Health and human rights

Chaos in Afghanistan: famine, aid, and bombs

An outbreak of scurvy in western Afghanistan at the beginning of this year was one small sign for aid agencies of the chronic food crisis that risked evolving into a famine. Afghanistan's past 3 years of drought—the worst in 30 years—have been catastrophic in a country where 85% of the estimated 21 million population are dependent on agriculture. Harvests have failed for the third year in a row, livestock have been decimated, and coping capacities are severely impaired by an increase in food prices and the collapse of the rural economy. In Kandahar, southern Afghanistan, rivers that are used as the main source of drinking water and irrigation are totally dry. A progressive decline in nutritional status has been seen since the beginning of the year.

These desperate conditions have forced millions to flee their homes. By late spring 2001, the number of Afghans taking refuge in neighbouring countries had been pushed to more than 4 million, and several hundred thousand more were displaced within the country.

Interviews done with refugees in Iran confirm that conflict, drought, and the food crisis are the main reasons why people flee Afghanistan. Between September, 2000, and mid-January, 2001, Médecins Sans Frontières (MSF) interviewed 570 refugee families in Gulshur (a district of Mashad, northern Iran) and the surrounding townships.[1] Of the 407 who stated why they had come to Iran, 87 (21%) had left because of the drought and 279 (69%) as a result of violence and insecurity. Refugee testimonies tell of arrests, beatings, forced enlistment, torture, lootings, and killings. One elderly man from Bamian, central Afghanistan, had lost his two wives and three sons to the war, and his house had been destroyed by bombing. He finally left Afghanistan when begging for food could no longer sustain himself and his 4-year-old daughter.

Afghanistan and surrounding countries

Aid agencies have found it increasingly difficult to meet Afghanistan's vast medical and nutritional needs. Following the Sept 11 terrorist attacks, the United Nations has massively reduced all aid operations in Afghanistan because of an increased security risk. MSF, who have been working in Afghanistan since 1979, have withdrawn expatriate staff from all but three locations in the north (Badakhshan and Takhar provinces and the Panshir valley), and while local staff continue to work in a further six provinces, many programmes have closed. Getting aid into the country is difficult at best, and in some locations impossible. Almost all aid agencies have withdrawn from Afghanistan to neighbouring countries. Tonnes of food and medical supplies and hundreds of staff are on one side of the border; on the other are millions of people suffering.

Before Sept 11, everything pointed to a worsening humanitarian situation in Afghanistan. The air strikes, lack of aid, and onset of winter will only magnify this catastrophe. The food drops that accompanied the US air strikes on Afghanistan will have done little to help alleviate the food crisis.[2] Airdrops are the least effective way of delivering aid—untargeted and unmonitored aid rarely reaches those who need it most—and the amount of food dropped was insufficient. More seriously, this act has damaged the effectiveness of humanitarian aid. Military involvement in delivering humanitarian assistance can be regarded by opponents as an act of war, and thus aid can be legitimately targeted, and so denied to people in need.[3]

In war, aid agencies depend on their reputation of being impartial and neutral. Access to those caught in war depends on the man with the Kalashnikov understanding—by recognising the Red Cross or MSF logo on the t-shirt—that the worker is not on one side or the other, but is there to provide medical assistance to whoever needs help.

In Pakistan, some United Nations offices, theoretically a beacon of hope for war distressed people, have been looted, sacked, and burnt. Security fears have forced aid agencies not only in Afghanistan but also

Nutritional data

During the first 6 months of this year, MSF collected malnutrition data through rapid assessment (measurement of mid-upper arm circumference) in three provinces of western Afghanistan: Herat, Badghis, and Kandahar.[4] Drought in these areas has caused cereal harvests to fall by 50% in 1999 and 85–90% in 2000, and many livestock have died. Between December, 2000, and July, 2001, children younger than 5 years were assessed during a large-scale measles vaccination programme in Kandahar province, and through random household surveys of villages. More than 10% of people in ten of the 11 areas surveyed were malnourished—an increase since the start of the year.

In May, 2001, a food distribution programme was done in three districts of Kandahar Province: Daman, Maywand, and Panjwai. Prevalence of malnutrition among under-5s was 22% in Damman, and 23·4% in Panjwai, with a modest improvement noted in the summer after the feeding programme. Deteriorating nutritional status was reflected by a 400% increase in caseload at five supplementary feeding centres in these areas from January to July, 2001 (1372–5489 beneficiaries). An outbreak of scurvy in Gulran, Herat Province, in February this year indicated micronutrient deficiency. 155 cases were recorded, indicating an overall prevalence of 3·8%, rising to 9·8% in women of childbearing age. Also reported were increases in malnutrition, diarrhoea, vomiting, fever, typhoid, and suspected malaria and cholera. Health care was a 5–6 h walk away for most people.

in Kashmir, Bangladesh, Indonesia, Kenya, and Somalia to reduce work, depriving many of much needed assistance.

