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HUMANITARIAN AND DEVELOPMENT AID IN THE THIRLD WORLD  
THE SOMALIAN CASE

Introduction

As a volunteer in the refugee programme during the last three years, I found my work to be difficult and challenging, interesting and enlightening, promising and disappointing. There were many facets to the problems we had to deal with, and coping with them helped me to learn about my fellow-citizens and to understand the needs and problems of my country better.

Contrary to the pessimistic attitude some people have towards the bureaucracy, I enjoyed the full support and co-operation of the Somali authorities. I should like to take this opportunity to express my gratitude for their help which contributed to the fruitful results of my team's efforts.

The first Stage of my Efforts to Aid the Refugees in Somalia:

Seeking Sources of Humanitarian Aid

As the first wave of refugees entered Somalia at the end of 1977 from Western Somalia, known as the Ogaden region, I began my own private initiative to help solve the resulting problems. As my first step, I wrote letters to most of the large charitable organizations in Germany, requesting help and assistance for the refugees. However, all of the answers were 'negative'.

Therefore, I changed my strategy and as my second step



approached hospitals, pharmacies, and pharmaceutical companies in Germany directly. They were more responsive and this strategy was more successful in so far as I was able to collect donations of about two tons of valuable medical supplies and pharmaceuticals. Together with German friends, I transported these supplies to the Embassy of Somalia in Bonn, where we turned them over to be dispatched to Somalia.

Altogether, this work took one semester away from my studies in Germany and a considerable sum of my personal saving. In order to spend more time closer to this problem, I decided to write my thesis for my degree on Somalia and to collect the necessary data in Somalia. Back in Somalia for this research by the end of 1978, I discovered to my great disappointment that all of my previous work seemed to have been in vain - since I was unable to trace where the two tons of medical supplies actually had gone to.

At the beginning of 1979, I returned to Germany in order to prepare and present my thesis, but I also continued to work on the problems of the refugees as well. Upon the completion of my studies, I obtained a very interesting position in the marketing and project-planning section for computer software of the Siemens AG in Munich - which gave me valuable experience in the organization and management of projects. One day in my office during February 1980, I received a phone call from the sister of a fellow student. She asked whether I was still involved with the problems of the refugees in Somalia. Then she suggested that I meet with her and a German medical doctor who had worked in Cambodia for a private German organization. I drove to Aalen to meet with them that Friday. The doctor, Dr. Irmela Seraphim, gave me a brief but precise report on her activities in Cambodia, as well as

about her organization, the German Committee of Emergency Doctors. She gave me the address of the head and founder of this organization, Dr. Rupert Neudeck. She suggested that I contact him directly to see if they could provide assistance for Somalia.

I called Dr. Neudeck and we spoke for nearly four hours on the phone. He stated that he was willing to help, but that he would need more information. I could not answer all of his questions myself and I knew of no written documentation on the situation of the refugees in Somalia at that time. Therefore, I called Dr. Aden, the Attache for Culture and Information at the Somali Embassy in Bonn. Dr. Aden told me that he did not know very much about the problems himself either, but the Minister of Tourism, who happened to be visiting Berlin at the time, might be able to help. I called the Minister and requested him to come to Bonn to discuss the situation with myself, Dr. Aden, and Dr. Neudeck. He gave me some information on the phone and he agreed to meet with us in Bonn.

At the beginning of March I met with Dr. Aden and Dr. Neudeck. We then went together to meet the Minister Omar Jeas (who is now the Minister of Information). He succeeded to convince Dr. Neudeck of the seriousness of the refugee problem in Somalia.

Dr. Neudeck then invited me to a meeting at his home together with several medical doctors and nurses who had worked in Cambodia and in Vietnam for his organization. We agreed upon the urgency of the need and decided to send a small team to Somalia, in order to collect more concrete information. I called a friend, Abdulaziz Ismail, who was studying medicine in Heidelberg at that time and asked him to prepare quickly to accompany the fact-finding team to Somalia. The team that



left immediately for two weeks in Somalia of Mr. Ismail, a medical doctor, and a journalist. They came back convinced that immediate action was required in order to save the lives of many children. They also brought an official invitation and authorization for the German Committee of Emergency Doctors to provide medical services at the Dam Camp, near Hargeysa in the Northwest Region of Somalia. We organized the first operational team of doctors and nurses and collected the necessary supplies, medicaments, baby foods, etc. to start work. Since the problem of the refugees in Somalia was not known in Germany at that time, Dr. Neudeck took a personal loan of 300.000 DM in order to start the operation quickly before donations could be raised. I took all of my accumulated leave time in order to be able to go with the first team and help set up operations in Somalia. After two false starts, I was convinced that we were on the right track and would be able to provide effective assistance.

