TIME OUT – THREE MONTHS IN SOMALIA

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THE INTERNATIONAL COMMITTEE OF THE RED CROSS (ICRC)

Henry Dunant observed the plight of the wounded at the battle of Solferino. His reaction to this suffering inspired him to form a committee which ultimately drew up the first Geneva convention in 1864.

The four Geneva Conventions of 1949 have been signed by 177 states. The International Committee of the Red Cross is supported by the National Societies of the Red Cross and Red Crescent and concerns itself with the wounded, the treatment and detention conditions of prisoners of war, political prisoners and civilian victims in areas of conflict. Medical staff are seconded from national societies usually for a period of three months. A mission might take one to any part of the world, either into the area of conflict itself or to a slightly more distant site, where the wounded may have to trek some days before receiving help.

After some years of being ‘on the books’ of the British Society I was given an opportunity to go to Mogadishu, capital of Somalia. The worst of the bloody civil war and crippling famine was over. There remained some interclan fighting and a huge number of chronic limb problems.

SOMALIA

With the exception of some Bantu all Somalis have a common ethnic origin, religion and language. Richard Burton described them as a “fierce and turbulent race of republicans”, going some way to explain Somalia’s violent history. The Somali are essentially a pastoral nomadic people (60 - 70%) and cultivators. The division of land and clans forms six distinct groups with many subclans. The majority of those involved in the continuing struggle in Mogadishu are Hawiye, but it is the subclans, Habar-Gidir, Hawadle and Abgal who are warring with each other. Increasing dissatisfaction with Siyad Barre’s government led to the civil war, halted only by an uneasy ceasefire in Mogadishu, which became divided in March 1992 with those loyal to General Aideed in the south and the forces of ‘President’ Ali Mahdi in the north. During that year a desperately severe famine exacerbated the hardship.

The ill-fated UN mission and the disastrous US-led operation “Restore Hope” in December 1992 did little, despite Somali hopes. Thirty thousand troops were unable to keep peace or to disarm the clan factions, and were not able to protect aid workers.

The ICRC had been active throughout the civil war and famine, and was the only aid organisation to remain in Somalia throughout the whole period. The Somali Red Crescent is the only national body which has remained intact and functioning in the whole country.

The division of Mogadishu into north and south had left the north without a functioning hospital. The ICRC considered many sites (including a ship) to house a hospital service. Eventually a recently built but unfinished prison which provided four wards and a theatre was utilised with little modification. In some ways an experimental venture by the ICRC, the hospital was to be staffed and run by the Red Crescent with the help of a medical co-ordinator and visiting medical teams from the ICRC.

GETTING THERE

The team (myself, a British anaesthetist and three nurses from Germany, Sweden and Norway) met in Geneva to be

![DISTRIBUTION OF THE SOMALIS IN EAST AFRICA](image)

Somalia and its clan distribution

![The famine 1992](image)
briefed. We eventually arrived in Mogadishu in early March 1994 replacing a mostly Finnish team, just as the American forces were pulling out. Arriving at Moga airport by small plane, some two and a half hours’ fight from Nairobi, the scene recalled those early newsreels of the mobilisation of forces for D Day. There were tanks, armoured personnel carriers, guns of every description, huge transport planes and helicopters, many smaller helicopters buzzing like angry flies and troops everywhere. In a small corner of the field, Save the Children, ICRC and Medicos Sin Fronterds transport planes were visible. The light was blinding, the heat blistering and the humidity dense as a Turkish bath – the worst month of the year. Leaving the airport in a fourtrack, Red Cross flag fluttering, we were joined by two guard cars full of very young men all casually draped with Kalashnikov rifles, and chewing qat. The delegation was our next stop, surrounded by high walls and iron gates, manned by armed sentries. This is where the whole operation was conducted from, be it medical, water engineering or famine relief. After a short briefing we reached the residence in the south, a once beautiful villa with flamboyant trees, a courtyard garden with bougainvillaea but full of aimed truck. The owner of the house and their family, beautiful girls in vividly coloured dress, cleaned and cooked and waited. A generator provided electricity for some part of each day and water was brought by tankers. The staple diet was camel, pasta (a residue of Italian colonisation) and fruit.

