

SOMALIA

NO MERCY IN MOGADISHU

**The Human Cost of the Conflict
&
The Struggle for Relief**

Africa Watch

Physicians for Human Rights

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Introduction

"The worst humanitarian disaster in the world today," were the words used to describe Somalia by Andrew Natsios, the former director of the U.S. Office of Foreign Disaster Assistance (OFDA).¹ The International Committee of the Red Cross (ICRC), which is spending 20% of its entire worldwide budget on assistance to Somalia, has come to the same conclusion. As this report shows, these words are no exaggeration. In fact, the true dimensions of the crisis have been largely hidden, and systematic investigation reveals that the number of casualties caused by the war is substantially greater than had been feared, and that a famine unequalled in Somalia's modern history is all but inevitable. The entire country, including the north which has seceded to form Somaliland, is in desperate straits. However, Mogadishu has been the hardest hit as a result of the full-scale war raging there since mid-November. According to our estimates, 14,000 people have been killed and 27,000 people have been wounded between November 17 and February 29 in Mogadishu alone. The carnage inflicted upon the civilian population by indiscriminate use of weapons of extraordinary force and by the failure on all sides to abide by minimum standards of international humanitarian law (the laws of war) has already earned Mogadishu a special place in the annals of human cruelty.

A central tenet of humanitarian law is the duty of warring factions to distinguish between civilians and combatants. Civilians should not be used as targets or subjected to indiscriminate attacks. Special care must be taken to protect them from harm and efforts must be made to ensure that the sick and the wounded are cared for without delay or discrimination. The passage of food and medical supplies must not be impeded. This report describes in detail the near total disregard by the warring factions of the fundamental principles of the laws of war and makes it clear that the continuation of this fierce power struggle puts the entire population at peril -- not only now but for years to come.

The report is based upon findings gathered during two missions to Somalia sponsored by Africa Watch and Physicians for Human Rights (PHR), both conducted during February, 1992. The focus of both missions was Mogadishu, although a visit was also made to the refugee camps Ifo and Liboi on the Kenyan-Somali border. Hospitals were visited in both the northern and southern sectors of Mogadishu and

¹ Mr Natsios is now Assistant Administrator of Food and Humanitarian Assistance.

interviews were conducted with medical staff and representatives of several humanitarian and relief organizations, in particular the International Committee of the Red Cross, Save the Children Fund-UK (SCF), the International Medical Corps (IMC), Médecins Sans Frontières-France (MSF) and CARE.

Africa Watch and Physicians for Human Rights would like to pay a special tribute to the dedication and courage of the Somali and expatriate doctors, nurses and their administrators who remain in Mogadishu. Against the greatest odds imaginable, they are struggling to save lives, to provide food, to improve the security situation and to offer what comfort they can to the civilian population. It is difficult to exaggerate the importance of the role played by the ICRC in Somalia. The scale of its assistance, the care with which it has thought out, organized and implemented its programs and the vigor with which it has attempted to bring the plight of the Somali people to the attention of the world have been the nation's lifeline during the last few months.

The Current Situation

The roots of the present disaster lie in the 21-year rule of President Mohamed Siad Barre (1969-91). The former dictator destroyed all independent institutions, making it difficult for voices of moderation to emerge. He manipulated clan loyalties and encouraged regional rivalries in order to maintain his grip on power. The absence of democratic channels to protest and to curb severe and widespread human rights abuses made armed resistance the only possibility for challenging Barre's monopoly of power. Until 1977, his government was a close ally of the Soviet Union. After the Soviet Union switched sides in the war between Ethiopia and Somalia over the Ogaden, he was strongly backed by the United States for a decade beginning 1978. In 1988, mounting criticism of Barre's extraordinarily brutal counter-insurgency campaign in the north finally led to strong criticism from the U.S. Congress and to a suspension of U.S. military and, ultimately, economic assistance. This campaign involved the destruction of the northern city of Hargeisa in an attempt to defeat the rebel Somali National Movement (SNM) and its Isaak clan supporters.² In the late 1980s, armed opposition groups began fighting in the south and central regions, including the Somali Patriotic Movement (SPM) and the United Somali Congress (USC), and the same tactics were used against the civilian population living in the southern and central regions.

Though a latecomer to armed struggle, the USC played the central role in the final assault on Mogadishu in December 1990, as it was able to draw support from the Hawiye clan, who dominate the population living in and around Mogadishu. The insurrection forced Siad Barre to flee on January 26, 1991. A mere three days later,

² See **Africa Watch: Somalia: A Government at War with its Own People: Testimonies about the Killings and the Conflict in the North. January 1990.**

without consulting the armed movements, or even the other factions of the USC, Ali Mahdi, a businessman and member of the USC, declared himself Interim President. General Mohamed Farah Aidid, leader of another faction of the USC, objected. The following ten months saw repeated attempts to resolve the political conflict, and intermittent fighting.³

On November 17, 1991, General Aidid's forces, drawn mainly from the Habr Gidir subclan of the Hawiye, launched an all-out attack on President Mahdi's positions, manned largely by members of the Abgal subclan. Aidid's forces overran most of the city, but failed to dislodge Mahdi's forces from their strongholds in the north. Since then, the fighting has been continuous but inconclusive.⁴

For months now, Mogadishu has persisted in the grip of war and piecemeal destruction, as the two rival forces of General Mohamed Farah Aidid and Ali Mahdi fight a bitter war in the northern sector of the city. Virtually every street corner is hostage to one or more groups of heavily armed young men and boys, travelling in jeeps, trucks and tanks.

The city population is down from an estimated 1.25 million as of one year ago to a best-guess size of 600,000 to 800,000, the remainder having fled to camps on the fringes of the city or to sites elsewhere within Somalia. Civilians huddle in fear and scramble for food, hoping each evening that the night's barrage of shelling and machine gun fire, and the advance and retreat of forces fighting in streets and compounds, will spare their homes or squatter's lodgings.

People and homes have not been spared. Large areas of the city have been reduced to brown rubble of cement and sand. Thousands of civilians camp out in the streets, displaced by the shelling, fleeing to whatever part of Mogadishu they perceive to be the safer sections of the city.

Mogadishu has become a place of unpredictable death, with no one in authority and no one capable of enforcing a social commitment to order. Everyone appears armed. Whoever draws first carries the day, since there is no civil authority to punish someone who robs or kills. Many people are short-tempered, stressed by hunger and fear and many men -- and boys -- are consuming too much qat (a widely used mild stimulant that comes as a chewable green leaf) which is more powerful when eaten on a hungry stomach. In this climate of marginally contained chaos, the ICRC and the NGO community working in Mogadishu are stretched to the limits of their own endurance

³ See: *News from Africa Watch*, "Somalia: A Fight to the Death?" February 13, 1992.

