Understanding Complex Humanitarian Emergencies in the Horn of Africa: Causes, Determinants, and Responses

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Abstract
Over the past one hundred years, billions of dollars and countless man hours have been spent on humanitarian relief efforts, yet these humanitarian emergencies are continually occurring, and some at even greater frequencies than ever witnessed before. The contemporary approach to humanitarian aid has, thus far, in many cases, led to little or no sustainable change in the communities of interest. The purpose of this paper is to explore and identify the reasons these emergencies continue to occur, gain an understanding for why many aid efforts have largely been ineffective in the Horn of Africa, and to present alternative approaches to humanitarian aid. To accomplish this aim, a thorough review of pertinent articles and documents outlining the region’s past and present was conducted. The research has highlighted the fact that the complex emergencies occurring in the region today cannot be credited to a single catalyst or event. Those working in humanitarian aid need to make a concerted effort, using evidence based public health, to understand and address these emergencies and all of their driving factors, be they religious, political, climactic, tribal, or any other cause identified.
Introduction
Many situations can be categorized as a humanitarian emergency. Famine, drought, civil war, ethnic violence, and any number of events that place a large number of people at risk can be correctly classified as large scale emergency situations. However, there are occasions when multiple hazards coalesce in a way as to make them difficult or impossible to deal with separately. These “complex emergencies” can involve any combination of the mass displacement of a population, disease outbreak, social or political instability, and food or resource shortages [31]. The difficulties involved in dealing with emergencies of this nature, are what make complex emergencies such a serious concern for humanitarian aid workers. In medicine, to eliminate a disease we must identify what causes, prevents, and effectively treats it. This same model of disease intervention can be applied to humanitarian aid efforts. For this reason, this paper will attempt to identify and explore all variables affecting the present humanitarian situation in the Horn of Africa.

Region and History
The Horn of Africa includes the nations in the eastern most point of Africa. Although, there is some debate over exactly which nations make up the Horn, for the sake of simplicity, this paper will adopt the World Health Organization’s (WHO) classification. The WHO considers the Horn to include Somalia, Eritrea, Djibouti, Ethiopia, Kenya, Rwanda, Burundi, and Uganda [29]. Over the years, many of these nations, like much of Africa, have developed reputations for civil strife and political unrest. When we examine the course of history in the region, it is clear that this area has never been considered a bastion of stability.

Going back to the fifth century A.D, the Aksum Empire, a predominately Judeo-Christian culture, ruled much of what is now Ethiopia with, what was believed to be, the Punt Empire, as a neighbor to the east [11]. As time passed, the empire of Punt gave rise to the Ifat Sultanate, which occupied primarily the same geographic region. This transition was all but complete by the during the twelfth century A.D [2]. However, during the tenth century A.D., the Arabian empire began to work its way into the Horn of Africa. The Arabian Empire establishing trading posts in an area where the Ifat Sultanate would later develop, bringing with it, Islamic culture.

Many factors came together and led to an eventual decline in the strength of the Aksum trade network and economy, and the rise of the Ifat Sultanate and trade network. For example, the continued eastward growth of Christian empires, the comparable westward growth of Islamic empires, like Ifat, and regional angst caused by news of a series of European incursions into the Middle East, in what became known as the Crusades, all created a powder keg waiting for the smallest spark [2]. These early economic, power, and theological struggles would, by the fourteenth and fifteenth centuries, turn into all-out war.

The warring, between wying factions in the region, continued on and off until the late nineteenth century, when both the economic and societal fatigue, caused by prolonged wars and the introduction of European forces, began to show their affects [2, 32]. The opening of the Suez Canal in 1869, which allowed ships from Europe a more direct route to Asia, significantly increased the strategic importance of the Mediterranean area [8], which in turn increased international interest in the region, for both strategic economic and military purposes [16]. By the early 1900s, much of the Horn of Africa was under either British or Italian control [10]. These
two nations partitioned the region into agreed upon colonies and protectorates [19]. While these borders were agreed upon in Europe, this was not the case on the ground in Africa. As the nations in the Horn began to gain independence, by the mid nineteenth and early twentieth centuries, the old land disputes once again arose. Many of these conflicts, which have their roots in battles, began, but not ended in the distant past, continue today.

