td>
<td></td>
<td>434</td>
<td>8.5</td>
<td>11.6</td>
<td>16.3</td>
</tr>
</tbody>
</table>
The facts:
- The health information of NGOs in Somalia is neither standardized nor analyzed nor distributed to all aid actors
- In August 1992, MSF had the idea of a "interagency epidemiological secretariat" (SEPIA) for which planning was entrusted to Epicentre after making contact with the headquarters of the ICRC, SCF-UK, and CONCERN
- After one month in the field, the consultant provided a finding of non-feasibility for this project as conceived

Problems encountered:
- Lack of pre-feasibility study
- Varying agency reactions, divergent interests, distrust, no understanding of the project
- Lack of motivation from the agencies for such a project
- Impaired access to information, logistical problems, security, filtered information
- Lack of means; project goes well beyond the capacities of a single individual
- Lack of a single point of contact
- Potential shift of objectives, SEPIA becoming an information office
- Funding from one single agency, linking with Epicentre, who loses the required neutrality
- Management of this project by Epicentre as a "consultation" when it was really a mission

Items for discussion:
- Possibility of an inter-agency project without the NGO mandate above (UN type or Ministry of Health)?
- Possibility for Epicentre to work under the UNICEF banner, then decried by all agencies?
X - INTERAGENCY EPIDEMIOLOGY SECRETARIAT

INTRODUCTION
On August 1992, during a visit of the deputy director of operations to Mogadishu, the idea was born of a coordination body for health information between different agencies / NGOs. This idea comes from the observation that clear and precise information on the interventions of different humanitarian actors in Somalia was not available. As of April 1992, even though only 5 agencies / NGOs were intervening in Somalia (ICRC, MSF, SCF-UK, IMC, Care), mainly in Mogadishu, it was already difficult to know who did what and where. Once the Somali situation captured the media’s attention, the arrival of many other NGOs, starting in June-July 1992 and deploying outside the capital, made the aid situation even more confusing. The idea of a coordinating body for information was specified, along with the aim of collecting data to calculate indicators of coverage and impact per site and per region.

In September 1992, MSF entrusted Epicentre with this mission aimed at establishing a system for collecting and analyzing data (nutrition, mortality, morbidity, immunization). Establishing an "interagency epidemiological secretariat" required the support and participation of the majority of agencies working in central and southern Somalia. This epidemiological surveillance, with redistribution of the analyzed information to all agencies / NGOs, was ideally to benefit everyone with the goal of improved coordination and planning. Epicentre had positioned itself as a private organization, not under the direct mandate of an agency, offering its expertise to each and for the benefit of all.

After a week of preparation in Paris, one week in Nairobi, and two weeks in Somalia (including a quick survey in Baïdoa), the Epicentre consultant reported a finding of non-feasibility. When leaving Somalia, Epicentre expressed to the various stakeholders encountered a willingness to intervene in the future in the form of periodic surveys. This project would be taken over by the CDC acting as a consultant for UNICEF. Why did the "epidemiological secretariat" fail?

1- Legitimacy:
The legitimacy of the project was not at issue. Each agency / NGO was generating a very significant number of data that were usually never analyzed, used, or shared. At the weekly interagency meetings in Mogadishu, the position granted to health programs was reduced due to the lengthy debates on the political situation and security. However, the urgent need for reliable information was felt more by the agency managers (in Nairobi or Mogadishu) than by the field teams, as evidenced by the visit of the Epicentre consultant to Baïdoa.

2 - The lack of pre-feasibility study:
It was undoubtedly this crucial point that was behind the failure of the project. Despite weeks of preparation in Paris and the contacts made previously by MSF on the ground, the consultant left with his "rifle loaded with flowers" [i.e. – with excessive confidence] with the mission of implementing the project. It would have doubtless been better to treat this as exploratory mission with the objective of conducting a feasibility study. This would have led to a better understanding the magnitude of the project and the local constraints and permitted the adaption of those resources to be implemented if the project had been accepted.

But the arrival of Epicentre had already been portrayed on the ground as being operational. Epicentre then made the mistake of underestimating the magnitude of the project and of failing to propose a preliminary feasibility study. It is true that Epicentre exploratory missions are not part of the traditional MSF-Epicentre relationship.

The lack of Epicentre experience for a project of this type led to an error of judgement. The project was managed as a consultation, whereas it should have been seen as a real mission.
This "rush" can also be explained by the desire to occupy the ground before the CDC, whose arrival – according to rumor – was imminent. Indeed, shortly thereafter, the CDC agreed to a contract with UNICEF and sent four epidemiologists based in Nairobi and fifth in Mogadishu.

3 - The reactions of agencies:
The various agencies contacted, for whom the objectives of the project were summarized, displayed a variable welcome: clearly positive (MSF (B, F, H), AJCF, CDC / USAID, UNICEF), positive but with reservations, in the form of needing further clarification or time to find out the opinion of their respective headquarters (SCF, ICRC), or rather negative (Concern) arguing that it was not the role of an NGO to coordinate information with other NGOs. In addition, there was concern among some NGOs regarding the close relationship between MSF and Epicentre. In fact, Epicentre assumed the role of an additional NGO, coming to collect data and not to provide a shared service.

The reactions encountered were explainable by the fact that the interests in such a secretariat varied from one agency to another. Some saw it as an effective means for the standardization and analysis of data that they do not have the time or resources to take care of; others foresaw that surveys conducted in non-evaluated areas would lead to more wisely directing those NGOs continuing to arrive; others though that this centralization of information would lead to their own actions being evaluated and compared with others and therefore became suspicious of such a tool. These different reactions would all be verified by the consultant. Just after attending an inter-agency meeting in Mogadishu and another organized by UNICEF on nutrition, the consultant was asked to go assess the situation in Baïdoa; a decentralized interagency meeting would take place at the end of this rapid assessment. In fact, the information from Baïdoa which was arriving in the capital at that time was very incomplete, even contradictory, and did not provide a clear picture of the situation. On the ground in Baïdoa, the understanding of what exactly the epidemiological information was and what was its usefulness varied considerably depending on the stakeholder. For the most part, this understanding extended only to include their own monitoring needs, and their expectations were expressed accordingly. However, reflecting on program coverage and impact was more limited.

4 - Access to information:
Apart from the results of the survey in Baïdoa, information obtained from agencies was often filtered.

The number of meals provided (kitchen or feeding centers) by the ICRC, Care, Concern, World Vision, and Goal were theoretical figures calculated on the basis of potential beneficiaries – but rarely the actual figures (taking into account attendance). The stated number of beneficiaries was linked to donor funding and also played a part in the inter-NGO competition. A few visits by the consultant in the field confirmed the NGOs’ overestimation of their aid programmes. Other information known locally was provided but an embargo was placed upon their distribution. Thus, the ICRC, which was organizing the collection of the dead, does not want it known that an average of 200 deaths were recorded each day in the city of Baïdoa (making an approximate mortality of 30/10,000/day).

