

Humanitarian Relief in Afghanistan: The Singapore Perspective

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ABSTRACT

Afghanistan is a land-locked south central Asian country with an estimated population of between 21 to 26 million. Years of war and political instability have left the infrastructure of the country in disarray. Economic decline has aggravated the level of poverty. The Afghans are now affected by the fight against international terrorism conducted by the USA and its allies. Armed conflicts within its border have adversely affected its population. After 11 September 2001, an estimated 200 000 more refugees and internally displaced persons fled into neighbouring countries. The humanitarian crisis here is one of the worst in the world. The Singapore International Foundation, together with partner organisations (Singapore Red Cross Society, Mercy Relief/Perdau, Singapore Health Services and National Healthcare Group) mounted several missions in aid of these Afghan refugees. This paper discusses the complexities of the missions, the challenges, as well as the highlights of the programmes undertaken by the Singapore volunteers.

Keywords: Afghanistan, complex emergency, healthcare, humanitarian relief, internally displaced persons, refugees

INTRODUCTION

Afghanistan is a south central Asian country bordering with Pakistan, Iran and the central Asian states of Turkmenistan, Uzbekistan and Tajekistan, in the north (Fig. 1). It is land-locked, with an estimated population of between 21 to 26 million (exact figures are not known). Its capital is Kabul and it comprises 30 provinces. Afghanistan is extremely poor and its economy used to be highly dependent on farming and livestock raising (sheep and goat). There is also cross-border trade in domestic and foreign commodities between Afghanistan and both Pakistan and Turkmenistan.¹

Many years of war and instability have left the country in ruins. The transportation and communications systems, education and agricultural infrastructure are seriously damaged. The economic decline has also exacerbated the level of poverty. A large proportion of the population still depends on food imports distributed by aid communities.^{1,2}

Afghanistan was invaded and occupied by the former Soviet Union in 1979. The latter withdrew 10 years later, but fighting continued amongst the various factions. The fundamentalist Islamic Taleban movement subsequently seized most of the country. The Afghans are now affected by the fight against international terrorism conducted by USA and its allies. The resulting armed conflicts within Afghanistan between the Taleban regime and the coalition forces formed by the Northern Alliance, USA and other foreign forces, have adversely affected the Afghan population, leading to an acute and chronic situation. Over the past 23 years, there have been more than 7.5 million displaced Afghans and refugees in need of humanitarian assistance including food, shelter, healthcare and education. Nearly 20% of those in need are children under the age of 5.³ In the aftermath of September 11, 2001, an additional 200 000 Afghan refugees fled to neighbouring countries. The humanitarian crisis here is described as one of the worst in the world by the United Nations.

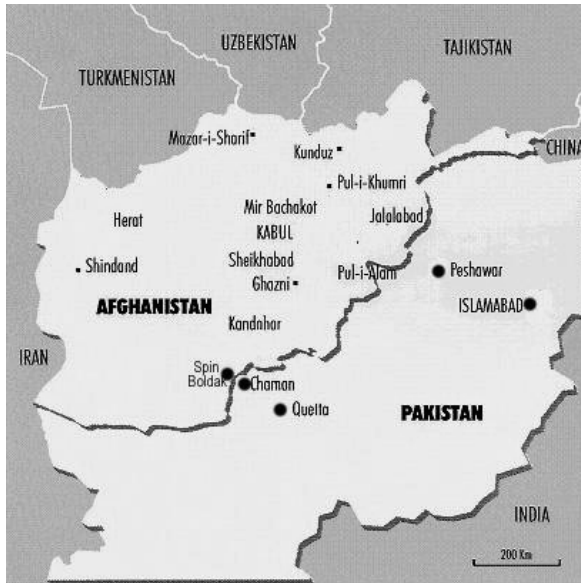


Fig. 1. Afghanistan is bordered by Pakistan, Iran, Turkmenistan, Uzbekistan and Tajekistan.

HUMANITARIAN CRISIS AND RELIEF

“Humanitarian crisis is a term of the nineties that denotes the extreme suffering of tens of millions of people driven from their homes — dependent on humanitarian aid and destitute for lack of shelter, security, food, clean water and basic care. These can be sudden onset events or may last for years of civil strife. The health impact is evident, but not well-studied and documented.”

