

Emerging Issues in Afghan-Iran-Pak (AIP) Border Areas: An Overview

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ABSTRACT

In my present paper I would focus on Emerging Problems in Afghan-Iran-Pak Border Areas: An Overview. Hundreds of years, people in the AIP region (the Afghanistan-Iran-Pakistan borders) have been challenged by conflict and political and civil instability, mass displacement, human rights abuses, drought and famine. Given this sad history, it not surprising that in this region health and quality of life of vulnerable groups are among the worst in the world. In spite of national and international efforts to improve health status of vulnerable populations in this region, the key underlying socio-cultural determinants of health and disparities, i.e. gender, language, ethnicity, residential status, and socio-economic status (SES), have not been addressed or even systematically studied, nor have their relationship to environmental challenges. Overall, the health problems faced by this underdeveloped region can be categorized into those resulting from lack of essential supplies and services, as well as those stemming from the existing cultural practices in the area.

Key Words: Border, Human Rights, Health, Gender, Language, Ethnicity, Security.

Introduction

Thinking in public health has moved beyond the physical, biological, behavioural, and environmental causes of disease to embrace the relationships between health and social context: i.e., poverty, gender, culture and ethnicity. Social, political, economic, cultural, and environmental factors are important in understanding community health status, and in demonstrating often underlying health disparities among different sub-populations. To date, knowledge of such health determinants and disparities mainly reflects the interactions of socio-economic factors and health in developed countries, and may not necessarily be reflective of these in less-developed nations, as interventions using such knowledge have not been extensively studied in developing countries and particularly in highly vulnerable communities within these countries. Moreover, information that is available, both from within and outside the health sector, is often not effectively utilized. These gaps in knowledge are themselves a

reflection of the broader “10-90 gap” wherein 90% of the world’s health research dollars are devoted to 10% of the burden of disease in more developed countries.

With increasing globalization has come the increased recognition of the importance of addressing health disparities globally, as evident in the report of the Commission on Macroeconomics and Health. Following a widespread decline in institutional commitments and funding for development and research into correcting global health disparities in the 1990s, positive developments have been emerging. A particularly encouraging step in this regard has been the Global Health Research Initiative in Canada, whereby the Canadian Institutes of Health Research (CIHR), the International Development Research Centre (IDRC), the Canadian International Development Agency (CIDA) and Health Canada have agreed to a strengthened and coordinated funding of health research into correcting global health

disparities. Thus, in preparation of a proposal to the Canadian global health funding agencies for implementation and evaluation of an evidence-based intervention, we reviewed current health literature, official documents, and other information (e.g. UN agencies reports) related to the social, cultural and environmental factors that may influence the health outcomes of subpopulations living in the AIP region, as well as interviewed individuals who had recently worked in this area. The objectives of this article are to summarize existing information regarding the socio-cultural, environmental and traditional determinants of health disparities among different populations groups in the AIP region; identify the gaps in relevant research regarding the communities' needs in the region; and highlight factors of importance in developing future health intervention studies in the region.

Geographic and linguistic setting

The three countries of the AIP region share a long border along which people share similar cultures, language, and customs. This region is home to approximately 4 million people, of whom 1.5 million are Afghani, 2 million are Iranian, and 500,000 people are Pakistani. The border provinces include Harat, Farah and NimRoos in Afghanistan; Sistan-and-Baluchistan and southeast Khorasan in Iran; and Baluchistan in Pakistan. The region has two main local languages (Baluchi and Dari), shared across the national borders. Baluchi is a modern Iranian language of the Indo-Iranian group of the Indo-European language family. Baluchi speakers live mainly in an area now composed of parts of south-eastern Iran and southwestern Pakistan, once the historic region of Baluchistan. They also live in Central Asia and southwestern Afghanistan. It is estimated that over six million people communicate in Baluchi today.

The other common language is Dari, the Afghan dialect of Farsi (Persian) and of the Iranian branch of the Indo-Iranian family of languages. It is written in a modified Arabic alphabet, and it has many Arabic and Persian loanwords. Over two million people in the borders of Iran, Afghanistan, and Pakistan speak Dari today. There have been some attempts, particularly by international agencies and NGOs, to modify individuals' attitudes and behaviours, using the official languages of Farsi, Pashto, and Punjabi. The problem identified by many researchers was that health education materials and schoolbooks provided by these agencies are based on official languages in each of the three countries, while most people, particularly women, communicate in either Baluchi or Dari, such that their limited knowledge of the official languages and low literacy levels may be a barrier in communicating health issues with them effectively. This has an immediate impact on their own and their families' health, particularly children's quality of life, as it is the women who mostly visit health clinics and health houses alongside their children to receive primary care services or attend health education classes.

