

## Global Health Dr Osman Dar

In recent weeks the tragedy unfolding across the Horn of Africa following prolonged drought in the region has been a prominent news feature around the world. The increased attention has been critical in raising funds for the aid effort and prioritising the disaster in the global conscience.

**T**HE MOST EFFECTIVE STRATEGIES FOR MITIGATING the effects of the drought have not been given sufficient media coverage or discussed critically enough in the public arena. Instead, while important and necessary, the focus has largely remained on emotive pleas for increased aid using graphic images of emaciated African children and wide-angle shots of the skeletal remains of livestock strewn across a barren, hostile landscape. This, unfortunately detracts from a considered discourse on the most effective interventions in the current circumstances and reduces scrutiny of the performance of the primary agencies responsible for coordinating the relief effort.

These concerns are best highlighted in the Dadaab refugee camps, located in the North Eastern Province of Kenya approximately fifty miles from the Somalia/Kenya border and about 320 miles from the capital, Nairobi. The three camps, Ifo, Dagahaley and Hagadera were established in the early nineties following the fall of the Said Barre regime and onset of inter-clan conflict in Somalia. The vast majority of refugees are Somalis from central and southern regions of Somalia. The populations in the camp remained relatively stable from 1994 to December 2006, when approximately 177,000 refugees were accommodated in total. Further political changes in 2006 and 2007 in Somalia led to increased numbers seeking asylum.

With the population of the three camps having recently crossed 400,000 according to the United Nations High Commissioner for Refugees (UNHCR) - the primary agency responsible for overall co-ordination of NGO service provision in the camps - Dadaab is now the largest refugee camp complex in the world. In response to the current crisis, and after much negotiation, the Government of Kenya, as of July 2011, has approved in principle the opening of a fourth camp,

# The Dadaab Camps - Daemons in the Detail



Somali  
refugees  
carry  
firewood  
outside  
Dadaab.



Ifo-2, in an area of land between the Ifo and Dagahaley camps. However, persisting government fears around the new camp becoming a permanent settlement for refugees has meant that as of the end of August the camp has still not become fully operational, with only a trickle of refugees being allowed to settle in it.

## CURRENT CHALLENGES

The paediatric age group continues to be the most badly affected in terms of severe acute malnutrition and global acute malnutrition rates amongst newly arriving refugees. With constant anecdotal reports of children dying and being buried along the route to Dadaab from Somalia, sometimes within a few miles of Dadaab following days of walking, the location of the new camp was an issue of crucial importance. A recently concluded rapid assessment of mortality survey amongst new refugees conducted by the Centre for Disease Control at the Dadaab camps during July and August similarly attests to this concern. The study found a Crude Mortality Rate (CMR) amongst refugees of 1.94 deaths per 10,000 people per day for the time period during their journeys versus a CMR of 0.86 prior to departure - a more than doubling of the risk of death upon undertaking the journey.

One of the most effective interventions to reduce this continuing morbidity and mortality would have been to open a processing centre or camp on the border with Somalia at Liboi, where many of the refugees cross and where they could be registered and provided with initial care and food rations. Inflexibility in UNHCR regulations on the placement of new camps have in part been responsible for such a facility not being established.

Site selection guidelines recommend refugees be “settled at a reasonable distance from international borders as well as other potentially sensitive areas such as military installations.” In practice this translates to at least fifty miles from an international border. While security concerns for refugees and humanitarian workers are legitimate given the conflict in Somalia and the associated rampant lawlessness, the current movement of refugees is being driven primarily by drought and not the fighting.

With many reports of deaths of children and rapes of women occurring en route to the camps within Kenya and the risks of refoulement (forcible repatriation of refugees by the host country) being small, a refugee centre at the border may well have been the best option for new refugees. Furthermore, any risks to humanitarian aid workers for a border camp could have been mitigated by having it run and relief coordinated by a strictly neutral agency with the involvement of a mixture of international and local NGOs acceptable to both parties in the conflict in Somalia.

## EQUALITY IN ACCESS.

The other major area of concern in Dadaab is equity in the distribution of relief aid and service provision within refugee camps and adjacent areas. In the surrounding districts of Dadaab, Liboi and Faffi, the Host Community has also been suffering the consequences of the same drought plaguing the

rest of the Horn.

It, however, does not have equal access to services and relief routinely available to refugees. Healthcare services in the region exemplify these inequalities in aid provision. The three camps are serviced by three hospitals with a total of 320 inpatient beds, three operating theatres, and specialist outpatient services manned by doctors and visiting specialists. A structured referral system for specialised surgery and medical care in Garissa, the provincial capital, and Nairobi is also available to refugees. The Host Community, which is approximately 150,000 strong and of a similar ethnic background to the majority of refugees, only has access to outpatient health facilities within the camps.

The only in-patient hospital service the Host Community has access to is a thirty bed district hospital (open to both the Host and refugee community) with one operating theatre. The most senior routine medical staff providing clinical care at this hospital are two clinical officers - not medically qualified doctors. A single Red Cross ambulance serves all three districts. These disparities are mirrored across other service sectors with old and new refugees having access to free food rations, water, sanitation and housing in an impoverished area where host communities are not routinely provided with any of these services by the government or NGOs.

## DADAAB THE CITY-STATE

Supported almost entirely by international NGOs, a perversely functioning artificial city-state has thus developed where after years of free utilities and services older refugee camp residents have developed successful businesses and even rent out their refugee shelters to newer arrivals or Host community members and who can undercut any Host Community business with lower overheads. Host Community Kenyans often register as refugees themselves in order to avail improved healthcare services and obtain rations when necessary. In light of these circumstances the incentive for eventual repatriation for refugees is minimal, and the drive for more people to arrive in an area of barren land not best equipped for naturally settling such large numbers of people is greater. Current abstractions at Dadaab from the Merti aquifer that provides the groundwater for the region have already led to measurable reductions in both water quality and quantity locally. All this in a town traditionally just one stop on the route of pastoralist, nomadic tribes used to traveling in search of water and fresh pastures for their livestock.

The large collections of food and clothing being organised by longer-term refugee camp residents and the Host Community to help badly suffering newly arrived refugees is inspirational for any witness to the relief effort. Given the generosity of spirit and selflessness on display amongst these groups - people themselves suffering the effects of drought - it becomes even more important that an equitable distribution of relief aid and service is ensured by both international donors and national authorities. Guidelines for the development of refugee camps in the future should necessarily give due consideration to the resource and service

circumstances of local host communities, as well as incoming refugees. This will ensure that equitable provision based on identified need can be ensured comprehensively for both groups.

It is easy to forget in the far removed air-conditioned meeting rooms of global health and development institutions that defining a 'Somali refugee' in the current tragedy, in essence, stems from a British colonial decision to reward a newly fascist regime in Italy with a vast territory extending westwards from an older colonial border - the Jubba River in southern Somalia. In this vast region where national borders are artificial and arbitrary and often divide communities of similar ethnicity, famine and disease have unfortunately remained common calamities. Under such conditions there cannot be any distinction made between 'refugees' and 'host communities' when providing relief.



**DR OSMAN DAR** is a physician and public health specialist working at the Health Protection Agency in England. He recently returned from Dadaab where he carried out an emergency needs assessment as a volunteer for Doctors Worldwide - an international medical charity operating in Kenya.



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