Gro Harlem Brundtland, M.D, M.P.H
 Director-General
 World Health Organization⁴

The recent events in Afghanistan is a good example of a humanitarian crisis, which is a complex humanitarian emergency, whose origins are political, social and economic.^{2,5} In addition, a devastating regional drought, now in its fourth year, has compounded the crisis by drying up wells, parching agricultural land, killing off livestock, collapsing rural economies, and eventually exhausting the coping mechanisms of many ordinary Afghans. All this results

* According to the 1951 UN Convention Relating to the Status of Refugees, a refugee is a person who, “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country”. Internally displaced persons may have been forced to flee their homes for the same reasons as refugees, but they have not crossed an internationally recognised border. In the case of the “refugees” in Spin Boldak, they are classified as internally displaced persons. However, for the purpose of simplification and expediency, this paper will refer to the Afghan IDPs in Spin Boldak as refugees.

in mass population dislocation, destruction of social networks, civilian insecurity, suffering and abuse of individual rights. Since historical times, civilians have always suffered in war situations.⁶ Only of late has this been given recognition and prominence by the international community. More medical and public health relief workers than ever before are working in extreme circumstances to provide assistance.⁷ Funding for such aid and programmes may come from the public or private sectors. Some examples of humanitarian relief agencies include United Nations Children’s Fund (UNICEF), United Nations High Commissioner for Refugees (UNHCR), International Committee of the Red Cross and Medicins sans Frontieres (MSF). There are also many smaller, national and regional agencies. The relief workers must be made aware of the stress and psychological effects they will experience during the course of their work in these situations. Besides this, they should also be made to understand and appreciate the cultural sensitivities in the part of the world to which they would be posted.⁸

It was in this context that the Singapore International Foundation (SIF), together with partner organisations (Singapore Red Cross Society, Mercy Relief/Perdaus, Singapore Health Services and the National Healthcare Group) considered the feasibility of mounting a Singapore Relief Mission to provide humanitarian assistance to the Afghan refugees (at the Pakistan-Afghanistan border) and internally displaced persons (IDPs).*

SINGAPORE INTERNATIONAL FOUNDATION

The SIF is a non-profit, non-governmental organisation (NGO) founded on 1 August 1991. SIF’s mission is to enable Singaporeans everywhere to think globally, feel Singaporean, be responsible world citizens and foster friendships for Singapore. This mission is realised through 5 core programmes — Singapore Volunteers Overseas, Youth Expedition Projects, Humanitarian Relief Programme, Friends of Singapore and Overseas Singaporeans. Three of SIF’s 5 core programmes (Singapore Volunteer Overseas Programme, Youth Expedition Project and the Humanitarian Relief Programme) enable Singaporeans to volunteer for technical assistance, community development projects and disaster relief assistance abroad, respectively.

SIF established the Humanitarian Relief Programme (HRP) with the specific aim of enabling Singaporean professionals to volunteer their help and services to communities affected by disasters. HRP focuses on



(a)



(b)

Fig. 2. Refugee camps.

acute emergency relief, post-disaster stabilisation and rehabilitation. SIF's role in the HRP includes:

1. Organising and coordinating training to prepare Singaporeans for effective disaster relief work
2. Providing financial, administrative and logistical support for volunteers
3. Gathering various forms of support from local and overseas partners, organisations authorities
4. Raising disaster relief awareness in Singapore

THE ASSESSMENT TRIP

From 10 to 17 January 2002, a specialist team was sent to Pakistan and Afghanistan, to study the situation and ascertain as accurately as possible the pressing needs and subsequently decide on the relief team to send and its composition, as well as the objectives to launch the mission in aid of the Afghanistan's refugees and IDPs. The assessment team had to perform the critical function of information gathering, assessing the severity of the situation at hand as well as the needs of the affected population. This was important in order to ensure the assistance provided would be appropriate and targeted at the most vulnerable groups. The host partner of the SIF was the Pakistan Islamic Medical



Fig. 3. A malnourished infant.

Association (PIMA), a well established NGO that had been operating in Pakistan and Afghanistan for more than 25 years. PIMA coordinates international relief efforts for Afghanistan refugees and it comes under the umbrella of the Federation of Islamic Medical Association (FIMA).

The assessment team led by SIF consisted of medical specialists and full time and volunteer disaster relief workers. The team visited key refugee collection areas such as Peshawar (North Pakistan), Quetta and Chaman (South Pakistan) and Spin Boldak in Afghanistan (Fig. 2). Interviews were conducted with local and overseas NGOs' representatives and other key personnel. Local facilities and resources were also assessed. The following conclusions were reached:

1. The most critical area of need was at the border of southern Pakistan and Afghanistan, ie between the provinces of Balochistan and Kandahar. In particular, the area referred to as Spin Boldak, some 5 km from the border of Pakistan.
2. Food was barely sufficient, despite international relief.
3. State of healthcare was dismal, with minimal primary care, little secondary care and inaccessible tertiary care. The latter may be found in Quetta, a 3-hour mountainous journey into Pakistan.
4. There was a serious need for female medical staff and specialists. In Afghanistan, most of the doctors and medical relief workers are male. There were very few female doctors. The Afghan culture is such that a lady would not allow a male doctor to examine her, even if the problem was serious. Only in extremis, would she agree to this, but even then, not all women would agree to this. Hence, the desperate need for female doctors.