This access-to-information phenomenon and this lack of transparency could have put Epicentre out of kilter with its own ethics. The Epicentre position, defined as "interagency" for the sake of independence and credibility, translated in practice to a right of veto being given to each of these agencies regarding the dissemination of information and a gradual risk of being "caught" with each veto. Accordingly, the information risked being reduced to its lowest common denominator, and thus quite often of being void of any interest.

5 - Feasibility:
The establishment of an inter-agency health information system requires some degree of standardization of the data collected; it also requires sources to be verified (to ensure a minimum
level of reliability). In order to be useful, this system must be able to analyze and disseminate the information gathered quickly, ideally on a weekly basis. The information provided should not be a simple compilation, but should provide analyses that bring something more to each agency. At each stage of the system planned, the time spent went well beyond the capacity of a single person. Over 4 days, it was only possible for the consultant to meet 4 NGOs in Mogadishu (MSF, SCF, Concern, Swede Relief). Obtaining information from 20 to 30 agencies, many of which are outside the capital and not regularly reachable, made it difficult to establish an early warning system – essential to emergencies. Traveling from one NGO to another, inside and outside Mogadishu, also posed logistical and safety problems. The lack of a single point of contact considerably impeded the project's success. The role of an information coordinating body should have been the purview of UNICEF, which was positioning itself as the lead agency in the coordination of aid. The supra-NGO status, even if it was not recognized or poorly-received locally, gave UNICEF the potential power of a medical coordinator equivalent to that of UNHCR in refugee situation. If Epicentre had been commissioned by UNICEF, this placement might have permitted the roles to be clarified and Epicentre’s approach to be facilitated. We must recognize that in this also, Epicentre was not clear regarding the place to be adopted vis-à-vis the UN.

This project was very ambitious, and yet Epicentre did not have an sufficient international reputation among NGOs. Epicentre was treated as an additional NGO with limited resources (one single person). Moreover, before the project started, a shift in the original objectives was imminent. Requests originating from Mogadishu were proliferating in all directions. The United Nations communications representative as well as journalists came to the newly created Epicentre office to look for all kinds of information that could feed their headlines. The information distributed by journalists could have better reflected the epidemiological reality; at the time of 200 deaths/day in Baïdoa, (August-September 1992), the press was speaking about an improvement in the situation due to the arrival of food. Certain NGO representatives made their monthly report and waited for compilation of information. Others mainly emphasized surveys to be conducted with the principal aim of steering new NGOs to priority sites.

6 - **Funding:**
Initially MSF had concluded an agreement with Epicentre to fund one person for two months in order to implement this project. The principle of external funding (NGOs, UNICEF, EEC, USAID) was planned by Epicentre but on the condition that the project be independent (desired and supported by the various actors in Somalia) without assuming the title of any given donor agency. This position was not necessarily compatible with reality, since in those cases when the funding was from UNICEF or USAID alone, Epicentre would nevertheless find itself bound by a contract-type of consultation, acting as a provider of services on behalf of a donor agency. It was difficult to establish the independence of Epicentre with this type of funding that was possibly linked with the location marked on the Epicentre office in Mogadishu.

7 - **The "timing":**
This attempted project took place after the media coverage of the situation in Somalia, when dozens of NGOs were already on the ground and others continued to arrive. The lack of epidemiological information and shortcomings in their dissemination had already existed for many months, when only five agencies were present in Mogadishu. The weekly inter-NGO meetings and later the creation of a consortium were not sufficient to offset the low availability of data and their use. Without dealing with all the difficulties, it would no doubt have been more appropriate to launch this project between April and June 1992, when the number of NGOs had decreased and were mainly located in Mogadishu. If the project had taken shape at the time, it would have been easier for it to be accepted by those NGOs arriving in the future and to gradually adapt its resources while the aid was being extended.
8 - The Epicentre “departure”:
After spending two weeks in Somalia and judging the non-feasibility of the project, as had been planned, the Epicentre consultant left, in agreement with Paris, after having made a tour among the various stakeholders to explain the reasons for Epicentre’s departure.
The withdrawal came along with two proposals. According to the first, made to the various actors encountered, Epicentre would remain at their disposal to carry out surveys on a regular basis. This implied that funding would either come directly from the requesting agency or that external funding would be located.
The second proposal, made in the field, consisted of conducting an equivalent project but implemented with only 3 MSF sections in place. This idea had been welcomed by the local representatives (Somalia, Kenya) of the three sections.

9 - The fate Epicentre after its withdrawal:
The latter proposal (inter-MSF epidemiological secretariat) was judged premature by the headquarters of MSF and Epicentre in Paris. The reasoning was that it seemed difficult to hold this position after having defended the neutrality of Epicentre vis-a-vis the other agencies.
Thereafter, this option was not longer brought up since the discussions were more focussed on policy and security. At this point, the question can be asked: "Can technical programmes survive the strategic and political restrictions of an MSF mission?"
Regarding the surveys, Epicentre subsequently had the opportunity to conduct 2 surveys for MSF (Merca, November 1992 and Hoddur, January 1993) and 2 surveys for UNICEF (North-East and Somaliland in April-May 1993).

CONCLUSIONS
The analysis of this failure is important because an identical need may recur in the future. We should remember above all that this type of program is complicated, especially since there is no single supra-NGO stakeholder. It is therefore particularly important to sufficiently prepare for it, including a feasibility study in the field.
We should also remember that any inter-agency project – requiring by definition the collaboration of each agency – can only see the light of day if agencies make an actual written request. Even though the legitimacy of the project was not at issue and though the managers in the capitals (Nairobi, Mogadishu) reacted rather favorably because they understood its importance, the actors in the field were less enthusiastic. This can be attributed in particular to a certain lack of understanding, due to a lack of "maturity" vis-à-vis epidemiology, an excessive workload, and distrust regarding the use of data and regarding Epicentre, whose links with MSF were known. Thus this project was never been "an independent position, desired and supported by the actors in Somalia, without no consideration other than to collect, organize and disseminate information to all those who require it", as had been envisioned by Epicentre.
The resources needed for this type of project went well beyond what was originally foreseen. House, office, vehicle, administrator, coordinator linked to two mobile epidemiologists, and security personnel are those that could be proposed after the fact.
The issue of how to fund such a project was mentioned above. The premature termination of the mission did not permit all of its aspects to be envisaged, but it is nevertheless certain that it seems difficult to position oneself as a service provider for everyone with funding originating from a single NGO or a governmental organization.
An operational solution (?) might have been to sell the project sufficiently early to UNICEF and to accept the role of consultant and partially abandon the idea of a total independence where “no relationship can exist between the various partners and Epicentre”. But this solution could not be contemplated at the time of withdrawal, since UNICEF had already entered into a contract with the CDC in Atlanta.
This project would soon come to light under the name "Center for Public Health Surveillance in Somalia" (CPHSS). With the CDC’s approval, UNICEF would propose that Epicentre assign an
Epicentre consultant there, but this solution will not be accepted given the unfortunate past experience. Furthermore, working for UNICEF Somalia, which had such a bad reputation among NGOs, in particular MSF, did not appear to be an acceptable solution at the time. This judgement was probably premature.