The second Stage of my Efforts to Aid the Refugees in Somalia:  
Leading the Team from the German Committee of Emergency Doctors

The first operational team travelled to Somalia in two groups in May of 1980. Dr. Neudeck, a photographer, and I flew on a French cargo airplane with our supplies. Using a Landrover that we brought with us on the plane and three trucks that we rented in Djibouti, we drove with our first set of supplies in one convoy to Hargeysa. The other group, consisting of two medical doctors and two nurses had already arrived in Hargeysa via Mogadishu. Some of this team stayed in a small hotel, some stayed in a private home, but Dr. Neudeck and I spent the first night at the Dam Camp. We started our

operations at the Dam Camp on the following day, May 13, 1980 - less than three months after my first contact with the German Committee of Emergency Doctors.

Dam Camp had been created earlier by the Somali government, in cooperation with the UNHCR. There were about 45.000 refugees at this camp when we arrived. There were a few nurses, but no medical doctors there, and the infant mortality rate was very high. We provided the first professional medical treatment at this camp - which helped to save many lives.

We were told that many children were dying every day at Tog Wajaale, due to lack of proper care and treatment. I reported the situation to the Regional Office Representative of the UNHCR, who, I presume, also reported the situation on to the UNHCR Head Office in Mogadishu.

However, the UNHCR refused to give us permission to work in the transit camp at the border post of Tog Wajaale, primarily for security reasons. Even the Somali government was reluctant to allow foreigners to go there, since this was supposed to be a very dangerous area on the border (due to hostilities nearby). Nevertheless, I drove to this camp, together with other members of our team, for our first inspection of this camp in June 1980 - less than ten days before Dr. Seraphim was scheduled to return to Germany. The conditions were so horrible at this camp that Dr. Seraphim insisted upon staying at this camp until professional medical treatment was operational there on a continued basis. She asked that a tent be brought to this camp immediately so that she could start work without any further delay. I supported her decision, despite the contrary instructions from both the UNHCR and the Somali authorities. I am sure that if this team had been headed by a foreigner, no action could have taken place,



despite the goodwill and intentions of Dr. Seraphim. Most of the refugees at Tog Wajaale, like the other camps, were women and children. From 1500 to 2500 such refugees arrived at Tog Wajaale from across the border every day - after having walked four or five days, usually without food or water. Therefore, they were nearly all on the verge of death when they arrived - skeletons which were thoroughly dehydrated and undernourished. The relatively healthy refugees stayed here an average of two or three days - to recover their strength - before being transferred to the normal permanent refugee camps that were in safer areas further from the border. Babies, small children, and nursing mothers often had to stay much longer - to recover their viability with the special supplemental foods that we were able to provide. This provision of supplemental foods and medical services by the German Committee of Emergency Doctors played a direct role in saving the lives of several thousand children. This was one of the major accomplishments of the German Committee in Somalia - converting this informal transit camp into a well-run camp - in spite of the bureaucratic obstacles that would have stopped most larger and more bureaucratic relief organizations.

As a result of the success that we had achieved at both the Dam Camp and the transit camp at Tog Wajaale, the National Refugee Commission (NRC) and the Regional Governing Office of the Somali Government asked us to organize the medical services at a new camp being created at Adhi Adays. Within five months, the population at this new camp rose to 65,000 refugees and within seven months, it was the largest refugee camp in the Northwest Region (with 80,000 refugees). From the beginning, the German Committee provided all of the

medical services and the supplementary feeding program at this camp.

The main services that were provided for these three refugee camps included:

- medical diagnosis and treatment with our own staff of medical doctors, nurses, and technicians and supply of medicine and medical equipment at the beginning;
- supplementary feeding - a basic ration of food was provided for the refugees from other sources and our contribution was in the form of supplemental foods, such as infant milk formula, special foods for nursing mothers, special foods for children and old people, and vitamins and mineral supplements;
- general support services, including drilling wells for water, laying concrete foundations for buildings, and supplying materials such as blankets, tents, etc.