The total number of refugees/IDPs at the Spin Boldak area was unclear but was thought to be between 60 000 to 90 000. The majority were Kutchis, a nomadic tribe, with the Pashtuns being the largest ethnic group. The majority were living in camps run by Pakistani NGOs, Saudi Arabia's World Association of Muslim Youth and other smaller groups. The camps were poorly maintained with very rudimentary sanitary facilities. Food was provided by the World Food Programme but there was no food suitable for babies and infants. As a result, infant deaths from malnutrition was high. Mothers were feeding their children diluted green tea with sugar for lack of milk. MSF would later conduct a measles vaccination programme for the IDPs in Spin Boldak.

The common medical problems encountered included infant malnutrition, respiratory illnesses, gastrointestinal illnesses, anaemia, obstetric problems and trauma-related diagnoses (Fig. 3). Major illnesses with high mortality included measles, malaria, diarrhoeal diseases, cholera, hepatitis, pneumonia and meningitis.⁹⁻¹¹ Pulmonary tuberculosis too continues to be a problem.¹² In leaving their native surroundings, the refugees were often exposed to a variety of new pathogens, introduced new diseases into the areas they entered or were settled in situations where there was overcrowding, contamination and transmission of new agents. As such, the crude mortality rate in these communities was 20 to 30 times higher than that of the adjacent local community or that of the refugees' country of origin.^{12,13}

Ignorance amongst the refugees and their traditional, conservative culture were also identified as a concern. Patients did not understand the nature and use of medications despite explanations, as these were liable to interpretation problems. Translation of adequate "medical quality" was hard to come by. Patients also tended to "clinic-hop" and "doctor-hop" from camp to camp, getting additional medications, which when consumed simultaneously could give rise to drug interactions and overdose. First line medical assistance was provided by Afghan doctors who ran the basic health units (BHU) in each camp. These doctors are all male and had very limited training. PIMA ran a secondary medical centre in Spin Boldak, housing an operating theatre (OT), equipped with basic surgical and anaesthetic apparatus, a paediatric ward, and 15 to 20 beds at any one time. The centre received intermittent power supply from a generator.

The team also looked at the security aspects, knowing that there would be some apprehension amongst volunteers as this was an area which until recently, was



Fig. 4. Sterilisation in the operating theatre.



Fig. 5. Baby and toddler bath programme.

rife with tribal militia, infiltrated by Al Qaeda fighters and subjected to bombing raids.⁸ This mission was going to be one with daunting challenges such as working in a remote area, coping with unstable security situations and limited resources.⁸ PIMA's reputation amongst the locals in the area and with the local provincial authorities on both sides of the border greatly enhanced the security for relief teams. Security guards from the Afghan authorities were stationed at the centre and PIMA vehicles had free access from its base camp in the border town of Chaman, Pakistan, to the medical centre in Spin Boldak. The Spin Boldak area, which was where the Singapore volunteers would be working, was also declared safe by the United

Nations Security Coordinator (UNSECORD). Other security measures would include contingency plans for evacuation in the event of emergencies. Throughout the missions, SIF staff would also maintain contact with UNHCR for regular updates on security issues.

THE SINGAPORE AFGHAN REFUGEE RELIEF MISSION

From 10 March to 12 May 2002, 5 relief teams comprising 41 Singaporean volunteers were dispatched to Spin Boldak. In all they would treat more than 4700 refugees and perform more than 60 minor and major surgeries. The aim of the mission was to provide medical assistance alongside other international NGOs

at the medical centre in Spin Boldak. The Singapore volunteers helped staff the roster of medical doctors and nurses needed to run the medical centre from March to May 2002. The teams focused on 3 areas of assistance:

1. Surgical and Acute Care

General surgeons, orthopaedic surgeons, anaesthetists and scrub nurses ran the operating theatre (OT) at the centre (Fig. 4). This included setting up the operating theatre which until then had not been used as there were insufficient medical specialists and equipment. A local Afghan male nurse was also trained in OT procedures. In addition, orthopaedic surgeons also conducted advanced surgical operations on referred patients at a hospital catering to Afghan refugees in Quetta. There were also general practitioners and nurses who would provide initial care for chronic cases, minor trauma and emergencies. They coordinated a small “emergency room” at the secondary hospital in Spin Boldak. It is worth noting that trauma-related cases were a mixture of conflict-related injuries (mines, Unexploded Ordnance — UXOs), crime-related injuries (grenades, bullet wounds) and numerous car accidents as no car licenses were needed and even young children were seen driving vehicles. The team also encountered a fair number of mental trauma-related cases with patients complaining of musculo-skeletal pains and a few showing symptoms of Post Traumatic Stress Disorder. Interestingly, most Afghan women were receptive towards the male doctors treating and examining them. This could perhaps be attributed to the fact that the Singaporeans were perceived as foreigners and non-Muslims and therefore could not be expected to follow traditional cultural and religious customs.