From September 1992 to February 1993, the CDC sent 20 consultants, including epidemiologists. Their work was to be mainly focused on rapid surveys and the attempt to implement a standardized form for data collection. Disagreements between UNICEF and CDC would lead to the non-renewal of the contract. UNICEF would then employ an epidemiologist based in Mogadishu. In May 1993, the CPHSS was still not operational.
COMMUNICATIONS

The facts:
- 1991: MSF bears witness to the war in Mogadishu. It calls for a political solution to the conflict.
- 1992: The heads of the communications division support aggressive intervention against the famine; controversy over free food distribution
- Large-scale media campaign on the famine is launched in Spring 92; generates no major response until August 92. Massive influx of journalists confronts the coordinator’s section of the Mogadishu mission.
- Admission that humanitarian action is ineffective; calls for the international community to shoulder its responsibilities. August 92: press conference in Nairobi to oppose the intervention of the blue helmets.
- September 92: the post of regional communications manager for the Horn of Africa is established in Nairobi.
- Position taken with respect to the confusion between military and humanitarian action, but none vis à vis UNITAF’s arrival.
- No communications on MSF’s withdrawal.
- July 93: communiqué filed at the United Nations; press campaign and lobbying to denounce UNOSOM’s deviation from its mandate.

Problems encountered:
- Extensive delay in media coverage of the famine; MSF communications dependant on media images for the impact of its message.
- Growing complexity, even lack of clarity, in the message being produced. Apparent contradictions in MSF’s successive positions, and in MSF’s positions themselves (individuals; sections). Weak impact of message until the filing of the communiqué.
- Constraints imposed by the field (neutrality/security)
- Poor internal flow of information on the situation and MSF’s activities, and between the various MSF sections.
- Underlying conflicts—of priorities (and of power?)—between the operations and communications spheres over managing information.

Discussion points:
- In the management of information what should the equilibrium between MSF communications and operations be?
- In terms of communications, how can MSF’s self-questioning and internal contradictions be circumvented, while at the same time respecting debate and spontaneity at MSF?
- How should external constraints be managed (security in the field; the changing political context, media demands); should limits be placed on adaptability for the sake of greater consistency?
- What should MSF’s mandate to bear witness include: objective facts, denunciation, pressure, solutions?
XI – COMMUNICATIONS

INTRODUCTION
Somalia, a mission of far-reaching scope, was the subject of a considerable volume of external communications, of varying degrees of clarity and unequally distributed to different sectors at different stages. Several communications targets were focused on: the media, public donors, and institutions. Several messages were delivered: news of the situation, first during the war and later about the famine; statements of political position with respect to the arrival of the first UNOSOM blue helmets and, later, UNITAF; diagnostic critiques of UNOSOM II’s operations, MSF’s withdrawal; and, in the end, filing communiqués and lobbying the UN.

It would not be possible to speak of communications “policy” because these campaigns were designed according to the course of events, depending on MSF’s reaction to these events. And the very function of MSF’s communications evolved from straightforwardly bearing witness to espousing political positions. Apart from these shifts of purpose, there were sporadic communications failures in Somalia. The Somalia mission generated a good deal of ambiguity and disagreement and, accordingly, it also spotlighted ambiguities as to the specific roles communications has inside MSF, as well the role of lobbying and how it is used.

This chapter will therefore not attempt to present an in-depth or chronological account, but rather to identify the factors that help explain certain of the problems encountered in communicating about Somalia, using several examples.

1: The nature of the message
Throughout 1991 communications from Somalia reported about the war, the disastrous situation facing Mogadishu, the number of victims, and MSF’s activities there. Nevertheless, the communications sector remained cautious as to the information it was delivering to the media due to the heavy security constraints it was under at the time. The messages were objective, clear, and carried a particular legitimacy because MSF was, along with the ICRC and SOS Children, the only western organization onsite. The aim of MSF’s communications was to inform by bearing witness, and this was already a part of its customary communications framework. It even served to support one of the MSF Belgium’s most “fruitful” marketing campaigns, in the form of a documentary by Frédéric Laffont.

Given the international community’s inertia in the face of the conflict’s intractability and severity, MSF decided to become further involved, launching a wide-ranging campaign to build international awareness as to the need to find a political solution quickly. General Aidid’s deeply hostile reaction to the United Nation’s initiatives caused MSF to abandon the project so as to avoid any possible identification of MSF with the UN and thereby safeguard the teams’ security. For these same reasons the press conference MSF’s local representatives had organized in New York, to be held by the program director, based its appeal to the international community on MSF’s eyewitness accounts in Somalia.
In 1992 a study by Epicentre confirmed rumors of famine, and the content of the message changed. For a few weeks the object was to draw the attention of international opinion to the situation in the country. Then the goal was to spark widespread mobilization and appeal to other organizations to intervene. Here again, the message was clear and in keeping MSF’s mission, and thus easy to convey. After a long-delayed reaction caused, among other things, by the media’s focus on ex-Yugoslavia, the message being spread by MSF, the ICRC, and SCF was for the most part taken up and had a significant impact during the summer of 92.

Communications became far more difficult when MSF became involved in promoting solutions. For example, during the summer of 92 the nature of the message tended more towards taking a position on what measures could be set in motion to solve the Somali famine. “We must flood Somalia with food aid”. The communications sector could no longer base itself on straightforwardly bearing witness, which the media had always accepted as legitimate. It had to advocate, even if the message could still be based on MSF’s presence and efforts to cope with the nutrition crisis.

When the United Nations decided to send in the blue helmets, MSF’s communications evolved into taking a position politically. And indeed from the autumn of 92 onward, Somalia—because it represented a first or near-first in the area of humanitarian intervention—would be a special focus of political communications, for which MSF would be highly sought after. Two observations in this respect:

- although the media had always willingly picked up on MSF’s raw data for the wounded or the famine, the media impact of MSF’s political communications declined.
- This was the moment when the first internal dysfunctions arose.