⁴ For details see *News from Africa Watch*, February 13.

and institutional integrity, struggling to provide small amounts of medical care and food under constrained and tense circumstances. The almost total absence of the United Nations (U.N.) since Barre was ousted in January 1991 has put the entire burden of meeting the needs of civilians on the ICRC and the small NGO community in the country.

It is essential that the U.N. begin a massive program to deliver food, medicines, shelter and other essentials now, without any further delays. On March 5, 1992, the ICRC issued an appeal to donors because, it said "the fate of the Somali people lies in the hands of the international community."⁵ Warning that "without external help, the death rate from malnutrition will rocket within the next few weeks", the ICRC said it was issuing its Emergency Plan of Action "to stimulate donor interest in the plight of Somalis, but also to instigate a hefty commitment from the United Nations to move in fast with an extensive relief programme. For the ICRC cannot hope to cover all the needs alone."

Since it was embarrassed into action at the end of 1991, the U.N. has sent various missions to Somalia, but it has yet to begin the delivery of desperately needed assistance which is in itself an essential step towards the prospects of a lasting ceasefire and a negotiated settlement. Representatives of the U.N., the Organization of African Unity (OAU), the Arab League and the Islamic Conference visited Mogadishu more than two weeks ago to finalize the ceasefire agreement which was first negotiated in New York in mid-February. For the last two weeks, Mogadishu has been quiet, as the warring factions and -- much more importantly -- ordinary Somalis wait for the U.N. to deliver on its promises, both with regard to practical assistance and concerted political action for the protection of the civilian population.

Just as it appeared that the UN was finally debating the need to take meaningful diplomatic and humanitarian initiatives, the U.S. Administration has gone to extraordinary lengths to undermine the prospects of a diplomatic role for the U.N. The Administration is clearly worried that Congress, which has already balked at the financial cost of peacekeeping operations in Yugoslavia, El Salvador, Western Sahara and Cambodia, will not agree to pay additional funds for similar operations in Somalia. Angered by the U.S. response, African members of the U.N. have publicly accused the U.S. of double standards on Africa and Yugoslavia. Instead of trying to win Congress over, the Bush Administration prefers to limit the role of the U.N. to purely humanitarian concerns and to defeat collective efforts at the Security Council to search for a political formula to end the carnage.

Numbers of Casualties

⁵ **Emergency Plan of Action: Somalia, Proposed by the ICRC for April to June 1992, March 5, 1992.**

Estimates of human casualties since fighting began in September and then escalated to high intensity on November 17, 1991, are based on review of daily and weekly hospital records, which are kept with varying degrees of reliability and regularity. Based on these records, the ICRC believes that approximately 30,000 people have been wounded or killed in the last five months of fighting.

The uncertainties behind these estimates are several: only those casualties that reach the hospitals are counted; some hospitals keep more careful records than others; in all the hospitals, the record systems are rudimentary and not designed to handle large numbers admitted through the casualty wards; on days with heavy casualties, staff assigned to record-keeping are deployed to other tasks or simply cannot keep pace with those admitted; and the most seriously wounded who die in the casualty wards within moments of arrival are most likely not to be recorded at all. All these factors tend towards making estimates based on casualty records an undercount of what has actually occurred.

There is no civil government remaining, so the usual structures of death registries and death certificates, medical examiners and police records do not exist. Discussions with hospital medical personnel and administrators indicate that other possible methods of ascertaining numbers of casualties, such as counting the daily number of new graves, are impossible to carry out in the dangerous setting that Mogadishu has now become.

During the missions conducted by PHR and Africa Watch, an attempt was made to arrive at an independent assessment of the numbers of people injured and killed. This assessment looked at two main issues: the extent to which hospital admission records represented an undercount of actual casualty incidence and the extent to which a qualitative and careful cumulative inpatient death rate, from time of admission through the inpatient hospital stay, could lead to a more complete compilation of all deaths that had occurred.

The first phase of this assessment relied on the existing hospital records for admissions and discharges from the casualty wards, and on a questionnaire administered to a random sample of 145 hospitalized patients in two of the three functioning hospitals in the southern sector of the city. The questionnaire included 12 questions. One of the questions asked the surviving patient to state how many people were injured or killed as a result of the same incident that caused the injury that brought him or her to the hospital. They were also asked to indicate how many others were injured at the time of the same incident (if any) and how many were brought to the hospital.

The second phase of the assessment of casualties involved calculating the death rates that applied at various stages of the inpatient hospital setting: the casualty ward, the observation ward, the operating theatre, and the inpatient wards. Based on interviews with hospital nurses, physicians, and administrators, and on joint review of the fragmentary records that were available, it was agreed that the following death rates conservatively applied at each phase: casualty ward, 10%; observation ward, 10%; deaths in the operating theatre, 5 to 10%; deaths on the inpatient wards, 5 to 10%.

Extrapolating from these estimated rates, we concluded that from mid-November 1991 until the end of February 1992, approximately 14,000 people in Mogadishu have been killed and approximately 27,000 people have been injured, for a total casualty figure of 41,000 people, 10,000 over the estimate provided by the ICRC for this time period.⁶

These numbers do not include deaths and injuries among the estimated 200,000 people living in displaced persons camps ringing the outskirts of the city, where conditions are reported as severe: high levels of malnutrition and near starvation; widespread skin and gastro-intestinal illness and festering war wounds.

Weaponry

There are probably in excess of 30,000 armed men and boys in and around Mogadishu. The majority are supporters of Ali Mahdi, but General Aidid's forces possess most of the heavy weaponry.

Most of the artillery is old and designed for use in conventional field confrontations or for use against air attack. Most requires handling by crews of six or seven trained men. In Mogadishu, artillery pieces are often fired by untrained and unschooled teenagers.

Some of the common weapons in use include:

- * 122mm D-30 howitzer, 1938 model, made by Soviet State Factories. There are a few of these towed field artillery pieces in use. They fire shells weighing over 25kg, the heaviest rounds in use.
- * 23mm ZU-23 anti-aircraft guns, made by Soviet State Factories. These have been mounted on trucks and pointed horizontally for use as mobile artillery.

⁶ Extrapolations were performed with the assistance of statisticians working at the Center for Survey Research at the University of Massachusetts in Boston. A detailed report of the analysis of this data is now in preparation.

- * 37mm Type 63 anti-aircraft guns, 1939 model, made by Soviet State Factories, mounted on trucks for use as mobile artillery. These are one of the most common weapons in use.
- * 89mm LRAC anti-tank rocket launcher, manufactured in France, mounted on pick-up trucks for use as mobile anti-vehicle or anti-personnel artillery. These are perhaps the most numerous heavy weapon in the city.
- * 106mm M-40A1 anti-tank recoilless gun, manufactured in the U.S., mounted on jeeps or pick-up trucks.
- * 82mm M-41 mortars, Soviet-made. These are very common, highly mobile, and have the capacity to throw a 3kg shell over 2.5 km.
- * 81mm mortars, U.S.-made. These are similar to the M-41 mortar.
- * 120mm M-43 mortars, Soviet-made. These are relatively few in number but much more powerful, able to throw a 15.4kg shell for 5.7 km.
- * 105mm M-56 field gun, US-made. This is very common.