2. Maternal and Child Health

Obstetric/gynaecology doctors and nurses, paediatricians, a nutritionist and general practitioners took care of deliveries, neonatal care, as well as obstetric and gynaecology emergencies. Mobile runs were also conducted to remote villages in Spin Boldak to provide primary healthcare assistance. The teams also assisted other Asian NGOs in carrying out hygiene programmes for mothers and infants (Fig. 5).

3. Food and Other Supplies

Thirty thousand cans of “halal” certified meat were distributed to the refugees and various

medical equipment and supplies were also provided for the medical centre in Spin Boldak.

CHALLENGES

The teams were located in a base camp in the border town of Chaman, Pakistan and commuted daily across the Afghan border to work in the medical centre in Spin Boldak. Some of the challenges that they faced were:

1. Cultural and Religious Customs

Coming from modernised and westernised Singapore, the volunteers had to face the challenge of working in an Islamic country with strict religious and cultural norms. Female volunteers had to adapt to the practice of constantly covering their heads and necks at all times, except when they were bathing or sleeping. Living and working directly with and alongside local and international NGOs in such close proximity presented its own unique set of challenges involving the fine balance and tolerance of each other’s objectives, methods and styles of work.

2. Community Expectations

The expectations of the refugees receiving medical aid had to be managed as it was often perceived that foreigners would be better equipped and possessed greater ability than the local medical staff. Furthermore, the teams could provide assistance up to the level at which resources were available. Tuberculosis was prevalent amongst the refugees but as treatment required intensive follow-ups and reliable sources of medication, it was not feasible to begin treatment.

3. Personal Comfort

Volunteers worked in harsh conditions where daytime temperatures reached 38°C and sandstorms commonly occurred. In addition, frequent blackouts were common and water supply intermittent. At times, surgeons worked by torchlight when power supply was temporarily cut off. The physical and mental demands on the volunteers were strenuous and most volunteers would encounter bouts of diarrhoea while learning to adjust to the local food.

4. Logistics

Time was needed for members of the medical team to familiarise themselves with medications, especially local medications that differed from

what was used in Singapore, before they could start prescribing them. Shortages and delays in receiving medical supplies were common due in part to inaccessibility and other problems.

5. Security

Team members had to remain vigilant at all times as there were on-going incidents of grenade attacks and bomb blasts from criminal activities in Chaman and Spin Boldak. At times, security convoys were arranged after such incidents took place.

6. Communications

Ground communications was difficult as there were no landlines available in Spin Boldak. Communication between Singapore and Pakistan was also difficult as landlines are extremely limited and unreliable in Chaman. Reception from satellite telephones was occasionally jammed as the activities by the US and its allies to locate Al Qaeda elements continued.

CONCLUSION

The Singapore Afghan Refugee Mission provided civilian volunteers from Singapore a unique opportunity to participate in a multinational humanitarian relief project in aid of a chronic refugee and displaced persons situation, exacerbated by the US war in Afghanistan. The value to the community in receipt of this aid was both in terms of alleviation of suffering through provision of medical services as well as improvement of morale as foreign nations cared sufficiently for them to mount the effort at all. The refugees' needs being endless, the actual aid given might have been a drop in an ocean of need. However, the psychological and emotional support provided by the presence of the overseas volunteers should not be underestimated.

For the mission volunteers, the experience was potentially a life changing one, as all of them came from an affluent modern society and were unfamiliar with both the privations suffered by the Afghans as well as the harsh conditions in which they were compelled to adapt in order to carry out their mission. Many issues of sociology, economy, religion,

culture and global politics were explored by the volunteers amongst themselves while in the field and subsequently upon return home. The volunteers have committed themselves to educating Singapore society about humanitarian needs of the world, through exhibitions, talks, media articles and personal testimonies. They are also committed to helping to build up the corps of humanitarian volunteers in Singapore through participation in the training process put in place by SIF. Such engagements strengthen civil society, spread an attitude of compassion and build the soul of the nation. This benefit to a community that engages in such relief work cannot be understated.

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