2: Taking positions

Is it an issue of clarity?…of mandate?…of technique? MSF’s mandate, and the principle that its commitment to bearing witness necessarily has political import, are not being called into question here. Still, it is worth pointing out the connection between the nature of the message MSF’s delivers and its possible impact. Regardless of the fact that an MSF political position is always informed by its direct presence and its activities, and however accurate the analyses that has led it to adopt this given position may be, its successful communication or non-communication are no longer based on objective facts alone, but on their interpretation, including the subjective aspect this implies. This can have several different consequences:

Simplification: Since this is a political position being taken, MSF needs to promote and defend it. This brings with it the risk that journalists will focus only on the position itself without picking up on the explanations, or else oversimplify…

Misperceiving or diluting the message: As we have observed for ourselves, the messages concerning the confusion between military and humanitarian action, or MSF’s opposition to the intervention by the blue helmets, were themselves the subject of confusion at first. They were complex and it took time for them to resonate with the media (the end of 92—but more so in 93). How, indeed, does one explain in a simple manner why MSF is opposing the symbolic agents of peace? What public was being addressed? It was a difficult issue for the communications team, because there was no message in now, only a rationale that demanded of the public a certain amount of background. And if, in order to prevent any possible confusion or simplification, the message is set forth in a precise, in-depth manner, it then runs the risk of being diluted in the process of communication, and having less impact.
Contradictions—and being contradictory: Over the summer of 92, when free food distribution was not yet a settled issue, MSF was delivering two messages concerning what the response to the famine should entail: “Somalia must be flooded with supplies” (an appeal for humanitarian aid), and, “it is up to politicians and their governments to embrace their responsibilities, because humanitarian actors cannot curb the Somali famine on their own” (at a breakfast held for diplomats—the first of this type). Later, MSF adopted a critical position on the intervention of the blue helmets; then it expressed its general position in terms of the confusion between military and humanitarian action. How should the apparent contradiction between these messages be managed, in terms of communications? Must we refrain from communicating? This was the question being considered at headquarters and within the board of directors’ the day before UNITAF landed. Opinions were divided on the issue, although the field was pushing to oppose the intervention. In the absence of any consensus on the subject the board of directors decided that MSF would issue no communications on the landing. Internal frustrations (at headquarters and in the field) mounted and every conceivable statement appeared in the media with respect to MSF’s position. The cacophony of voices spread beyond MSF France, and differences of opinion arose not only among MSF members and between headquarters and the field, but between the different sections as well. Was it necessary to settle on one message alone and enforce it within MSF? Even with one message—to the extent that the field could be brought on board—that message would have to be consistent with those of the other MSF sections. But, as was made clear throughout the entire Somali adventure and in Bosnia as well, the different sections appear to be incapable of taking a unified position. Must we, then, go back to the objective facts, emphasizing the risks the intervention could be imposing on the teams in the field—even if we can do so only in the form of questions (What system is planned for the borders? Has the reaction of the armed guards been considered? What security exists outside of the zones covered by the military forces, etc.)—as a way of getting back to a consensus?

To sum up, communications regarding the Somali crisis was marked by the self-questioning MSF went through when confronted by an international political scene and a humanitarian mandate in transition. The primary difficulty facing the communications team as it tried to carry out its functions consisted of how to circumvent these internal differences. If it wished to release a clear message to guarantee at least some impact, it would be virtually forced to take sides. This was the state of affairs during the period of the debate over the nutrition issue.

3: The duty to bear witness
From the beginning of March on, the heads of the communications team were solid advocates for intervention (although, at the start, only an individual basis) and were pushing for MSF to launch exploratory missions; first for a large-scale nutrition program, later for free food distribution. As the weeks passed tensions mounted between members of the communications and the operations teams. On top of this conflict was the uncertainty that prevailed due to indecisiveness inside operations itself. This, along with the changes of program directors, was leading to dysfunction within; information was flowing poorly at MSF, especially between operations and communications. It was all the more difficult, as a result, to spread it to the outside.

Next, the major news campaign based on the results of Epicentre’s study was coming to a close. What should MSF be communicating now? Because in critical circumstances such as these, and insofar as MSF is on the ground, communications feels a duty to react. By saying what, however? Appeal to other organizations to act? Difficult—since the “company” seemed reluctant to intervene, itself. Appeal to the UN to intervene? There hadn’t been sufficient time for reflection to take a position on a question such as that. Launch a fundraising campaign? It is duly launched—but very soon interrupted because MSF is still not in the field.
The quality of communications is in fact highly dependent on how operations and communications work together. Yet, beginning in summer 1992, as Somalia slid into an international political crisis and the operations team hesitated, the equilibrium between the two spheres at MSF—and between headquarters and the field as well—was disrupted by internal debates about the issue and what positions MSF should adopt and maintain. In addition, for several months information had been flowing directly between communications and the field. And in theory information is power. The desire of the leaders at operations (with the administration’s agreement) to take back control over how information was being managed gradually began to manifest itself at this time. This tilt towards a lack of transparency in turn affected the quality of both internal and external communications.

4: The communications/operations/field balance
As the nature of the message changed and its conceptualization grew more and more broad, the source of the driving force behind communications shifted at MSF. For two years it had been situated somewhere between communications and the field (virtually until UNITAF landed, in December 91). Now it came more and more frequently from the operations level, directly in touch with the field, and also, in an off-and-on manner, from MSF’s policy heads (the president, the board of directors). As an illustration: the last coordinator, who was present in Somalia from January 93 until MSF’s withdrawal, would never have been in direct contact with the heads of communications in Paris. Control over how information was managed and shared was divided between the coordinator and the program director. Clearly, the prospect of withdrawal and the security constraints that this entailed provide a partial explanation of this situation.

Based on the above observations the flow of “political” information can be reconstructed to produce the following overview:

In the beginning information is possessed by the team in the field and transmitted, therefore, by its coordinator. Now, if we could get her account…the coordinator cannot be expected to be an actor in the midst of the problem and at the same time keep sufficient perspective to assess the value of the information she has—to conceptualize it before determining MSF’s position. The responsibility for managing it therefore goes to someone not in the field. But for this a thorough knowledge of the country, the circumstances, and MSF’s activities is indispensable. Because the program director is the person best informed as to the local political situation and its constraints on the teams in the field, this responsibility goes to him/her. But when the information no longer consists of objective data alone, it needs to be transformed and refined—while remaining clear—if it is to have the desired impact. Consequently this demands of the program director not only a good deal of available time but also skills of political analysis, and communications techniques.

Very well, but…at which stages should the communications team intervene in this circuit of information, beyond the editing and distribution phases that are its particular province. Coordination? Clarification? What tools does it have that might help the program director manage this information. What political communications initiatives should it have under its control? What value does it add to the process of consideration over, and the choice of, the message? What part of the coordination process does it have?

Although communications about the Somalia mission, and its glitches, helped to bring these questions to the fore, its recent developments (the announcement of another MSF withdrawal in October 93) demonstrate that the team hasn’t come up with the answers, yet.