The most common small arms in use are AK-47 assault rifles and Browning machine guns.

Fortunately, much of the heaviest artillery is currently not in use because of the lack of trained personnel. Such weapons include the U.S.-supplied M-198 155mm howitzer, which can fire a 40kg shell up to 30km, and the Soviet-supplied 152mm 1937 model howitzer, which has similar power. The US howitzer requires a crew of 11, while the Soviet model needs seven men.⁷ While such crews are not currently available within Somalia, there are unconfirmed reports of missions from General Aidid attempting to recruit such personnel abroad.

Perhaps the most remarkable weapon in use on the streets of Mogadishu is an air-to-air missile taken from a MiG-17 fighter-bomber and mounted on the back of a pick-up truck for use against ground targets.

In trained hands, the field artillery and mortars can be used with great precision. There are estimated to be a mere 200 trained artillerymen in the city. Most of the weapons are used by unschooled teenagers who would be unable to read the manuals even if they had them. Firing positions are often taken up and abandoned hastily, and

⁷ For details, see *Jane's Defense Weekly*.

there are few, if any, systematic attempts to identify where a shell has fallen, and how a subsequent round could be made more accurate. Most of the weapons are fired indiscriminately in the general direction of the opposing forces. The results can be seen in the numerous civilian casualties.

Medical Problems

Hospital Resources

No non-trauma medical care is being delivered at the hospitals, on either the north or south side of the city. If the needs of those with chronic or acute medical conditions, such as diabetes, are being met, it is likely to be through the efforts of private physicians working out of their private homes in the community.

Three main hospitals (Digfer, Benadir, and Medina) provide casualty care to the southern sector of the city. Digfer Hospital has the capacity for about 650 inpatient beds, with an estimated current inpatient census of 1,000 patients. Benadir has approximately the same capacity and current census. Medina Hospital currently holds approximately 400 patients. Hospital needs on the north are served by a team of five Somali physicians who set up the "Health Emergency Committee" on November 18, the day after the fighting broke out. They work out of 27 converted villas, and two larger villas in the same area facing the ocean, which have been combined to form what is called Karaan Hospital, where most of the emergency surgery takes place. An additional set of 16 villas on the north constitute a collective inpatient ward, Karaan 2, for patients who are convalescing from acute injury. The total number of patients hospitalized in these 45 villas is approximately 5,000 to 6,000 people. For medicines, the Karaan Hospital relies entirely on weekly supplies brought in by the ICRC.

The physical condition of the acute care areas of these hospitals is uniformly austere and, with the exception of the casualty and operating areas of Medina Hospital, where the expatriate staff from Médecins Sans Frontières-France (MSF) have taken over and renovated the most advanced of the city's surgical units, conditions are unsanitary. As the fight against Siad Barre prompted urban fighting and then as the intra-clan conflict broke out, makeshift casualty wards were set up in the existing entryway in the other two hospitals in the south during the course of the past year. During this year, both parties to the conflict have looted and destroyed public and private facilities. They have not spared hospitals. Digfer Hospital was particularly hard-hit and stripped almost bare of equipment, furnishings, and supplies. The ICRC had opened a hospital for the care of acutely injured casualties for the north in early February, but after one week of operations, was forced to close it abruptly in the face of active hostilities. (The hospital is operational again; see below). The surgical care structures on the north are even more minimal, since they were built as private homes.

With the exception of the acute casualty and surgical areas of Medina Hospital, none of these hospital structures have screens over the windows to keep out flies and other insects. Electricity is available only to the operating areas on an intermittent, limited basis, from locally maintained diesel fueled generators. Running water is infrequent and unclean. There is no oxygen available in the city and no inhalation anesthesia possible. Surgical drapes are scarce or non-existent, depending on the site or hospital. Sterilizers occasionally work and are used according to varying routines and frequency. Much of the surgical equipment in most of the sites is re-used without interim sterilization over a 24-hour period. Casualty and operating areas are mopped down intermittently, depending on the volume of cases arriving in acute condition.

Available antibiotics included penicillin and erythromycin; medicine for the prevention of tetanus was in short supply. Medical support can continue to be provided at its current rudimentary level only if the lifeline provided by the ICRC can be maintained. Medical supplies to both sides of the city and food rations for the Somali hospital staff cram the small ICRC plane that arrives six times a week at the airport on the southern side of the city. The main commercial seaport is routinely shelled and no ships have entered for months. Other supply routes are two sea disembarkation points along the coast, one north, the other south, of the city's borders.

Acute Surgical Care

Surgical care for the daily burden of casualties (approximately 500 to 1,000 per day in late February, the total for both sides of the city, counting only those who make it to the hospital) is provided by Somali doctors and nurses who have dared to stay and approximately 30 to 40 expatriate physicians, nurses, and logistic support staff. The entire attention of hospital-based personnel is on the initial triage, stabilization, and emergency surgery of war casualties. There are too few staff to attend for more than a day or so to the post-operative needs of the trauma victims, who enter hospital inpatient wards that are swollen to two or three times capacity and lack even minimal nursing support.

From interviews with hospital personnel it is evident that after the first shock of heavy casualties began to hit the hospitals in November 1991, the staff settled into a routine of triage, stabilization, and emergency surgery that was based on a sound and realistic assessment of what was possible under these extraordinary conditions. The principal of triage was invoked for all people expected to die from their wounds, that is people arriving with serious head injuries, chest injuries involving the heart or major vessels, abdominal injuries with gross evisceration (wounds where the abdominal contents are exposed and extruding) and hemorrhage, and all patients in a state of traumatic arrest (cardiac arrest due to shock). Stabilization in the casualty area included

pressure occlusion (pressure to stop bleeding) of all accessible sites of hemorrhage, insertion of intravenous lines, administration of intravenous fluid (saline and lactated ringers), typing for blood (only ABO typing is available), administration of blood when available from family members, insertion of chest tubes for pulmonary injuries, and application of traction and plaster splints for all simple and compound limb fractures. Most superficial bullet and shrapnel wounds and upper extremity fractures were treated and released, as were most superficial and non-extensive burns.