The Impact of Politics
It has been said that, “public health is politics.” This is has proven to become an incredibly apt statement, when we begin to consider the causes and origins of many complex emergencies. To understand, and confront, complex emergencies we must understand where, how, and why they began. More often than not, complex emergencies are a direct outcome of war, both inter and or intra-state.

Political disputes over land and ideologies led to war between Ethiopia and Somalia, in 1977 [25]. Over the next decade, the military, political, social situation in Somalia quickly deteriorated, culminating in the ousting of the nation’s longtime leader Siad Barre. His overthrow set in motion a series of events which ended in Somalia’s eventual descent into chaos and failed statehood. The state of perpetual war in Somalia has had devastating affects on its people. According to the United Nations High Commissioner for Refugees [28], there are currently 770,154 Somali refugees living abroad, which is the 3rd largest refugee group from one nation behind only Afghanistan and Iraq. The gravity of this number is further emphasized by the fact that Somalia is a nation with a population estimated at just above ten million individuals [6]. In fact, in 2009 alone, 119,000 Somalis, or one percent of the nation’s population, fled the country out of fear for their safety [28].

The majority of those who fleeing Somalia find themselves in Kenya, which hosts the third largest number of refugees in relation to size of its economy [28]. Such massive movement of desperate and poorly supplied individuals has a deleterious impact on the economies, health systems and governments of all nations involved. It has been estimated that the cost of opening a second refugee camp in Jordan, to host refugees fleeing the Syrian Civil War, was $28 million (US), with a monthly operating cost of $140 million [12]. Such massive investments in nations operating with limit budgets can have far reaching effects.

A very similar, yet not as volatile, situation is seen in Eritrea. After Eritrean liberation from Italy, in 1941, the United Nations, led by Great Britain, felt that in order to better safeguard the Horn of Africa from Soviet intrusion, Eritrea should become part of Ethiopia [10]. The UN General Assembly resolution of September 15, 1952 [19], was intended to loosely link Ethiopia and Eritrea, however, Haile Selassie I, then the Emperor of Ethiopia, took this opportunity to change Eritrea’s national language along with their flag, move many Eritrean national industries into Ethiopia, and start a very harsh and brutal campaign to minimize dissention [30]. Needless to say, the systematic annexation of Eritrea was met with immediate resistance and open hostilities. For nearly fifty years, the fighting between these nations continued, until December 12, 2000, when both nations signed a border demarcation agreement [15]. Much like Somalia, the people of Eritrea have borne the brunt of the damage from years of combat. Despite the fact that Eritrea only has a population of close to six million people, giving it the 108th largest population in the world, it was the ninth largest contributor to the world’s refugee population, as of 2010 [26].
The years of corrupt and nepotistic ruling by Siad Barre, in Somalia, created a great deal of resentment and anger in those whom were not in his favor. As displayed earlier, unresolved conflicts and historical wrongs have a way of festering, and growing into resentments so deep they become nearly unresolvable. In this way, blood feuds are born. The decisions made decades, even centuries, ago have created the intractable problems that continue to plague the Horn of Africa today.

Politics is possibly the largest causative factor when it comes to complex emergencies. At times, government officials, in both developed and developing nations, can act in their personal or ideological best interest and not in that of their citizens. Still worse, in cases like the Rwanda genocide of 1994, where an estimated 800,000 Rwandans lost their lives [24], governments can directly work to cause physical harm to their own citizens. In Uganda, the extremely brutal dictator Idi Amin was responsible for the murders of over 300,000 of his own citizens, over the course of eight years [21]. Humanitarian aid workers owe it to the people they seek to help, to consider the political variables of a situation before planning an intervention. Beginning an aid effort without doing so can be counterproductive and even place individuals at risk of greater harm in the long-run.