An important key to our success under the difficult operating conditions was the highly effective logistical system that we developed for storing and distributing supplies.

Another important function of our team, as with other organizations who were active there, was training refugees to take over some of the medical and supply functions of running their own camps. This simple and practical training was primarily in the areas of nursing, laboratory (performing simple clinical tests), and logistics for pharmaceutical and medical supplies.

For each of the three refugee camps we built a dispensary building with rooms for storing supplies, diagnosis, treatment, and supplementary feeding and living accommodations for the staff working at the camps. These we have turned over to the local staff who run these operations now.



Our team was the first group to

- propose drilling water wells for a refugee camp;
- to acquire the necessary drilling rig and supplies;
- to actually drill wells for water successfully in the Adhi Adays Camp.

Later several of the other organizations who were active in this region also started to give contracts for drilling water wells.

In addition to the three refugee camps we also provided similar logistical support, medical services, and training at the Hargeysa Group Hospital, the Hargeysa Tuberculosis Hospital and the Hargeysa Nursing School.

At the Hargeysa Group Hospital we renovated all buildings, installed the complete water and sewage systems (which were not functioning properly), installed electricity, supplied two electrical generators, so that the hospital would be independent of the local supply of electricity, supplied 350 beds, mattresses, bedsheets, and blankets, and supplied medicaments. The size of our staff supporting the Hargeysa Group Hospital ranged from 10 to 15 personnel, but it has now been reduced to only two medical doctors, two nurses and one coordinator, since most of the duties have been taken over by the Somali staff.

At the Hargeysa Tuberculosis Hospital we renovated all buildings, installed water and sewage systems, installed electricity, provided 220 mattresses and blankets and provided a continuous supply of medicine for their patients for the first time - previously, the patients were only checked at the hospital and told which drugs they should buy on their own (but these drugs were not available continuously on the local market). We have supported this hospital for the past 18

months and our staff there is limited to only one medical doctor to strengthen the local staff.

At the Hargeysa Nursing School we built four classrooms (the previous buildings were falling down), supplied 350 chairs and 100 tables, built four dormitory rooms and four dormitory rooms for girls, improved the sewage system in both the school and the dormitories, provided blankets and free training materials, and provided part-time assistance from our staff for training in the school as well as on-the-job training under the supervision of our staff in the hospital.

The medical services and supplementary feeding programs at all three of the refugee camps have now been turned over to the local staffs. They are still considered to be models of well-organized refugee camps. The German Committee of Emergency Doctors continues to provide services and supplies as needed on a smaller scale to the three refugee camps and the three other medical institutions in Hargeysa. The total size of the local team from the German Committee varied from 10 to 30 professional personnel plus a staff of local non-professionals - depending upon the immediate tasks at hand. I served as the Team Leader from May 1980, when the first operational team arrived, until February 1983. I would not have served this long as an unpaid volunteer, without being convinced that this work was very effective in solving very urgent problems.

The third medal of honour from Somalia since independence was granted to the German Committee of Emergency Doctors for the effectiveness of their operations in Somalia during this period.

Among the larger relief organizations active in Somalia at this time, the work of the British Oxfam group should be singled out for special praise. They did an excellent job



in organizing and administering the medical services at their camp at Sabaad, 13 km east of Dam Camp. In particular, they applied technology that was appropriate to the circumstances with personnel who were both experienced and well qualified. They have also turned the medical services at their camp over to the Somali staff, but they have also maintained contact with their former camp and they provide supplies and services as needed.

The acute short-term problems of death due to starvation and lack of medical treatment have been effectively solved. However, the long-term problems of these refugees - as is the case in similar situations around the world - remain unsolved, since most of these refugees will stay in these refugee camps for many years - with only the dim hope that the original political problems will be solved so that they can return to their homelands. In the medium-term, the emphasis must shift to education and learning handicraft skills that the refugees can use in the refugee camps - in order to make life more tolerable for these unfortunate people, as well as to keep them prepared for the possibility of returning to their homelands and a normal way of life.