5 – Prior consultation
As the number of actors on the ground Somalia continues to grow, so does the number of contacts ready to talk about the situation there. Somalia has gradually come to be everybody’s
business, especially after UNOSOM’s arrival on the scene in 92. With regard to communications the problem is to reconcile security constraints in the field, the duty to bear witness, the obligation to be coherent, political responsibilities, and external demands—in particular from the media. This is a fragile equilibrium, and can easily lead to poorly supervised glitches. For example, in August 92 MSF’s president, back from Mogadishu and confident of his analysis, called a press conference in Nairobi at his own initiative to come out against the arrival of the blue helmets—without first informing either communications in Paris—which felt doubly bypassed because MSF Belgium had taken the opposite position a few days earlier—or the team in Mogadishu, which dreaded the reaction of Ali Mahdi, who had pronounced himself in favor of the intervention.

But, conversely, coordination that is too heavy handed, involving conciliation and mutual consultations, compromises spontaneity and crispness of the message at the risk of diluting it or even not getting it out. The day before UNITAF landed a general conference was organized to determine MSF’s “official” position. Within the board of directors, MSF’s position (not to comment) was so vague that it was understood differently by the program director and the communications director, who released two contradictory articles. MSF’s various headquarters also went off in different directions. On the other hand, at the regional coordination meeting at Addis Ababa in the very beginning of December, the representatives of the different sections on the ground in Somalia and Kenya reached a consensus based on a reasoned document of “warning”. However, after the process of going around the table referred to above, and in light of the discrepancies among the various European headquarters—as well as from a wish to be consistent—the Paris decided not release the document, nor even to question the United Nations with respect to their mandate, strategy, and system. Yet, MSF had a legitimate right to do so, just as the other humanitarian actors did, because it had not been informed on these questions. The circumstances and individual reactions created not only confusion, but also frustration for the teams, who felt betrayed (sic) by headquarters.

To illustrate the fragility of this equilibrium, we could conclude by citing the counter-example of a decision not to comment that nearly succeeded. When at the beginning of March 93 in Nairobi the decision was made jointly among the teams in the field and the directors in Paris to withdraw from Somalia, it was also decided, as a security measure, to maintain silence concerning the withdrawal until the end of the process. There was an agreed-on commitment, however, to explain the reasons for withdrawal after the fact. Upon their return the Parisian directors explain that, on the one hand, the emergency had passed, but that MSF is hostage both to the armed guards and the UNOSOM forces. Communications sees a chance to spread this message…. Very well, but how can you say that the emergency has passed without saying that MSF is consequently withdrawing? How do you go about condemning the UN intervention when in fact it is publicly perceived to be a success? Given the difficulty (and because MSF Belgium was holding to its position), it was easy to observe silence. In fact, the information leaked out via an issue of The Mission that was released too early, which then forced the coordinator to deny the news to the other NGO’s presenting Somalia. But, in terms of the media, the embargo was observed…so completely that, even after the closing of the mission was complete, MSF’s departure was never afterwards explained to the public! At the end of the day the scrambling of public opinion provoked by the affair of the Pakistani blue helmets provided a favorable context for MSF to communicate its position. In terms of communication it was hard to be right before others were and to have legitimacy on this type of question, because the message relied so much on arguments that seemed to be of a moral nature (on the order of “You mustn’t dance in cemeteries”) not on precise, tangible, uncontestable facts. The Pakistani affair was what allowed the communiqué MSF filed with the United Nations in July 93 to resonate widely with the media.
6 - Lobbying
Complex messages of this kind at times lead MSF to choose lobbying rather than mass communications. As we have seen, it is difficult to communicate, in a simple manner, that the military-humanitarian apparatus leads to failure and that the emergency is over when, to begin with, the public is predisposed to believe the opposite and, furthermore, MSF Belgium remains in Kismayu, congratulating itself on the presence of Belgian military forces in the region. It was only in June/July, following a tough decision in Paris in mid-May 93, that MSF decided to communicate the reasons for its departure and, more broadly, its disagreement with the policies UNOSOM was pursuing. MSF did so indirectly, via the communiqué it filed with the United Nations and a large-scale campaign of communications and lobbying in July both in New York and Washington.

Lobbying is still frequently contrasted with mass communications. But it is merely stating the obvious to say that a war without a picture doesn’t exist, and that, more than ever before, the media has a decisive impact on the conduct of international politics. Consequently, in most cases, lobbying gains in effectiveness to the extent that it is bolstered by media pressure, as relayed through public opinion. Quite apart from the arguments advanced, it is this pressure that in fact pushes a contact to use the power they possess, and this pressure includes the power of lobbying. MSF can have very high media visibility at times, as the Somalia mission demonstrated again and again, which translates into impact on its political contacts. An impact that could be far more frequently utilized—that is if MSF would really make lobbying part of its mandate, and determine where and when it is within its province to express itself and exert pressure. Defining a space for humanitarian action? Solutions for crises of the type that occurred in Somalia? UNOSOM’s mandate? The answer is still not clear at MSF. Should it be content to bear witness and ask questions, or should it design solutions? Because, while there is a duty to bear witness, there is no duty whatsoever to lobby.

Is it due to this indecision as to MSF’s mandate that lobbying and communications are as opposed as they are on the organizational level at MSF? Media campaigns are in fact run by communications, while lobbying is the particular domain of the program director, MSF’s in-house “politicians”, and of their respective rolodexes...

7 – International communications
Somalia did not induce MSF international members all to sing from the same hymn book, any more than Yugoslavia did. On the contrary—as was the case at the very core of MSF France—this unusual new political environment supplied the perfect music for various sensibilities to express themselves…in a cacophony. In the most successful scenarios there was an agreement to remain silent so as to avoid the likelihood of everyone humming different tunes. What is more, in autumn 92, with a soaring number of programs and sections in the field and the ongoing political developments in Somalia, no one was in a position to take overall stock of the situation there or of the activities of the various sections. The influx of journalists into Somalia from August 92 onward overwhelmed the coordinator’s office in Mogadishu, and even impeded the opening of new nutritional centers.

In light of these circumstances the post of regional communications manager was created in September 92 to manage communications throughout the Horn of Africa. This first initiative of its kind resulted in a mixed record, however, in terms of external communications—on Somalia, in any case.

In the first place, the communications manager received only lukewarm support at the start from the Belgian, French, and Dutch teams working in Nairobi. First of all, they were overwhelmed with work. Second, the headquarters of the various MSF sections had all determined there was a
need for one, and only one, person to be in charge of gathering information from the different mission in the field, running MSF’s external communications in the region, and managing journalists. But their respective representatives in Nairobi did not place equal priority on this—perhaps they were wary because it was the first time one person would be retaining all the information...

Another difficulty that confronted the communications manager for the Horn stemmed from a lack of clarity as to where he/she was attached. Initially part of “MSF France-Belgium”, the post was occupied by a Frenchman and in theory was to be under MSF Belgium’s coordination. It was then attached to MSF Holland in January 93 because Brussels had been providing little in the way of regular supervision or specific guidance, even as MSF International was attempting to co-opt this operational post for itself. When all was said and done, Horn communications was run solely on the basis of the communications manager’s own motivation and initiative.