**Food & Resource Insecurity**

Wars are costly and demanding endeavors. The deleterious impacts of war affect a nation’s economy in a variety of ways. The destruction of infrastructure, the loss of human capital, and the reallocation of funds from development projects to defense spending, all have negative effects on the population. Take for example the nation of Ethiopia. From 1974 to 1990 the nation’s military expenditures increased from an estimated $5.7 million (U.S) to $124.3 million (US) [13]. This reflects a 2080.70% increase in defense spending. During that same time period, Ethiopia’s expenditures on health decreased from 6.1% to 3.2% of nation expenditures [13]. It is estimated that Ethiopia’s conflict with Eritrea, has cost Ethiopia $2.9 billion, between 1998 and 2000 [3]. Between 1999 and 2000 Ethiopia spent an estimated $777 million dollars (US) on defense [3], which was forty-nine percent of their total expenditures for the fiscal year. When compared to U.S. spending during the wars in Iraq and Afghanistan, in 2010, the most expensive year up to that point, the U.S. spent $689 billion dollars on defense, which is a substantial amount, but still only 20.3% of all expenditures [7]. Some nations have been at war for such an extended period of time, that no real development has occurred in decades, as is the case in Somalia. The lack of health infrastructure, government safety nets, and economic opportunities leaves these countries frighteningly vulnerable to economic and environmental shocks.

Refugees are a principally vulnerable population, often living in improvised camps outside of their native communities. They frequently struggle to survive in unfamiliar environments with little to no safety nets and are forced to live in the absence of the social support systems of their home communities. A study of individuals displaced by the Ethiopian famines of the mid-1980’s found that the crude mortality rate (CMR) for those living in the refugee camps was 7 to 10 times higher than what was recorded for locals living in the same region [5]. While we do not possess the technology to completely control droughts and famines, with planning and adequate resources, we can mitigate their harmful sequela. The fact that individuals must flee their
homelands in order to find food and water shows that these nations are not strong enough economically or lack the political will to provide for and protect their people.

During complex emergencies, the problem of malnutrition is of great concern. The Center for Disease control (CDC) found that in refugee populations with protein energy malnutrition (PEM) rates lower than 5%, a CMR of 0.9 per 1,000 population was recorded [5]. However, in camps with PEM rates of greater than forty percent, CMR rates reach as high as 177 per 1,000 population. Although refugees often receive food rations, the limited nutritional makeup of their diets makes them especially susceptible to micronutrient deficiencies. One group of researchers documented an elevated number of scurvy cases, which is caused by vitamin C deficiencies, in Ethiopian refugees hosted by Somalia and Sudan. In their study, scurvy rates were found to be as high as forty percent in some camps [9].

Vitamin A deficiency can be a very serious situation leading to stunted growth, septicemia, exophthalmia, and, in serious cases, death [23]. The CDC reported signs of vitamin A deficiency in 7% of Somali children, in the late 1980’s [5]. The 2011 famine in Somalia put an estimated 750,000 at risk of death by starvation [26]. The serious problems that can arise from food and resource insecurity explain why it is one of the most important determinant to the outcome of complex emergencies.

The ineffective health systems that are usually associated with countries locked in prolonged war and complex emergencies, places their citizens at increased risk of disease and infection related morbidity and mortality. Many diseases that have been eliminated, or largely controlled, in the developed world continue to cause a great deal of suffering in the Horn of Africa. This region of the world is disproportionality at risk of meningitis, diarrheal diseases, malaria, HIV/AIDS, tuberculosis, acute respiratory infections, and polio [2]. Cholera, although preventable through vaccination and improved sanitation, has remained endemic and, at times, epidemic in this region. One of the worst outbreaks of cholera occurred in Somalia, in 1985, when 6,560 cases were confirmed with over 1,000 of those resulting in death [5].