#### General Observations, Conclusions, and Recommendations

My three years of experience as the Team Leader for the team gave me a unique opportunity to study humanitarian aid in practice. My observations included also the methods and results achieved by other organizations who were working on the same problems of the refugees in Somalia at that time. I may have generalized some of my conclusions beyond the

basis of my actual observations, but even these tentative conclusions should also serve at least as a useful basis for discussion.

First and foremost, it is essential to include local staff in the management of any humanitarian or development aid project in the Third World. Only they are in a position to - accurately determine the true needs and desires of the recipients of such aid;

- effectively manage the selection and application of appropriate technology and methods within the local infrastructure and conditions.

Second, a strong counterpart is needed outside of the Third World country to provide logistical and management support on a very non-bureaucratic and pragmatic basis. However, as much of the management decision making as possible must be delegated to the team that is actually doing the work. As one example, experts who are successful at home do not always succeed in adapting to the operational requirement of an aid project in a Third World country. In our case, I had to place several individuals on the next airplane back home and Dr. Neudeck always supported my local decision fully, even in cases where there was dissent. We were able to define our needs locally and then the organization in Germany accepted our requests and organized supplies of exactly that which was actually needed.

Third, we have a major problem in humanitarian and development aid in that nearly half of all contributions are useless and some are even harmful for the recipients. Unneeded supplies are sent, inappropriate technology is sent, useless prestige projects are implemented, and there is a duplication of efforts among the various organizations involved. This



situation is caused by

- donors donating what they want to donate without consideration of the true needs of the recipients (such as to dispose of surpluses of their own or to create publicity for their products);
  - a lack of knowledge as to what is actually needed;
  - a lack of coordination among the different organizations.
- The only way to solve this waste of unneeded effort and lack of appropriate effort will consist of
- involving the right local intellectuals more intensively in the analysis of the local problems, the specification of the needs, and the selection of the technology and methods to be used;
  - the local government taking a more active role in coordinating the efforts of the different organizations - in order to obtain appropriate aid that meets their requirements without a duplication of effort.

Fourth, greater care is needed to keep new technology and methods from having harmful disruptive effects upon the local economic and social structures. Through a lack of knowledge and understanding for the local culture, donors too often try to change the people to adapt to their technology - rather than to adapt their technology and methods to the local culture. Although well-intended many donors often have ulterior motives behind their donations. In particular, religious donors often take advantage of the helplessness of small starving children in order to pervert their thinking away from the religious training of their parents.

Fifth, more care is needed in selecting the foreign personnel who work in aid organizations in Third World countries. Particularly the larger and more bureaucratic organizations tend

to send personnel who are

- young and enthusiastic, but have no practical experience beyond their formal training;
- older people, who are too rigid in their approach to solving problems.

The people who volunteer for work in these organizations all too often do so in order to run away from personal problems at home. These people often cause more harm than good in a Third World country, since they are unable to adapt to the new conditions surrounding them as long as they are emotionally upset themselves. The most effective personnel are those who are already successful in their professional careers at home and have a solid home to return to after their volunteer duty. A major factor in the success of the German Committee of Emergency Doctors was their ability to recruit doctors, nurses, and technicians who were professionally very successful in Germany and had normal family lives at home.

Sixth, we talk too much about using 'experts' for aid projects. In this field we jokingly define an 'expert' to be "anyone who is more than 1000 miles away from home". In practice, many of the so-called 'experts' are young people with no practical experience. They may know the theory in their field, but they have never implemented that theory, even under the much simpler conditions of their home country. In reality, we seldom need experts as specialists for humanitarian or developmental aid, but rather generalists, with a broad background of training and practical experience, together with the proven creativity to mold and integrate new solutions for the new problems that they encounter. Experts as specialists can only be used in highly structured societies



where the jobs and tasks are highly organized and structured. Since the jobs and tasks in Third World countries are almost never highly structured and specialized, there is little need for such experts here.