With respect to external communications on Somalia, in particular, the manager arrived in Nairobi at a late stage in the Somali crisis. By the time he was up to speed, the influx of journalists had begun to subside. Besides, MSF’s positions were becoming more and more political and the differences of opinion between the sections more and more pronounced (from UNITAF up to the withdrawal). The positions were not conducive to vigorous external communications efforts out of Nairobi.

Despite this, it should be pointed out that one of the more solid achievements in this division was, in fact, to re-initiate communications between the various sections on-site. In addition, it produced “The Horn”—the first regional sitrep aimed at internal and external communications, which helped somewhat to improve the flow of information.

CONCLUSION

Somalia, scene of the armed UNITAF intervention and, later, that of UNOSOM, marked the debut of government humanitarian intervention. Space for humanitarian organizations was reduced, and this generated debates and controversy at MSF. These new circumstances led to a whole series of consequences, of which the most important:

- Communications and operations grappled with the problem of managing the self-questioning and contradictions stirring within MSF, and getting out a unified message. Further, they found themselves up against a process that fragmented information on the situation and on MSF’s activities as well.

- Security constraints in the field limited MSF’s capacity to bear witness.

- As the political situation continued to evolve external demands (media) increased, pushing MSF to react, but not always leaving enough time for the reflection and consultation needed to formulate a position.

- The various MSF sections reacted in a scattered manner and were unable to manage their disagreements.

- The onrush of events influenced MSF to shift from bearing witness, based on objective facts, to condemnation based on its anticipation of political consequences.

Together, these factors generated frustrations and glitches that called into question MSF’s proper functioning and the role and legitimacy of its communications efforts. This might indicate the need to re-think how communications is organized overall. Yet, no matter how successful MSF
is in getting control over the operational management of communications, it will still be subject to the hazards of media pressure, to political developments, and to constraints in the field. Wouldn’t it be make more sense, then, to optimize the communications team’s capacity to adapt to these external factors so that, among other things, the duty to bear witness can be fulfilled while preserving the spontaneity characteristic of MSF?

PARIS-MOGADISHU-NAIROBI COORDINATION

The facts:
- **October 90:**
  - Task description outlined at Nairobi office: gathering information, making contacts, opening missions, logistical support

Winter 91:
- Coordination of Mogadishu becomes global
- Direct communication between Paris and Mogadishu becomes more and more important and frequent
- Nairobi is more involved in problems of the mission’s functioning than in political issues

Spring-Summer 92:
- Refugee camps open in Kenya
- Nairobi has become a very important logistical-administrative-transit rear base; it now has a central, systemic role in the mission, but has lost its political role

Problems encountered (beginning winter 91-92):
- Poor flow of information
- Inadequate human resources
- Lack of clarity as to distribution of tasks (logistics, management) between Paris, Nairobi and Mogadishu
- Disparity between the regional office’s original mandate and its actual functions
- Disparity between Nairobi’s logistical importance and its degree of representation in Paris

Discussion Points:
- How should the Nairobi job description—along with the respective tasks of the coordinators in Nairobi and Paris and the regional representative—be reformulated with respect to managing and coordinating the Somali mission?
- More generally, what should the regional office’s mission be?
The role of the Nairobi office evolved throughout the Somalia mission. Conducting exploratory visits, opening the mission, coordinating the mission, serving as a logistical platform: the mandate was not clear, generating frustration on all sides. However, while an in-depth evaluation of the role of the Nairobi office would be of value, it would not be specifically relevant to Somalia. For this reason only certain aspects of such an evaluation will be explored here, those that will provide a basis for reflection or discussion.

1 – The Nairobi office’s mandate

When the Nairobi office was opened 1989 it was intended to be a regional office, not a regional coordination team. Its mission was gathering information for the entire Horn of Africa, making contacts and conducting exploratory missions, and planning and facilitating the opening of missions. The initiatives launched by the regional office were to be handed off to the mission team upon their arrival.

When Thierry Durand’s job description as general representative for East Africa was outlined in October 90 the Sudan mission was already open. The regional office’s mandate had expanded. It comprised three main areas:
- making contacts;
- observation and analysis of the regional situation as well maintaining a broader perspective with regard to the field
- formulating strategies and modalities of intervention for MSF in the region

The second area emphasizes the need for initiative and adaptability on the part of the regional representative, working closely with the program director in charge of the region. The third area is logistical—acting in support of the missions. It is understood, finally, that the office can evolve in size as needs dictate, and that “With Nairobi’s role vis-à-vis missions no longer relevant once they have been set up, the classic blueprint favored at MSF re-emerges.”

Three years later the Nairobi office seemed to fit this description only partially, as can be seen in the case of the Somalia mission. This evolution can be divided into several phases.

2 – Phases of Nairobi’s role in the Somali mission’s development
The first phase goes from opening of the mission in January 91 to autumn 91. Throughout this phase the Nairobi office’s activities corresponded exactly to the task description described above: making contacts (this was how MSF was able to return to Mogadishu on the USC side in January 91—also how Osman Ato became a part of the MSF history); exploratory missions; supply and logistics; along with transit and serving as a rear base as teams rotated. In addition, the rapidly paced succession of new coordinators in Mogadishu and the difficulty of communicating between Paris and Mogadishu, as well as the steady oversight of the program director in Paris and the smooth functioning of the program director/regional representative duo all contributed to place Nairobi at the functional center of the MSF program in Mogadishu.

Later, coordinators began to be present for longer, and no doubt busier, periods of time, communications by satellite phone became easy, and the mission was better developed. Nairobi’s political role and its impact on decision making began to diminish in the winter of 91, even as its logistical role became more and more dominant during the war. Besides, the security problems the team was encountering called for immediate decisions made directly between Paris and Mogadishu without going through Nairobi. Even so, the problems encountered by the Somalia team caused Thierry Durand to intervene again and again.

The third phase got underway with the opening of the camps in Kenya, which required extensive mobilization by the Nairobi office. In addition, the Somalia mission had been open for over a year by then and was beginning to receive a great deal of help and special oversight from Paris. With the start of the nutrition program, the influx of journalists and, lastly, the arrival of UNITAF, the coordination team in Mogadishu would be in near-constant communication with Paris for program matters as well as the more political aspects of the mission. Besides, the regional representative was no longer visiting Somalia—even though the coordination team in Mogadishu sometimes felt it was kept on too short a leash by headquarters. On the other hand, with the opening of nutritional centers and refugee camps on the Kenyan border, Nairobi now constituted an enormous logistical and administrative base. Indeed, most of the financing and budget requests were being handled directly from Nairobi and all of the team in the Horn traveled through the Kenyan capital. In 1992 Nairobi supervised about 250 expatriates, 3,000 tons of cargo, and 65 [MF]. There wasn’t enough capacity to respond to orders and manage inventory, not enough sharing of information and, more generally, opposition to the regionalization of MSF: Paris did not perceive Nairobi’s true importance until later. For its own part, the Nairobi office was slow to call for more human resources.