Surgeons in the operating theaters performed amputations on limbs irretrievably damaged by high velocity gunshot wounds or artillery shells and in less severely damaged instances attempted debridement (removal of dead, damaged and dirty tissue in the area of a wound caused by bullet or shrapnel) and plaster of paris splinting and traction. Exploratory laparotomies (abdominal surgery) were performed on almost all cases of penetrating injury to the abdomen, and the range of procedures included splenectomies (removal of the spleen), liver repair, and nephrectomies (removal of a kidney). In the many instances where repair or resection of the bowel was required, it was rare to exteriorize any portion, since post-operative follow-up care was known to be minimal. On days when the casualty burden was relatively light, the surgeons would attempt more complex genito-urinary surgery (either emergency or reconstructive) and occasionally would perform tracheotomies (surgical hole in the airway so as to facilitate breathing). In both sets of cases, the problem of post-operative care and complications weighed against performing these procedures as often as they were otherwise indicated.

Inpatient Care

The inpatient wards have few beds and most patients lie on mats or cloths on the floor. Sanitation systems do not work. There is no electricity for these wards, so particularly in hospitals, such as Digfer that have many internal rooms and stairways, darkness is pervasive. Flies are ubiquitous. Since nursing staff is so sparse, most of the medical and personal care these patients require after their first day of admission has to be delivered by family members, whether or not they know what to do. The hospital pharmacies function and distribute medications as directed by the nurses, whenever the nurses manage to see patients and assess their ongoing needs. Physician rounds on the inpatient services either do not occur or (in the case of Medina) are limited to post-operative laparotomy or orthopedic cases.

There is no food available to hospitalized patients aside from what their families bring in to them. In the inpatient wards, the common refrain, "if you have no family, you die" is true for the orphans or people whose support systems have been killed or scattered. They are most at risk of death from starvation. Because food is so scarce in the city in general, however, even those with families have little to eat. It is well

understood by all, health professionals and others, that the prospects of healing and recovery are delayed by the chronic hunger and poor nutritional condition of the patients.

Many of the patients remain on the wards after their wounds have partially or completely healed, for reasons of shelter and security. Their homes were destroyed and hospitals are considered less likely to be deliberate targets of artillery bombardment or involved in active ground engagements.

Public Health Issues

The food and medical situation in Mogadishu will worsen with the passage of time. According to medical personnel, people are slowly becoming visibly thinner (even Somali hospital staff who are surviving on one meal a day provided by the ICRC). Severe malnutrition among the civilian population is becoming more widespread. There is no central electric power or water supply for the city. Most of the water mains have been tapped. Deep wells in private compounds provide water to those who have access to fuel to run the pumps. Only a few are working. There is no sanitation or waste collection service. The numerous shallow graves encroaching on the streets and compounds of the city are easily uncovered by animals and artillery bombardment. When the rainy season begins in April, it will add new burdens to the drainage and sewage system.

Under these conditions, without major reversals of current trends, relief officials are concerned that in a few months the city of Mogadishu, now afflicted with war wounds and attendant suffering, will also see famine and epidemic disease, particularly meningococcal meningitis, which Mogadishu has experienced in the past, and a particularly virulent form of infectious hepatitis, which, according to ICRC officials, in 1991 killed 4% of those with the disease, and among pregnant women with the disease, it killed 14%. Malaria, a severe threat elsewhere in Somalia, is less prevalent in Mogadishu. An epidemic of cholera, however, is considered possible. The rainy season will make it even more likely that such an epidemic will occur. Cholera has been present in Somalia since 1858, with the last major outbreak occurring in 1985, principally among residents of refugee camps.

Long-Term Medical Consequences

The nature of the physical disabilities borne by the injured survivors of this conflict reflect the ferocity of the weapons used against them: thousands of people are amputees; perhaps hundreds of people are hemi or paraplegic. Thousands more are surviving with maimed if not useless limbs, the result of incomplete knitting of shattered fragments of bone. There are no facilities in Mogadishu to make prosthetic

devices. Even makeshift crutches are in such short supply that, according to hospital workers, many patients are still lying in the wards, unable to find supports to walk.

Short-term treatment of people with these injuries will require significant investment in physical rehabilitation services by any government that is eventually reconstituted. The long-term loss of productive life and activity for these thousands who are now disabled will present a daunting challenge to those who try to reconstruct the economy and social life of the city.

Long-Term Psychological Consequences

Another long-term consequence of the conflict will be numerous psychiatric disturbances among the survivors. Even those not physically injured may be deeply psychologically scarred. There are three overlapping areas of principal concern. They are: pathological grief, Post-Traumatic Stress Disorder (PTSD), and aberrant behavior in children.

Pathological grief

Somali tradition dictates great respect for the dead. While there is no elaborate funeral, a person's death should be followed by 40 days of mourning, after which ceremonies are held to commemorate that person's life. As in all societies, the fulfillment of these practices serves important social and psychological functions for the bereaved.

In Mogadishu today, death has become commonplace. The dead are buried hurriedly, usually in shallow graves. The grounds of the hospitals, the yards of houses and street corners are filled with shallow unmarked graves. Of equal or greater significance, the traditional period of mourning can not be observed; the lack of security makes it difficult for relatives and friends to visit and comfort the close family by sharing their grief, and only the most perfunctory prayers are said for the deceased, if any. Not only are the traditional networks of social support for the bereaved not functioning, but the bereaved themselves feel a burden of guilt towards the dead for failing to fulfill their customary obligations. Many of the survivors will have been bereft of not just one close friend or relative, but many.

This combination is likely to lead to widespread pathological grief among the bereaved. This may be expressed in chronic depression, somatic complaints such as severe headaches and body aches, loss of confidence in oneself and others, social withdrawal, lethargy, and attempted suicide.

One common preventive treatment for widespread pathological grief is to hold

communal mourning ceremonies. In the West, this function is partly fulfilled by monuments such as "the tomb of the unknown soldier" and by special memorial days. Similar practices for collective remembrance could play an important role in the psychological health of the survivors of Mogadishu.

Post-Traumatic Stress Disorder

PTSD is a condition common to survivors of wars and other exceptionally traumatic events. In the U.S., it has been widely diagnosed among veterans of the Vietnam war. It arises from exposure to a traumatic event outside the range of normal human experience, in which the person is both terrified and helpless.⁸ In Mogadishu, the events likely to cause PTSD among civilians include witnessing or being involved in firefights, seeing summary executions, being the victim of shelling,⁹ or witnessing the severe injury or painful death of a loved one. Combatants are also likely to suffer from PTSD.

The symptoms of PTSD include: recurrent re-experiencing of the traumatic event, often in nightmares; avoiding things or circumstances associated with the traumatic event; psychic numbing or emotional anaesthesia, including the inability to feel emotions or relate to other people; and being subjected to sudden-onset panic attacks, chronic anxiety and hyper-vigilance. PTSD sufferers who committed acts of violence themselves, for instance in armed combat, may also suffer from outbursts of anger or uncontrolled aggression. If the traumatic event also causes the death of friends or relatives, PTSD may be accompanied by pathological grief.

Despite being the subject of much psychiatric investigation, there are few successful methods for treating PTSD.