Seventh, I would like to mention the criticism that is often expressed about donated items showing up for sale in local shops or on the local black market. My observation is that these critics have simply not done their homework properly. This end result is normally not caused by theft, profiteering, or embezzlement, but rather by the donation of unneeded items in excess quantities. If you give a naked person ten shirts and nothing else, then you should not find it surprising or improper if he sells or trades nine of the ten shirts to obtain trousers, shoes, and food. In the case of our operations, we had no known losses of material, perhaps because

- we ordered only the items that we specifically needed (we did not have to barter locally to get other items);
- we transported all of our supplies ourselves through Djibouti to Hargeysa and we distributed them ourselves, without involving any other organization.

Eighth, I observed that many of the relief programs had difficulty in getting all of the components of a balanced diet at the same place at the same time. The result is a surplus of some food types and a shortage of other types, where the mixture changes with time. The end result is that the recipients have an unbalanced and unhealthy diet - which is not necessary. As one example, many foods were donated for use in Somalia which were canned. However, no can openers were provided and inadequate education was given to the nomads (refugees) who had never seen or heard of canned foods before.

The results were

- wastage of the contents when the cans were opened by primitive means, such as by hitting them with stones or nails;
- many were simply thrown away once the refugees discovered that they contained meat, because they were trained to eat only fresh meat and presumed that any meat that was not fresh could not be healthy and they were concerned that the meat might be pork, which is forbidden for them by their intense religious beliefs.

Ninth, outsiders do not seem to appreciate the damage that refugees cause to the land, property, and economy of the country to which they flee. In the case of Somalia and the refugees from the Ogaden region of Western Somalia there are now about 1.5 million refugees in a country with only 4.5 million citizens, giving a total population of about 6 million - a 33.3% increase in the population. It would cost several billions of US dollars to repair and compensate for all the damage that this influx has caused to the economy of Somalia. This is also a factor which limits the ability of a country such as Somalia to finance the support of refugees alone.

As merely one specific example of the damage caused to the countryside, the problem of collecting wood for cooking is interesting. When the refugees first arrived in the Northwest Region of Somalia they could collect enough firewood for cooking within less than one hour walk from their camps. Three years later, they had to walk at least one or two days to find and collect any firewood. Obviously, the complete use of all of the wood in an area exposes the ground to erosion with other indirect consequences for the productivity and usefulness of the land.

Tenth, I received the impression that there is a general



difference between large and small aid organizations. The larger organizations have access to more donations, since they are backed by their respective governments and have a large staff of highly experienced people back home, but send mostly inexperienced people into the field and are very slow and bureaucratic in responding to the local needs with inappropriate technology and methods.

The smaller organizations do not have as much funding and have very small permanent full-time staffs (if any at all) but send people to the field who are both qualified and highly motivated and respond to needs very quickly in creative ways that use appropriate technology with little bureaucracy.

Eleventh, for developmental aid it is very important to

- allow developing countries to define their own needs and goals first;
- train the local citizens to prepare themselves for the new technology and methods;
- mobilize all of the intellectuals of a country in order to do this.

No true development can take place unless the local citizens, including the local intellectuals, are fully integrated in each developmental project, so that the results can be taken over and run by the local citizens when the project is complete.

Twelfth, for both the developmental and humanitarian aid workers it is very important to

- allow the individual developing countries to select and recruit the foreign experts whom they need for various tasks, and expel without delay those who are not able to contribute any positive service to the jobs for which they

have been selected and are highly paid for;

- allow local citizens who are qualified and capable to take over posts which foreigners are occupying or intending to occupy.

The greatest mistakes that the governments of developing countries commit are

- not recognizing the work of their own intellectuals;
- not accepting the advice and proposals from their own intellectuals;
- not allowing and encouraging their own intellectuals to write feasibility studies for projects required in their respective countries;
- not giving the same facilities and salaries to their local intellectuals as they offer to foreigners;
- not letting the local intellectuals obtain access to the data and documents required for their research work;
- not tolerating the slightest criticism from their local intellectuals.

Finally, as a general conclusion and summary: There is a definite need for humanitarian and developmental aid in countries such as Somalia and there are donors who are willing to provide assistance in adequate quantities. If we can cooperate to solve the problems of

- accurately defining the true needs of the recipients first;
  - selecting appropriate technology and methods to meet these needs without disrupting the local economic and social structures;
  - coordinating the aid efforts from many different international organizations to keep them focussed upon the true needs without a duplication of effort,
- then we have a good chance for meeting the most urgent requirements in a reasonably efficient manner.