3 – A double disparity

There was what could be called a double disparity:

- between the regional office’s original mandate and how its duties evolved, on the one hand;
- between the importance of its activities and its degree of representation (and impact on political decisions) at Paris headquarters, on the other.

Indeed, if one considers the size of the budgets and the teams being managed by Nairobi, it was tantamount to decentralization. But in terms of political decisions, it was out of the question for Paris to turn Nairobi into a regional coordination office. Moreover, Kenya, Sudan, and Somalia are overseen by different program directors in Paris.

This dual ambiguity, which itself could be the subject of another discussion entirely, partly explains the lack of human resources available to Nairobi, and the frustrations there.
The rapid development and high profile of the Somalia mission compared with the attention given the camps in Kenya during the summer of 92 led to this “malaise” with respect to Nairobi’s place within the MSF organization. On the other hand, to bring this discussion back to the Somalia mission, it would be hard to say that it suffered in any way due to this situation, except perhaps with respect to the transparency and supervision of its budgets, as described in the preceding chapter. In this area, indeed, the relative dispersal of tasks among Mogadishu, Paris, and Nairobi took some time to be brought under control, as evidenced by the difficulties the authors of this report had in reconstructing the relative impact of security in the overall mission’s budget.

But although it did not suffer from it, the question remains whether the Somalia mission couldn’t have incorporated more of the regional representative’s in-depth knowledge of the region and rounded out its evaluations with a broader perspective on the political situation and MSF’s options.

**CONCLUSION**

By way of conclusion, the observations above suggest two questions.

Shouldn’t changes in the regional situation, especially in Somalia and MSF’s programs, have led to an effort to reformulate the task description at the regional office and the respective roles of its representative, the capital coordinator in Mogadishu, and the Paris office? One would think a blueprint for distributing information would have helped to avoid some of the misunderstandings and frustration.

Finally, are the ambiguities that remain concerning Nairobi’s role an indication that the debate concerning regional coordination offices is not over?
XIII – CONCLUSION

Somalia constitutes an important step in MSF’s history.

The security constraints, the scale of the famine, the obstacles to humanitarian assistance, the use of armed guards, the involvement of the international community and, in the end, political and later military intervention to deliver aid all charted new territory for humanitarian organizations. Faced with new constraints, MSF made continual adjustments, most of the time under emergency conditions. As a result the experiment was also conducted amidst improvisation, dysfunctions, and compromises of a sort that would have been unthinkable in earlier days.

The exceptional efforts performed by MSF in Somalia were of a kind that cannot be obscured by the critical analyses to be found in this report. They were heavily constrained by time and the scale of the crisis: at headquarters and on the ground, Somalia inundated MSF with work. The human resources available to MSF were no doubt insufficient for what it aspired to do in Somalia. But was it possible, given the security problems that accompanied this mission at every turn, to go any further? Certainly, less precarious security conditions would certainly have helped reduce the delay in addressing the famine. In any event, knowing that MSF could one day be called upon to act in a comparable situation, it was important for this report to analyze and then go beyond the “constant” of security, in order to identify the other difficulties encountered in Somalia and draw lessons from the experience.

From a larger perspective Somalia also presented the following problems: how should we evaluate the excesses and the costs—the principles flouted, some believe—when we weigh in the scale of the needs, the distress into which the country was plunged, and the results of MSF’s efforts? Should the end always justify the means in the sphere of humanitarian action? To what extent do needs legitimize MSF’s forms of intervention? Conversely: MSF has defended its abstention and withdrawal while denouncing the policy of the United Nations. Still…Somalia represents a precedent and it is likely MSF will face this type of situation again. Would it still be able to go on humanitarian strike, or does it need find other ways to adapt without compromising itself?

The Somalia mission hasn’t yielded the answers yet to all of these questions, as this report frequently demonstrates. But the end of emergency conditions gives us a chance to begin a discussion that can help us to anticipate how MSF will respond the next time it is tested.
SUMMARY OF FIRST ROUND OF DISCUSSIONS
Presentation of “MSF in Somalia” Report
Friday, November 19

I – RESPONSIVENESS TO THE FAMINE

Delayed detection:
- Absence of active research or coordination for researching information, with the ICRC, in particular: from Mogadishu and Paris alike
- Ariane Curdy’s report (ICRC) is passed on belatedly
- Focus on MSF programs (SCF began distributing supplies in Mogadishu from January on)

Delayed treatment:
- MSF should not totally dismiss the idea of free food distribution in order for it to launch its programs (limited in scope)
- Recruitment: difficulties related to the many criteria demanded: background in nutrition; MSF experience; male; security.

II – SECURITY/NEUTRALITY

- This was not the first time MSF had used armed guards (Afghanistan).

- Problem of familiarity with the field (clans…) exacerbated by the lack of supervision (a different coordinator every two months between January and August 1991). Because of this the problem of MSF’s “clan branding” (Osman Ato) is not raised until later, at the time of a field visit by an individual outside of the program. This kind of outside perspective needs to be encouraged, especially given that the coordinators are already overburdened with work.

- MSF’s intervention in Somalia was carried out “no matter the cost”; we never kept count. Lack of financial transparency. No one in Mogadishu, or Nairobi, or Paris ever knew how much the mission was costing. Problem exacerbated by the distribution of tasks among Paris, Nairobi and Mogadishu (Osman Ato’s invoices sent to Nairobi, etc.).

III – COMMUNICATIONS

- To be noted, and perhaps regretted:
• Absence of coordination, summer of 92, with other organizations, especially the ICRC and SCF.
• MSF’s absence at the inter-NGO meeting before UNITAF lands (?)

-No communications effort when the message was of an anticipatory nature

-There is no such thing as a communications “system” of any particular value in itself—only a mobilization on many fronts to be performed in each case.

**IV – ORTHOPEDIC SURGERY**

-Specific programs of this type should not be condemned out of hand, because this sort of initiative also constitutes the strength of MSF.

-There is no alternative to amputation—if the loss of substance is too extensive—in a situation of war and in a septic environment. Nevertheless, debridement is required beforehand. But this is difficult under emergency conditions with a large number of wounded.

-An interesting ICRS experiment: recreating, outside of the city, an environment conducive to this type of program: 1) sanitized, and 2) screening of entries to the hospital.

-NGO’s such as Handicap International should be encouraged to intervene in cases such as these—on-site, in emergencies—to help set an example and “justify” the use of amputation in the Somalis’ eyes.

**V – NUTRITION PROGRAM**

-High-energy biscuits were used too late: the number of children per center was already decreasing.