Effects on children

The psychological effects on children of the current war are extremely difficult to assess. Tens of thousands have lost a parent; many have lost both. Thousands have been injured. None have been to school for more than a year. All are familiar with different forms of weaponry and with their effects.

Casual observation suggests that many children, especially boys, are behaving in a manner that would normally indicate severe delinquency or disturbance. Many

⁸ The definition and description of PTSD are drawn largely from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition, Revised (1987).

⁹ During World War I, a condition akin to PTSD was commonly known as "shell shock."

children have joined the forces or have become looters. Occasionally, boys under ten years of age are seen wielding automatic weapons, and it is common to see boys of twelve years or so manning checkpoints or serving in fighting units. Unlike child soldiers in some other wars (e.g. Uganda), these boys have not been subjected to any discipline or training. For them, part of the function of battle is entertainment. The boy soldiers appear to court danger; they prance on streetcorners, taunting the other side, and dare each other to make raids into contested areas of town.

Younger children play with imitation weapons, and also manifest a range of unusual behaviors. Some are withdrawn, others are hyperactive and uncontrollable. The sight so common in most African towns, of children playing outside their houses and greeting strangers, has become almost unknown in Mogadishu.

In a study of boys involved in the war in Mozambique, it was found that children who have repeatedly witnessed war-related events or been forced to perform acts that would otherwise be considered shocking departures from normal life will experience serious problems in re-enter society on normal terms. The disrupted process of socialization can, for some children, prove to be a permanent condition.¹⁰

Violations of Medical Neutrality

Violations of medical neutrality occur in virtually all wars and civil conflicts. However, the pervasive frequency and severity of violations during the last five months in Mogadishu have been particularly shocking and have created serious stress for those relief and medical personnel who continue to try to care for the sick, the wounded, and the hungry.

Violations of medical neutrality refer to interference of military forces with the provision of care for the wounded and sick during times of conflict. Protection of medical personnel, facilities and patients is guaranteed under the Geneva Convention and Protocols. Specific violations can include firing upon hospitals and clinics, interference in the delivery of health care, establishing a military presence within a hospital, thus intimidating health workers and patients alike, and direct assaults or threats against health personnel.

According to interviews with medical personnel in Mogadishu, in the first six weeks of heavy fighting after November 17, it was routine for groups of armed soldiers to rush into hospital compounds, casualty areas and wards, dictating triage and treatment decisions by holding guns to the heads of physicians and nurses. Jeeps filled

¹⁰ Boothby, Neil. "Working in the War Zone: A Look at Psychological Theory and Practice from the Field." Lecture given at the Conference on Children and War, Sigmund Freud Center, Hebrew University, Jerusalem, June 25, 1990.

with men and boys armed with AK-47s would linger just outside the hospital entryways, harassing hospital workers, occasionally re-entering the casualty areas to check on what was happening to a wounded companion. Armed men were kept out of the operating areas with some difficulty. On occasion, hospital personnel said that they could plead or remonstrate with the soldiers, who would leave the premises for a time, only to return again when another bout of fighting resulted in another group of seriously injured casualties. The atmosphere within the hospital gates and in the treatment areas was always volatile and tense. No instance of actual physical injury to a hospital worker has been reported or described, but the incessant presence and threatening demeanor of these armed troops was intimidating and, in some instances, prevented health care workers from carrying out their duties in the order and priority determined by medical need.

In January, the health workers, led by physicians and nurses working with MSF, succeeded in obtaining an agreement from General Aidid that, in the sectors of the city he controlled, there would be no armed interference with the delivery of medical care. Large signs in Somali and English were posted at all hospital compound gates, clearly forbidding entry to those who carried weapons. Guards of Aidid's forces were posted at all these gates, and it was required that all personnel, including the armed guards who routinely travelled with all expatriate health care workers, leave their weapons at the gates prior to entry.

Although hospital personnel do not charge either side in the fighting with deliberate artillery attacks on the hospitals, during these months, all three of the hospitals on the southern side of the city and many of the converted villas on the north have been hit by artillery bombardment. No formal public record of these incidents has been compiled, but in interviews with hospital personnel attached to the three southern hospitals the following events were cited:

At Digfer Hospital: In December a heavy rocket landed in the compound and injured many people who had accompanied injured relatives to the casualty ward; on one occasion in January, a shell from an anti-aircraft gun had gone through the floor of the operating room, causing no injury to persons; but in another instance, a similar shell had seriously injured one Somali hospital worker.

At Medina Hospital: Many separate instances of "sky shots" (random firings into the air resulting in bullets falling from a height) caused many injuries and resulted in the deaths of two or three people within the hospital compound; one anti-aircraft cannon shot had gone through the roof of the laundry area, causing several injuries.

At Benadir Hospital: Shelling of Benadir was perceived to have been heavier than for the other two hospitals, with many artillery shells received over the course of the

preceding few months, resulting in many injuries and at least two deaths, to both patients and accompanying relatives; in early February, an artillery shell had landed just in front of the hospital gates, killing six people.

The armed invasion of the ICRC hospital on the northern side of the city on February 13 is the most recent and the most dramatic example of the ongoing violations of medical neutrality. The ICRC had built a back-up hospital for the north side on the grounds of a prior prison. This hospital, known as Keysaney, two and a half months in preparation, at the cost of \$200,000, had been in operation for approximately 10 days when it was forced to close on February 13. On that date, troops from General Aidid's forces invaded the hospital grounds and at gunpoint required the evacuation of all staff, including six expatriates, most of them ICRC staff members from the Netherlands Red Cross. This hospital compound was well-identified, with Red Cross flags flying from the parapets of the old prison gates. Under protest, the staff were forced to leave behind at least 45 acutely injured hospitalized patients. (It was later learned that these patients were transported to the villas of Karaan Hospital.) The Somali physicians and the Somali Red Crescent¹¹ were able to resume activities on March 1 and the ICRC was able to return on March 2. Both the building and the equipment, which had been stored in a safe place by the Somali Red Crescent, were in good order.

Interviews with medical personnel indicate that as a result of the organized protests of the hospital staff in January, some aspects of the problem have improved, so that now on the southern side of the city soldiers do not routinely rush into the hospital casualty areas and wards and in fact generally obey the signs that are prominently posted.

The persistent reality, however, is that these disorderly groups of armed men and boys have no knowledge of or respect for humanitarian principles. Hospital personnel have been robbed and harassed in their travel to work; guns are still prevalent on the inpatient wards and gunfights occasionally break out; there is a continuing risk that the transport of medical supplies will be threatened, despite the use of vehicles prominently marked with the emblems and flying the flags of the various relief organizations. On days heavy with casualties, armed forces still rush into the casualty ward, accompanying their injured companion. As the case of the ICRC hospital demonstrates, it is difficult to have any confidence, until the city becomes secure again, that people and premises will be protected so as to facilitate the delivery of medical care.