Another important, but often understudied aspect of these complex emergencies is mental health. The atrocities committed in this region scar not only the body, but also the mind. Surveys of Rwandan children, conducted after the 1994 genocide, found that seventy-eight percent of them experienced the death of an immediate family member [1]. This study also found that twenty-five percent of these children spent 4 to 8 weeks hiding alone [1], in order to survive the massacre. Still more horrifying, sixteen percent of the children reported hiding under dead bodies to escape detection [1]. These events would be difficult for any adult to cope with, let alone a child. Unmanaged grief or fear can lead to social and psychological disorders like depression and post-traumatic stress disorder. It is imperative that these societies deal with their grief properly, to avoiding falling into a cycle of despair, resentment, and mistrust that can corrupt a nation. It has been said that, “Man can live about forty days without food, about three days without water, about eight minutes without air, but only for one second without hope” (Unknown author). The psychological impacts of complex emergencies are too important to not be a fundamental aspect of intervention, planning, and emergency response.
Possible Solutions

Contemporary responses to complex emergencies generally follow a uniformed progression, regardless of the intervening organization. The first concern with, many humanitarian responses, is the organized resettlement of the endangered population, in a new and safer area [27]. Once the immediate safety needs are met the provision of food, water, and other essential resources needed to survive becomes the most primary concern [27]. The comprehensiveness of the intervention is generally dependent on the resources available to the organization, and their partners, conducting it. Interventions can be extremely basic, providing only shelter, food, and water. On the other hand, they can be fairly comprehensive, including medical and dental healthcare, reproductive health counseling, capacity building, and mental health programs. The primary, and often only, goal of many complex emergency responses is to limit the immediate morbidity and mortality associated with these events. The thinking behind this model, which we will call the “Contemporary Complex Humanitarian Response (CCHR) model,” is to save lives today and worry about everything else at later date. While the cost of planning for the mitigation of the tertiary consequences of complex emergencies can, understandably, be prohibitive, too often this stage of intervention planning and funding are neglected.

When it comes to the immediate protection of life, well managed, refugee camps do preform admirably. Legros et al. [16] reported administering oral cholera vaccines to eighty-three percent of the population, in a Ugandan refugee camp. This worked out to be 63,200 doses given at a total cost of just over fourteen dollars (US) [16]. While, ideally, covering ninety percent of the population is the goal, significant, population-wide protection has been achieved with the coverage of only fifty percent of a community [17]. A coverage rate of fifty percent would lead to an eighty-nine percent reduction in cholera cases [17]. Even the less grand interventions in refugee camps can have a large impact. Peterson et al. [20] discovered that the simple presence of soap in a family dwelling, regardless of regularity of use, has protective attributes against diarrheal diseases. Dwellings without soap were 1.25 times more likely to have an inhabitant contract a diarrheal disease [20]. It is clear that these interventions save lives. However, to be sure we, as a public health community, are taking the most effective course of action, we must evaluate the costs associated with the interventions we lead.

Although, the CCHR model has been adopted by the majority of humanitarian aid organizations, it is not the only model of humanitarian emergency response. A few researchers have presented the idea of helping by not helping. In their book “Dead Aid: Why Aid is Not Working and How There is a Better Way for Africa,” Dambisa Moyo and Niall Ferguson [18], document the history of international aid to Africa, and the extremely negative effects it can have. Along the same line, Carol Lancaster, in her book “Aid to Africa: so much to do, so little done [14],” outlines how it is possible for corruption and greed to cancel out any positive effects international aid could possibly create. These writers believe that by providing financial assistance to corrupt governments we (western nations) are actually perpetuating all of the events we are working to end. Another problem presented is the direct harmful effects of providing free humanitarian aid (i.e. food, roadway construction). Providing services, free of cost, prevents the local market from being able to compete for the jobs these services create, thus stifling economic growth. These authors have suggested ending, or at the least restructuring, international aid to focus on capacity building and self-reliance.
While the idea of ending international aid is difficult for researchers and public health workers to accept, changes are needed in the way humanitarian emergency response is done. The public health community must always evaluate its work, and perpetually research, to discover the best way to protect the vulnerable populations of the world. Applying the best all-around intervention practices is the only way to bring lasting change to these communities. This cannot do this with closed minds and unwillingness to change. After all, the purpose of any public health intervention is to help. In situations when the evidence may support the theory that the best way to help is by not intervening then, as difficult as it may seem, then the humanitarian aid community is obligated to at least consider the approach. Not helping those in need seems cruel, but may, at times, be the most altruistic course of action humanitarian aid workers can take.