MSF in Somalia is still paying the price a decade later for the confusion between military and humanitarian objectives in Operation Restore Hope. Confusion was created again during the Kosovo crisis by the presence of NATO troops in the refugee camps; the camps were subsequently shelled by Yugoslav forces. When the bombing stops, and humanitarian agencies can move into Afghanistan, how will the warring parties tell them apart from humanitarian bombers?

The military can provide help through, for example, logistical capabilities to respond to natural disasters, and peacekeeping operations to protect civilians. But every time a military party involved in a conflict describes their actions as humanitarian, the definition of this word is eroded. The work of aid agencies can be increasingly frustrated, and civilians be less likely to be treated according to the rules of war that should give protection from aggression and the right to independent assistance.

The vast needs of the people of Afghanistan will only be met by a large-scale independent humanitarian relief effort aimed directly at reaching the most vulnerable. One option could be a response led by the United Nations with a clearly understood humanitarian mandate, in collaboration with independent aid agencies. All parties to the conflict must allow for the delivery of large-scale aid convoys by humanitarian agencies. The Taliban and its allies have the same responsibility towards civilians during war. Aid must get into Afghanistan and must be delivered by people who are not involved in the fighting.

So-called humanitarian airdrops by the US airforce may feed a few people, but they also damage the effectiveness of humanitarian aid in this and other conflicts.

1 MSF report on new Afghan refugees situation in Gulshur town October 2000–January 2001. Paris: MSF, 2001.
2 Khabir Ahmad. Military strikes worsen desperate plight of Afghans. *Lancet* 2001; **358:** 1248.
3 Fiona Terry. Military involvement in refugee crises: a positive evolution? *Lancet* 2001; **357:** 1431–32.
4 Nutritional surveillance, Afghanistan: preliminary report. Amsterdam: MSF, 2001.

Nathan Ford, Austen Davis
Médecins Sans Frontières, 124–32 Clerkenwell Road, London EC1R 5DJ, UK
(e-mail: Nathan_FORD@msf.org)

Internally displaced people—refugees in their own country

In a recent planning document, the UN estimated that 5 million Afghans, including 956 000 internally displaced people, were affected by the humanitarian crisis before the Sept 11 attacks on the USA. According to the UNHCR (United Nations High Commission for Refugees), 387 000 such people were located in Afghanistan's northern regions controlled by the Northern Alliance, 200 000 were residing in the northwestern province of Herat, 200 000 were in southern provinces around Kandahar, 94 000 were in Badakhshan, and 75 000 in Hazarajat region. UNHCR also estimates that before Sept 11, there were 2 million refugees in Pakistan, 1·5 million in Iran, 15 400 in Tajikistan, 8300 in Uzbekistan, and 1500 in Turkmenistan. These figures exclude asylum seekers beyond Central Asia, including about 100 000 in Russia, 36 000 in Europe, 17 000 in North America and Australia, and 13 000 in India.

International Organization for Migration (IOM) has worked in Afghanistan for many years supporting voluntary returns of Afghans from Iran in close cooperation with UNHCR. Before Sept 11, IOM assisted 150 000 people in six camps in and around Herat city who had been displaced by conflict and drought. IOM also assisted 30 000 Afghans displaced by conflict in two camps in Kunduz province, and 42 000 highly vulnerable stranded people in Faryab province in the northwest.

In the short-term, IOM's priorities remain to manage camps for internally displaced people in Herat, Mazar-I-Sharif, Faryab, and Kunduz. The main aim is to deliver critical shelter (blankets, tents, construction materials), food, and other essentials (household fuel, personal hygiene and sanitation items such as soap) before the onset of winter to the camp-based populations of migrants.

Jeff McMurdo/IOM 2001

Building tents in Maslakh Camp, Herat, Afghanistan

As one of about 100 Afghan staff still working for IOM inside Afghanistan, an IOM national medical officer continues to assist in health-related tasks in two main camps in Herat city: Shaydee and Maslakh. His role involves monitoring disease morbidity and deaths based on information obtained from other agencies delivering health services, assessing new health-related needs, identifying gaps in health services with other partners, training health workers and community leaders in delivering health education messages, monitoring the distribution of food, hygiene, and sanitary rations, supervising the installation and maintenance of sanitary facilities, and providing medical support services to families voluntarily returning to their places of origin.

The report compiled from health clinics for the week ending Sept 16, 2001, in Shaydee camp alone, includes over 65 malnourished children admitted to supplementary feeding centres, nine cases of malaria, 275 children receiving oral rehydration therapy, 139 immunisations, and five deaths. Disease morbidity was dominated by diarrhoea and urinary-tract infections, which is typical of the period following the end of the second annual rainy season. It was not possible to obtain more recent health statistics reports after mid-September because of various restrictions imposed by the Taliban on international agency staff. However, most health agencies anticipate a sharp rise in acute respiratory disease in children during the imminent winter months.

Based on a survey in the camps on Oct 11, 2001, IOM's field team in