-Lack of coordination between organizations and imbalances in distribution. Free food distribution was random: in one line Somalis received 600 calories, in another, 2,000 Kcal.

-The choice of BP4 or 5 was tied to its price and requirements established by donors, who insisted on “buy local”.

-Problem with Unimix (cooking time: 45 minutes; instant form that takes 15 minutes to cook is preferable). Belated response by WFP in this regard, with MSF Belgium as intermediary (see report).

-Fact-gathering was too detailed for MSF centers that were impossible to supervise. Nurse workload too heavy. In addition, the response to this data was late in coming.

**VI - MORTALITY**

-Priority should be given to active surveillance systems

-Interesting ICRC experiment in Baidoa (gathering the dead in an ICRC van)

-Retrospective mortality surveys are not a panacea
SUMMARY OF SECOND ROUND OF DISCUSSIONS
Presentation of “MSF in Somalia” Report
Friday, February 4, 1994

I – RESPONSE TO THE FAMINE

Delayed detection

-Actually, the rumors of localized famine went back to May/June 91; MSF made a trip near Baidoa at that time and the report, warning of “a severe nutritional food crisis”, was not acted upon. Considerable risks were run during exploratory missions.

-Until the end of 1991 the famine was localized in certain zones and in the path of the war, not generalized.

-The exclusive focus on the surgical-orthopedic program, as well as on the problems in Mogadishu, delayed realization of where the situation in Somalia was evolving and the arrival of famine. In this kind of mission it is necessary to make more use of points of view from outside the field, because it is so hard for coordinators to get a broader perspective. There is no cause for calling the emergency surgical program into question; it was necessary to act on the two fronts simultaneously: surgical and medical (nutritional and curative).

-There was a lack of coordination and communication among the headquarters of different sections (The mission in Somalia was originally European). No message as to the severity of the nutritional situation circulated in the aftermath of MSF Belgium’s exploratory mission in Merca (a month before that of MSF France).

Delayed Treatment

-In early 92, after the war in Mogadishu had stopped, why didn’t MSF launch a nutritional program in Mogadishu, since SCF and the ICRC couldn’t cover all the needs? Why didn’t the call go out to other sections—particularly the Belgian and the Dutch sections?

-This appeal did go out, again and again, in February 91; it was the subject of a great deal of discussion, but in the end the Belgian and Dutch sections responded at length that they would not intervene in Somalia if it necessitated paying armed guards. (MSF Holland, which intervened in Somaliland, had already employed armed guards).

-MSF should have launched a limited nutritional program earlier on in Mogadishu; this would have also allowed us to assess the constraints of this kind of program in such an environment.
MSF is in a sense a victim of its successes, its shortcomings, and of the steady abandonment of the humanitarian landscape over the past few years. As a result MSF finds itself on the front lines more and more, taking on every humanitarian task and alerting other institutions (NGO’s, the UN) to the seriousness of the situation. This is what occurred again in Zaire recently, and during the crisis in Burundi.

In the past few years there have been problems delivering supplies in food crisis situations (the latest examples are Zaire, Rwanda, and Tanzania). In these cases our specialized nutrition programs are ineffective and absurd in the absence of free food distribution. When is MSF going to make up its mind to finally do free food distribution?

The way supplies are delivered in crisis situations has changed in roughly the past two years. Previously, the HCR delivered the supplies right to the camps; now this is up to the WFP who, in reality, pass this responsibility on to the national Red Crosses or other operational organizations. The result is vagueness as to each organization’s specific responsibilities. In Somalia, where no operational organizations are present except for the ICRC, WFP has proposed that MSF deliver supplies to sites. MSF refuses to do so for security reasons.

MSF does not completely dismiss the idea of conducting free food distribution, in cases of famine, for the sake of the effectiveness of its nutritional programs. But this kind of intervention must be well targeted and limited in scope if it is to be feasible.

MSF did not speak out about the famine in Somalia until after it had exact figures (May 92, Epicentre study). But it is true that, without distressing images, the media won’t channel the message. The timing of communications is also very important: in order to have a real media impact, factors under no one’s control must come into alignment.

To conclude, we need to have a far broader understanding of the mechanics of crises. Better foresight will come from a perspective that combines the skills of anthropology, geography, and politics.

II – SECURITY/NEUTRALITY

Did MSF commit a sin by insufficiently analyzing clan politics? In Somalia you either need an in-depth knowledge of a complicated situation (in order to cope with the political/cultural reality there), or very little knowledge, in order be more bold. It is an elitist mentality that holds one back—not wanting to launch into action until all the variables have been brought under control. Intelligence and complexity often inhibit action. A very clear, microscopic understanding of the clans sometimes gets in the way of seeing broader, underlying currents.

Having said this, MSF’s coordinators are in fact very familiar with many aspects of Somalia, even though the lack of a broader perspective has been pointed out again and again. Unlike other organizations and MSF sections, the mission has had very little looting.

With respect to neutrality, MSF France (as well as the other sections) did not make enough play of the fact that, via the different sections (Belgians in Kismayu, the Dutch in Baidoba, the Spanish in northern Mogadishu), MSF was working with many clans.

With respect to armed guards in Somalia: in hindsight, it seems not to have been possible to intervene without hiring armed guards. Even MSF Holland, which originally took a very firm
position, accepted this imperative when they returned during the famine. It also was the first time
the ICRC flouted its own principles. The problem at MSF had more to do with a certain image
that resulted (the mad max units…). In Sri Lanka and Afghanistan, by contrast, this debate did
not occur.

-In this sort of situation, it is really the machinery of events in which one becomes entangled that
deserves looking at. Although we did not choose this constraint, we were caught up in an
uncontrollable process.

-We mustn’t be naïve. MSF has often been driven to make compromises. In Thailand we knew
that our aid was not neutral; it was greasing the palms of the Thai military forces and the Chinese
merchants. Compromise in and of itself doesn’t lead to an absence of neutrality. It happens
because compromise doesn’t always benefit the same sides.

-MSF was not entirely the hostage of armed guards. We set boundaries—limits to what we
would tolerate. At the hospital, harassment of patients was not accepted; MSF promised to
withdraw, otherwise. The principal of accessibility to all clans at the hospital was respected.

-The image of MSF working with armed guards had no major impact on the public at large. It
may, on the other hand, have had an influence on the American military intervention. It might
have been a factor in their decision to intervene.

-According to Ambassador Shahnoun, MSF’s contribution to the war economy was “infinitely
marginal”. The funds MSF paid to Osman Ato were proportionate for logistical services (renting
vehicles with guards, etc…). In reality, every NGO had its “handler”.

III – CURATIVE ACTIVITIES

-The problem in Somalia was not famine alone; six months after the nutritional program the
mortality figures were still quite elevated. In the future we must not impose an artificial
separation between nutritional interventions and medical treatment. The curative aspect of
MSF’s program in Somalia was too timid—and too slow—in coming.