Refugee camps are typically funded and operated either solely, or in large part, by international donors. As stated earlier, many of the nations losing and receiving large numbers refugees are often not in a position financially to fully fund these camps on their own. In these cases removing international funding altogether may be a very undesirable option. However there are still alternative intervention models that can be applied. For example, the Cash on Delivery (COD) model, developed by the Center for Global Development, is structured to link disbursement of donor funds to progress on agreed upon goals [22]. This model is based on four key points (1) payments are linked to outcomes, not input (2) funders are hands off, leaving recipients responsible for outcome (3) high levels of transparency and (4) a wholly independent verification of progress [4]. To elaborate, instead of sending an international organization to into a refugee camp to dig wells, in COD model the donor and the recipient national government would agree on the goal of the provision of safe drinking water to refugees. Once this goal is met, and verified by an independent evaluator, then the recipient government would receive their payment. This model has the benefit of placing the responsibility for the refugees, solely in the hands of the nations directly involved. This has the potential to lead to capacity building and independence.

Complex emergency interventions should be thought of as medical procedures. To elucidate, a surgeon would not begin to treat a sick patient by cutting out and off body parts and inserting surgical implants as he saw fit. He would begin with a painstakingly detailed evaluation of the patient to ensure that the correct procedure is carried out for the patient in question. This all occurs before the first incision is even planned. This same level of planning, evaluation, and intervention selection needs to become an integral part of humanitarian interventions.

Discussion

Humanitarian aid is by no means an easy line of work. Aid workers must willingly go into war zones, disease outbreaks, and remote areas that lack any type of modern luxury. In the spirit of true humanitarian aid, it is time we make the tough choice to honestly and openly evaluate the effectiveness of every project and or intervention without exception. The ravages of unregulated and unevaluated aid have been well documented. Despite billions of dollars in humanitarian aid directed at sustaining and stabilizing the nation, in the late 1980’s, Somalia still crumbled into a failed state, plagued by perpetual combat, suffering, poverty, corruption, famine, disease, and now Islamic extremism. Perhaps there are situations where the CCHR model is inappropriate. For instance, when pervasive governmental corruption, malice, or apathy makes it impossible not to contribute to the harm of the nation’s citizens by intervening, perhaps it is best not to.
On the other hand, not helping is a difficult proposition to accept. This would mean standing aside and watching the deaths of tens of thousands, perhaps millions, of innocent civilians. Not intervening during complex emergencies would also mean effectively eliminating thousands of jobs, currently filled by humanitarian aid workers. No two situations or emergencies are identical. What may work in one instance, may not work in the next. For this reason perhaps the time has come to rethink our approaches to humanitarian response. Future research should focus on evidence-based public health in humanitarian aid and detailed analysis the cost-benefit of interventions (i.e. financial, political, cultural, and future impact).

**Conclusion**

Humanitarian aid workers are directly responsible for adding countless years to the collective lives of at-risk populations. Now, more than ever, complex emergencies pose enormous risks to millions of people around the globe. War, famine, drought, disease, and mass displacement of a population are problems that through determination, research, and effective partnership, we can one day conquer. However, to reach this goal successfully will mean that tough choices must be made in the field of humanitarian aid.
References