The shortage of food among some sectors of the population in Mogadishu

¹¹ In Islamic countries, national chapters of the Red Cross are known as the Red Crescent.

(especially hospitalized patients, pregnant mothers, and infants) now constitutes a medical emergency, yet food is considered so valuable that distribution of supplies carries substantial risk to those who attempt it. In settings of serious food shortage, where the delivery of food to the civilian population is a life-saving enterprise, interference with this delivery constitutes a serious violation of the laws of war. In Mogadishu, such violations have become routine.

The Impending Famine

Somalia has historically been subject to famines, especially in the pastoral areas of the center and north. The most common cause of these famines has been drought, which has recurred frequently. Records indicate that ten significant droughts occurred between 1918 and 1975.¹² Droughts have also occurred in 1979-80, 1983-6 and 1989-90. These famines have affected mostly the remoter rural populations, notably herders and, to a lesser extent, smallholder farmers.

The current famine that threatens Mogadishu and south-central Somalia is radically different in origin and impact. Drought has played only a minor role, and the main victims are poor townspeople, farmers, and rural laborers. Pastoralists are, at present, less affected.

In normal times, Mogadishu and the adjoining areas of the country are at the hub of a complex food system. Food is supplied to the area from smallholder rainfed agriculture in the Bay region, and irrigated agriculture along the Juba and Shebelle rivers. Following the main April-July rains, the principal harvest is reaped in August and September. There is also a large pastoralist population that sells meat to the urban market. Certain coastal towns specialize in fishing. Somalia has also traditionally imported food from neighboring countries and from Italy, and in recent years international food aid supplied to the former government, in part to feed the population of refugees from Ethiopia, has also made a large contribution to food markets.

All these sources of food supply have been disrupted in the last two years, though the precise damage caused is difficult to assess. Estimates of the agricultural production in 1991 vary widely, but agree that the situation is extremely dire. According to the U.S. Department of Agriculture (USDA), the total production of the country was 420,000 metric tonnes, down by about 40% on a normal year. USDA's forecast of food needs was 347,000 tonnes.¹³ The Food and Agriculture Organization of

¹² I. M. Boothman, "A Historical Survey of the Incidence of Drought in Northern Somalia," in I. M. Lewis (ed.) *Abaar: The Somali Drought*, London, 1975.

¹³ United States Department of Agriculture, *African Food Needs Assessment: Situation and Outlook Report*,

the U.N. (FAO) was more pessimistic, estimating import requirements at 480,000 tonnes.¹⁴ About half of the total shortfall is in Mogadishu and the central regions. The ICRC estimates that 7,000 metric tonnes of food per month is essential to feed "Greater Mogadishu", that is both the city itself and the displaced people living in camps on the outskirts of the city. The organization estimates that 35,000 tonnes of food per month are needed for the country as a whole, including the north-west "to save the approximately 4.5 million Somalis at risk [of starvation]."¹⁵ Of this 4.5 million people likely to suffer from famine, the ICRC believes that one third of this number will be severely affected.

The Vulnerable Populations

One of the casualties of the current war has been reliable information on the extent of the famine. Recent surveys by the ICRC and SCF-UK have indicated extremely high child malnutrition rates in the Gedo region and the displaced camps around Mogadishu. However, more extensive information is only available relating to the middle of 1991, when surveys were undertaken in most regions of the south and center.

The rural populations most affected have been the farmers. In the lower Juba, cultivation was severely disrupted by battles between the USC and the Somali Patriotic Movement (SPM) in April and June-July 1991. Many crops and seeds were stolen, villages destroyed, and people displaced. Irrigation pumps were a particular target for looters, and fuel was often unavailable for those that remained. Tractors were also looted. Farmers planted smaller areas, and often consumed their harvests before the cobs ripened, to pre-empt looters and due to sheer hunger. Many people were forced to survive on famine foods, such as boiled green mangoes, sugarcane, and wild vegetables. An ad hoc nutritional survey found that 60% of children were undernourished.¹⁶ In March, 1992, the ICRC said that "horrific levels of 90% moderate and severe malnutrition" had been detected in the region surrounding Belet Huen and in the camps of displaced people around Merca.¹⁷

November 1991, p. 34.

¹⁴ **Food and Agriculture Organization, *Foodcrops and Shortages, Special Report*, December 1991, p. 14.**

¹⁵ **"Somalia: Global Approach the Only Means of Averting Famine" in the *Bulletin of the ICRC*, March 1992.**

¹⁶ **Kenneth Menkhaus, "Report on an Emergency Needs Assessment of the Lower Jubba Region, Somalia," *World Concern*, July 1991. The definition of "undernutrition" is not given.**

¹⁷ **ICRC Emergency Plan of Action: Somalia, March 5, 1992.**

Similar conditions are reported from other farming areas, such as Bay, Mudug and the Shebelle valley. In July 1991, ICRC surveys of farming villages in the Jowhar area (middle Shebelle) and Hiran found child malnutrition rates of 90% and 86% respectively.¹⁸

Conditions among the farming populations will certainly have improved marginally during the second half of 1991, due to the harvest, meager though it was, which was brought in. However, the population has entered the year 1992 with no reserves and already in a critical state, making descent into famine almost inevitable.

The poorest strata of farmers, who normally rely on finding casual labor in order to earn money, are possibly the worst hit. The reduction in farming -- especially the closure of the banana and sugarcane plantations in the lower Juba and Shebelle -- has meant that these people are unemployed and destitute.

Conditions among the pastoral populations are reported to be far superior. Child malnutrition rates have been reported that are less than half of those found among farmers; for instance 27% in Hiran region in July. The reason for this is undoubtedly that pastoralists who retain animals are able to consume milk in large quantities, protecting their children from malnutrition. However, there are indications that many herders are being forced to sell their animals cheaply in order to buy food grains. As the famine develops and more herders lose their animals, they too will suffer severe hunger.

In mid-1991, the situation of townspeople was deteriorating but had not yet reached critical levels. ICRC nutritional surveys in the small towns of Adale and el Deer found malnutrition rates of 28% and 40% respectively. In the fishing town of Adale, the disruption in trade had ironically brought an unexpected benefit -- fish was plentiful, and available free to all residents. Conditions in other towns reportedly varied tremendously; if a town was on an active trading route, it might remain relatively prosperous; if its former sources of income had disappeared, it would probably be in dire straits. In Mogadishu itself, the nutritional condition of children was also precarious, but not disastrous.

The trade in food has been severely affected by the insecurity. There are frequent roadblocks along all major routes, at which traders are required to pay a tax in order to pass. Security demands that merchants hire armed guards, and often they are forced to travel in a convoy. The FAO estimates that no more than 12,000 tonnes of food can be

¹⁸ The method of measuring malnutrition used was the QUAC stick, which tends to give higher rates of malnutrition than more reliable but more difficult anthropometric methods.

imported commercially from abroad. This is mainly food brought across the border from Kenya by private truckers. These factors mean that the price of food in urban marketplaces is sharply raised, with serious implications for those, such as urban dwellers, who normally buy their food in the market.