Health and education in the region

Despite a long history of providing health education, as stated before, because of using unfamiliar languages to provide educational materials and also the low literacy levels of people, these efforts have not been successful. There are some reasons for observing little progress in spite of recent national and international efforts in the region in terms of behavioural and attitudinal changes. Among them are most international NGOs deal with disaster relief and humanitarian aid activities, rather than addressing real needs of communities. These NGOs are worked under the control of central governments in the involved countries, although they are

independent international agencies. In this region, the central governments historically ignored local communicating languages for many years due to political, social, and economical issues. These rules and mandates influenced the international NGOs' activities as well. Most often health education materials are produced by local health departments funded by an international NGO. These government-run facilities should fulfill the central governments' mandates and rules about producing health materials in official languages. Participatory programs are not a policy of choice nor practiced by local and central governments. Iran plays a dominate rule in providing health services in the region, and they mainly produce health education materials in Farsi. In the best case of scenario, the major goal of International NGOs is to ensure that local schools stay open, and to provide equal opportunity to schooling for boys and girls.

While providing basic education is still a major challenge for AIP region, no attempts are made to provide adult education for older family members in the community. By law, the language of school system is the official language communicated in each of the three countries, and thereby health education materials are also produced in official languages. Most local women's literacy levels are low and have limited capacity to receive proper training by an international NGO. Therefore, non-local volunteers or paid staffs take charge of educating local communities and producing health education materials, which in most cases are developed in official languages. Perhaps one of the most important problems of language-fit by international NGOs is the short lifetime staying in the region, as well as the costs of learning new languages by their staffs.

The short stays not allowing them to learn and communicate effectively the local languages or train and involve local women in their programs. Some of the staff of an international aid agency in the border between Afghanistan and Iran who were interviewed recently by the authors indicated that although there was so uncomfortable, the shower leaks, the generator is noisy etc., but Dari was quite easy to learn, and a few sentences or greetings helped them to win many hearts, both at work and in the street. The most challenging part of their stays in the region, as they indicated was failure to communicate properly with people, particularly with women, who traditionally not allowed contacting with foreigners, in particular with men. The lack of progress in the region might be also related to the international NGOs failure to contribute effectively into the region's development, although most foreign agencies or international NGOs state that they are there to make a difference and to help the marginalized people. Local people and community leaders, however, believe that these agencies are not there to learn about the culture or people of the region and to apply their new knowledge into their programs. But, they are there to complete their projects, tasks and mission the corruption and nepotism within some aid agencies in the region have also added to these beliefs. In addition, the magnitude of inequalities in the region and the inability of international agencies to do anything concrete about it 45 is another reason for such attitudes against foreigners by local community.

Environmental issues

Water supply is a major challenge in the region, due to five consecutive years of drought, dry lands, and lack of natural water resources. This is a problem particularly affecting women, as they are mainly responsible

for collecting and providing clean water for the family. Sometimes they have to travel for kilometres and stand in daylong lines to obtain clean drinkable water. The only natural waterway in the border region of Iran and Afghanistan is the 'Hillman River'. Its flow to the border area was blocked from the Afghanistan shore during the Taliban era. This blockage has caused tremendous environmental and climate changes in the region, specifically in the provinces of Sistan-and-Baluchestan in Iran, and NimRoos and Farah in Afghanistan. There is no other natural waterway between Iran and Pakistan or between Afghanistan and Pakistan borders. Due to lack of adequate water resources and also traditional unhygienic practices among different population groups in the region, i.e. using open fields for sanitation and cooking habits.