KEYSANEY HOSPITAL

The next day we travelled north to our base for the next three months, Keysaney Hospital. Drivers from south Mogadishu cannot safely drive in the north and so we entered a Red Crescent dressing station behind walls and iron gates (with the inevitable armed guards) and transferred to a trusty Red Crescent land rover and with our Red Crescent flag flying on we went to Kaysaney. The devastation and destruction of the city was virtually complete. We passed the old port with Arab trading ships and some humanitarian group ships, and continued to the road block on the ‘green line’, manned by Indian and Pakistan Blue Helmets. Once through with many salaaams, and past another two road blocks we entered a curious area by the Indian Ocean where soap stone and gypsum were mined and fragmented using explosives. We finally approached the entrance to Keysaney: high white walls, many Red Crescent flags flying, the prison guards walking on the walls, and the ocean twenty feet away. We first entered a huge courtyard, where we left our guards, and then moved on into a second, equally huge courtyard, with the whitewashed building forming three sides of the square. There were no windows below 12 feet, as befits a prison. We were ushered into the triage tent to meet all the staff – administrators, doctors, nurses, porters, cooks and so on – with speeches by everyone, a part of Somali life, seemingly never-ending we were later to discover. After a quick tour of the hospital we went to our quarters. These were the proposed solitary confinement cells of the prison (it was considered that more than ten men could be fitted in if circumstances required). The dining room was three cells broken into one. A cook, cleaner and washing man were to be our companions during the day.

THE WORK

We had a day or two to get used to the place then work started in earnest. Fighting was still going on in Mogadishu, mostly interclan disputes which provided a number of casualties. Armed robbery and general looting provided more. The hospital also gave what help it could to the local population; burns, mostly to men failing to take the senior wife’s advice on the advisability of having a further younger model, caused by water or boiling oil, caesarean sections, neonatal problems, tetanus, appendicitis and so on. Usually ICRC surgeons have to be generalists but here many of the problems were chronic, such as unhealed and infected fractures: the detritus of the civil war. In war approximately seventy percent of wounds are to the limbs, caused by bullets, mines and flying fragments. The state of the wards and operating theatres provided the first dilemma, neither being suitable for reconstructive surgery. The second dilemma was of technique. Internal fixation was not available and, in any case, totally contra-indicated because of the risk of infection. My first thought was that the best course would be to pack them all up and send them to Europe and the USA. Sooner or later however the situation has to be accepted and so work commenced. In all about 30 bone grafts and reconstructions were carried out including one mandible. Unfortunately time
was too short to see the outcome. Luckily most wounds healed primarily. Most of the reconstructions were performed in the evening when the hurly burly of theatre was over, and the area had had time to ‘rest’ from the infected cases of the morning. I always had excellent support and assistance from the local surgeons, some not qualified doctors, who despite a complete lack of formal training had learnt well the lessons of experience.

On the acute side, our worst night came when two subclans of the Hawiye, the Hawadle and Habir-Gidir, fought pitched battles in the south to maintain control of the jobs at the airport and the UN compound. There were over 50 injured in the triage tent, camp beds everywhere, and all patients with intravenous infusions. Laparotomies were performed first, then the debridements, then, if still alive, the heads explored, galia grafts and so on.

I had been told the Somalis were self-seeking and lazy, but on this night all surgeons and most of the nurses turned out. The autoclave men were there sweating in their laborious task of ‘pressure’ cooking an inadequate supply of instruments on charcoal fires. During our time there a widow who had been sleeping with her two children in the hospital courtyard was given money, clothes and food collected from staff, from the surgeons to the garbage man, for safe passage to the south. Many other examples during our stay dispelled the image of Somalis given at briefings. That is not to say, however, that this excuses violent and often lunatic behaviour. A cholera epidemic had begun and the only water engineer in Mogadishu, an ICRC American, was kidnapped and held for five days.

Apart from the initial fear and apprehension on arrival the only really frightening time for me was visiting a wounded Nepalese soldier, kidnapped and held by gunmen aged eighteen or so. The Nepalese, of all the UN forces, were remarkable in their bravery, patrolling the streets in an attempt to bring peace. This unfortunate man saw his five companions shot dead and was himself wounded and captured. He was moved from house to house, many without water or electricity. An attempt to debride and later suture his wounds by car lights in a street was, to say the least, foolhardy. He was released after two weeks, subsequent to many elders’ meetings and much bargaining. On return to UN headquarters he underwent questioning for hours and only after some days was flown home.

ON REFLECTION

For me the whole experience was invaluable and part of my heart will always be in Somalia. Frustration at not being able to see the outcome of the reconstruction of limbs and great difficulties in acclimatising to the heat and humidity left me feeling I could have done more.

“Was it for this the clay grew tall?
- O what made fatuous sunbeams toil,
To break earth’s sleep at all?”

Futility
Wifred Owen d. 1918

FURTHER READING

1 Surgery for Victims of War Dufour D et al ICRC 1990
2 War Wound of Limb Coupland RM Butterworth, Heinemann 1993
3 Understanding Somalia Lewis IM HAAN 1993