Of the Somali population, those most at risk are the displaced. The fighting of the last three years has caused many people to be displaced from their homes, sometimes several times. In July 1991, ICRC surveys found that in a long-term displaced population near el Bur (Hiran region), the child malnutrition rate was 72%; among recently displaced people in the same area the rate was 94%. Since November, the greatest concern is for the populations displaced from Mogadishu, living on the fringes of the city. Estimates vary from 150,000-200,000.

A final group of concern are refugees from Ethiopia. They are mainly ethnic Oromo who came to Somalia to escape war and repression in Ethiopia during 1978-85. About 35,000 Ethiopians remain in southern Somalia, including about 8,000 in Mogadishu itself (on both sides). The remainder live mostly in camps at Qorioley and Shelembot.¹⁹ The refugees recently sent a protest to the United Nations High Commissioner for Refugees (UNHCR), noting that in January 1991 the UNHCR "closed its office in Somalia, paying no attention to the Ethiopian refugees who were under its protection."²⁰ The refugees noted that they were receiving relief assistance only from the ICRC, and demanded immediate repatriation to Ethiopia.

Prospects and Remedies

There is little prospect of food production in Somalia increasing in 1992 compared to 1991, even if the weather is kind. Lack of seeds and agricultural equipment combined with insecurity means that smaller areas will be planted, and less food will find its way to market. The minimum estimated deficit for the 1991/2 year, 347,000 tonnes, will therefore be exceeded in 1992/3. Failing an effective program of intervention, full-scale famine is certain, with a death toll in the tens if not hundreds of thousands. "The entire population of Somalia is threatened with starvation, and only a global approach can prevent a disaster on an unprecedented scale", commented the ICRC in its most recent Bulletin. "Emergency food aid must be provided not only in the capital Mogadishu but also in the rest of the country" according to Jean-Daniel Tauxe, ICRC Delegate for Africa.

Most of the shortfall must be made good by international aid. "The ICRC and the

¹⁹ **Africa Watch interview with Ethiopian Refugee Committees, February 3 and 5, north and south Mogadishu.**

²⁰ **Letter from Ethiopian Refugee Executive Committee to UNHCR, dated February 2, 1992.**

NGOs on the spot can no longer meet the need for food. The United Nations and its specialized agencies must take massive action if a general famine is to be prevented", emphasized the ICRC.²¹ As of early 1992, food aid pledges amounted to no more than 70,000 tonnes, and the only distribution of staple food in the southern and central parts of the country was being attempted by the ICRC, which was distributing about 7,000 tonnes each month mainly by sea. Portions of a 1,000 metric tonnes scheduled to be distributed by road convoys in the border regions with Kenya have already been distributed. An ICRC airlift is due to begin on March 23 in Belet Huen. The ICRC's objective is to be in a position to increase its monthly food inputs up to 14/15,000 metric tonnes per month.

Distributing food in Somalia is logistically straightforward but requires extremely careful planning to ensure security. Both Ali Mahdi and General Aidid have shown themselves unwilling to let food relief move freely to areas of the city not under their control.²² As a result, the strategically located deep water port of Mogadishu has not been in use since before the latest outbreak of fighting in November. A ship chartered by the World Food Program of the U.N. returned to Mombasa about two weeks ago after it was fired upon by members of a neutral clan who complained that they had not been consulted. The ship has not returned in spite of interventions by leaders of the principal warring factions and the fact that Mogadishu has been quiet for the last two weeks. Even if it is felt that the situation is too volatile to unload the food, it would give an important psychological boost to the residents of Mogadishu and to the relief community if the ship were to return and remain nearby.

A more general problem is the danger of attacks by looters and undisciplined soldiers. None of the fighters in and around Mogadishu are paid, and all must loot in order to survive. As it is so expensive and scarce, food is an obvious target of looting. There have been several incidents in which food convoys have been halted and the food either stolen or diverted to people living nearby.

Delivering food can be hazardous; distributing it without involving the community is extremely dangerous. In December, an ICRC worker was shot and died during a dispute during a food distribution. Since that time, all distributions have been done by clan elders, not directly by the aid agencies themselves. While this means that the targeting of food to the most needy, especially women and children, may be less than optimal, it is by far the best arrangement under the circumstances.

²¹ See **Bulletin**, March 1992.

²² See **News from Africa Watch**, February 13, 1992, for an account of the obstruction to relief efforts from both factions of the USC.

Conclusion and Recommendations

Lessons for the United Nations

The security problems associated with food delivery by the U.N. are likely to be greatest in the first few weeks of a major delivery program. The dangers will lessen as food becomes cheaper and more readily available. The immediate task is therefore to bring in the first shipments without major incident. There are a number of elements critical to the success of such an operation. These include:

- * Sending food ~~without~~ waiting for the ceasefire negotiated by the U.N. to hold, ~~without~~ any other additional guarantees, before Mogadishu port is reopened or there is free access to all areas of the city. The simplest option is to use the seaports of Merca (south) and Adale (north), and several airfields around the city. The ICRC is currently unloading in Kismayu and at other points along Somalia's long coastline and there is no reason why the U.N. can not adopt a similar strategy.
- * Ensuring that all parties are fully consulted and fully informed of all shipments, their nature and destination. The ICRC already follows this practice. It would be disastrous if the U.N. specialized agencies, in their rush to become belatedly active, were to fail to do this; the worst likely consequence would be an outbreak of fighting over the U.N. food shipments.
- * Sending food simultaneously to ports or airports to the north and south of Mogadishu, so that the food relief program does not become a strategic asset to one side only, thereby inviting attack from the other side.
- * Making sure that the first shipments are heavily guarded, if possible by deploying professional troops from the armies of Ali Mahdi and General Aidid to serve escort duty.
- * Creating the confidence that the first deliveries will not be the last. This confidence is just as important as the food itself; if there is the expectation that food will become readily available, merchants will unload their stocks of food, thereby decreasing market prices, and the motives for stealing food will be reduced. This confidence could be achieved by sending very large ships to anchor off the shallow-water ports of Merca and Adale. Even though the speed of unloading these ships, which is done by using smaller boats, could not be increased, the visible demonstration of the imminent arrival of large quantities of food would have a crucial psychological effect.

The most important lesson for the U.N. specialized agencies is that a high-profile relief program, undertaken with one eye to redeeming the international credibility lost during the last year, is likely to lead to errors of judgement that could have disastrous or fatal consequences. The U.N. must recognize its shortcomings and ignorance about the current state of affairs in Somalia, and must follow the lead of the ICRC and other voluntary agencies, if its involvement is to improve the situation, rather than making things worse. In its recent appeal to donors, the ICRC said "co-operation between the ICRC and the UN is absolutely fundamental and the key to ensuring that assistance is delivered at the right time and place under optimal conditions. Any delay will cost thousands, if not hundreds of thousands of lives."

Problems of malnutrition, hunger, clan conflict, and refugee flight are also rampant elsewhere in Somalia, including Somaliland to the north. Political instability and social distress are increasing in every sector of the country and along its borders with Kenya and Ethiopia. The situation in Somalia has already forced tens of thousands of terrified and hungry Somalis to seek refuge in neighboring countries, further destabilizing an already volatile region of Africa. Unless the situation is brought under control, further waves of impoverished refugees is inevitable. Many observers think that a strategically aggressive intervention in Mogadishu must occur simultaneously in many regions, in order not to aggravate inter and intra-clan rivalries and not to promote further social migration from areas of need to areas of perceived resource.

Holding Back the U.N.: The U.S. and the Security Council

Until there is sufficient political pressure on the warring parties to cease the slaughter of civilians and to end the practices which have wreaked havoc, Somalia, and Mogadishu in particular, will continue to be a stark symbol of human suffering. It is therefore essential that political and humanitarian initiatives are taken simultaneously. On March 17, 1992, the Security Council, under the presidency of Venezuela's Permanent Representative to the United Nations, Ambassador Diego Arria, adopted a resolution on Somalia. The differences between the draft resolution of March 12 and the final document are significant. According to the draft resolution, "[The Security Council] strongly supports the Secretary-General's decision to urgently dispatch a technical team to Somalia to prepare an operational plan for a monitoring mechanism to guarantee the stability of the cease-fire." Under insistence from the U.S., the final resolution omitted any references to the need to monitor the ceasefire. Instead, it merely "strongly supports the Secretary-General's decision urgently to dispatch a technical team to Somalia, accompanied by [a humanitarian] coordinator..." The technical team which left New York for Nairobi on March 20, is due to arrive in Mogadishu on March 23. A humanitarian co-ordinator has been appointed temporarily for three-month.

The heated debate on the resolution highlighted the determination of the United

States to limit U.N. involvement in Somalia to humanitarian concerns, and to tone down any commitment to work towards a political resolution. African members of the Security Council and other African representatives who participated in the debate accused the U.S. of applying double standards with regard to Somalia and Yugoslavia.²³ According to press reports and to diplomatic sources, the U.S. and African members clashed on the issue during the Security Council debate. The Nigerian Foreign Minister, Maj. Gen. Nwachukwu, commented that "Africa must receive the same qualitative and quantitative attention paid to other regions."²⁴ He insisted that the Council "send immediately U.N. observers." Since President Ibrahim Babangida is the current chairman of the OAU, Maj. Gen. Nwachukwu spoke on behalf of the OAU.²⁵

The Administration is anxious that Congress, which has already expressed serious concerns about the cost of peacekeeping efforts in Yugoslavia, El Salvador and Cambodia, will refuse to pay the funds necessary for Somalia. Initially, the Administration justified its political inaction on the grounds that the Organization of African Unity (OAU) had not made any public statements about the war in Somalia. The Secretary-General Salim Ahmed Salim issued a statement on December 18, 1991, condemning the carnage, appealing to the international community to seek a peaceful resolution and offered his good offices for the pursuit of a "framework for constructive dialogue." The Administration then said that it was necessary to act through the United Nations. Once the U.N. began its diplomatic initiatives in early January, the Administration argued that it was important to give the U.N. time and to await until its efforts bore fruit. Now that the U.N. is finally debating the need to combine humanitarian action with important political initiatives, the U.S. has brought up yet another obstacle -- money.

Africa Watch and Physicians for Human Rights are concerned that the U.S., which no longer needs Somalia as a Cold War ally, is avoiding the larger costs associated in the short-term with a U.N. role in stopping the attacks against civilians. The reality is that without a resolution of the conflict, humanitarian assistance will only be of limited value. There will be no end to the fierce fighting which has already claimed so many lives, no possibility of giving the wounded the care they need and providing food for the hungry unless the warring factions are forced to stumble towards a political formula for a peaceful resolution.

²³ **The African members of the Security Council are Zimbabwe, Morocco and Cape Verde.**

²⁴ **Paul Lewis, Security Council Weighs Role in Somali Civil War, The New York Times, March 18, 1992.**

²⁵ **The U.S. was also responsible for watering down an earlier UN resolution on Somalia, sponsored by Cape Verde and adopted on January 23, 1992, so as to downplay U.N. engagement in conflict resolution in Somalia. For details, see News from Africa Watch, February 13.**

Internationally, the U.S. has been in the forefront of encouraging the U.N. to play an increasingly prominent role in the resolution of internal conflicts. There are few countries in the world that need the attention of a U.N. capable of delivering humanitarian assistance and taking bold initiatives as acutely as Somalia. While the OFDA has been generous in the assistance it continues to provide and public criticism of the U.N. by Andrew Natsios was significant in shaming the U.N. into action, the failure to match humanitarian assistance with political leadership condemns the people of Somalia to further despair. Firstly, the U.S. did not make any serious efforts to head off the current disaster. Secondly, it failed to provide the much-needed leadership internationally that would have encouraged the U.N. to act on Somalia much earlier. Today, the very least the United States owes the people of Somalia is not to undermine the efforts of other countries and the U.N. to end their suffering.

Africa Watch is a non-governmental organization created in May 1988 to monitor human rights practices in Africa and to promote respect for internationally-recognized standards. Its chairman is William Carmichael and the Vice-chair is Alice Brown. Its executive director is Rakiya Omaar; its associate director is Alex de Waal; Janet Fleischman and Karen Sorensen are research associates; Barbara L. Baker, Ben Penglase and Urmi Shah are associates.

Africa Watch is part of Human Rights Watch, an organization that also encompasses Americas Watch, Asia Watch, Helsinki Watch, Middle East Watch and the Fund for Free Expression. The chairman of Human Rights Watch is Robert L. Bernstein. Aryeh Neier is executive director of Human Rights Watch, the deputy director is Kenneth Roth, Holly Burkhalter is Washington Director and Susan Osnos is press director.

Physicians for Human Rights (PHR) is an organization of health professionals that brings the skills of the medical sciences to the investigation and prevention of violations of international human rights and humanitarian law. Its acting executive director is Susannah Sirkin and its president is H. Jack Geiger, M.D. PHR works to:

* *Stop torture, disappearance and political killings by governments and opposition groups;*

- * *Report on conditions and the protection of detainees in prisons and refugee camps;*
- * *Investigate the medical and psychological consequences of violations of humanitarian law and medical ethics in internal and international conflicts;*
- * *Defend the right of civilians and combatants to receive medical care during times of war;*
- * *Protect health professionals who are victims of human rights abuses, and Prevent physician complicity in torture and other human rights abuses.*