Health Status in the Region

In general, almost all reviewed reports and documents demonstrated that women and children are the most vulnerable populations in the AIP borders. As we can see from, maternal and infant mortality rates are high, especially among Afghani refugees. Many studies have linked these problems to lack of maternal and childcare, as well as inadequate first level referral centers in the region. Of the three countries, Iran has the lowest infant mortality rate (IMR) and under-five mortality rates (U5MR), peaking at 35 and 46 per 1000 live births, respectively. In Pakistan, a country where the status of children is terribly low- especially for female children- the IMR is 84 per 1000 live births and the U5MR is 109 per 1000. The situation in Afghanistan is even more alarming, with an IMR of 165 and a U5MR that soars to 257. The statistics for the these individual countries, however, do not compare to the dire state of the AIP region, where one-fourth of children die within their first year, and half die before the age of five,

mainly due to respiratory tract infections and severe diarrhea caused by the existence of chronic malnutrition. UNICEF, UNFPA, and UNESCO have conducted different need assessments in the AIP region, and report excess mortality and morbidity rates among children who live with their parents at the border areas, particularly among female children.

Food security, literacy, socio-cultural and gender issues

Literacy: In this region, males are more likely to attend schools, while females have limited access, specifically to high school and post-secondary education. Many governmental and non-governmental documents indicate that; "most children had dropped out, because there were no schools, or they were too far away." There are a number of reasons why hundreds of thousands children in AIP region would continue to miss out on education, including difficulties getting to schools, a lack of teachers, and families feeling that it is more beneficial for their children to work than go to school. One major reason for keeping girls out of school is remaining conservative opposition at home and in community towards females attending classes. Oxfam's study in year 2001 indicates that more than 85% of the Afghani women have never been to school, and in other reports, only 5 to 10% of studied Afghan women and girls could read or write. Given this scenario, literacy in the region is poor and female literacy, in particular, needs extraordinary efforts to improve. Even among educated women, there is discrimination against females in employment and wages, and acts of harassment occur even in more developed urban areas. Overall, the priority for hiring and promotion is mainly given to males, even in the face of equal educational and experience qualifications.

Food Security: The UN Food and Agricultural Organization (FAO) has established a food and

nutrition monitoring system in South Asia, and has identified Iran, Pakistan and Afghanistan as having moderate to severe undernourishment, stunting, and wasting among children under the age of five, specifically among females. In a recent report, the UN stated that “in times of diminished food resources, girls and their mothers are often last to be fed, resulting in a diet low in calories and protein.” Food insecurity and health threats are likely to increase even further in designated camps for refugees. In most refugee camps in the region, old women and young girls as well as families whose males have died or injured in war or conflicts have further problems due to discriminatory attitudes and ignorance.

Human rights: Young girls have little authority to select their own husbands: the senior male family member (father, brother, or grandfather) selects a spouse, with different political, economical, and tribal affiliations taken into consideration. Family and tribal intermarriage is very common, which may lead to different genetic and family-related health problems. Only men have the right to divorce, and are allowed more than one wife. This has led to many suicide attempts among young women who have no other choice to end their unwanted marriage. Discriminatory cultural-behavioural practices at home and in the community have caused severe developmental health and social disparities between children and adults, between males and females, and between boys and girls in the AIP region. Overall, the low health status of people, particularly women and children, in the AIP region as the official reports and other documents revealed is associated with poor hygiene, low literacy, and lack of access to healthcare services, cultural and traditional practices, stereotyping and discriminatory attitudes, and environmental concerns. In spite of local and international efforts to

improve the status of women and children in this area, and a general concern for their education, health, and quality of life, marginal improvement has been reported in the past decades in terms of reduced gender inequalities and health and social disparities. To compound the problem of identifying effective strategies is that there appears to be wide gaps between the statistics provided by health officials in the region and the real health needs of the sub- populations.

Religion: The dominant religion practiced in the area is Islam, which is associated with gender-specific beliefs and customs. Examples cited in the documents reviewed include issues of gender inequality; lack of access to education, particularly for girls; traditional health practices; and marriage customs. In general, the status of women and children, particularly girls, in the AIP region is significantly worse than that of men and boys. In most cases, men have the dominant role in governing the communities, both politically and socially. And there is a largely under-realized potential capability among women in the region to take charge of community activities, including environmental and health-related issues. Women have the dominant role in feeding the family (purchasing, handling and preparing foods), water collection, and taking care of elders and children’s health. They participate in health-related meetings and classes, e.g. family planning and health education, alongside their young children. Priority in most cases is given to boys, e.g. high nutrient foods, the better place to sleep, better clothing, higher emotional support, etc.

Security Issues in this Region

The basic problem is well known Iran accuses Pakistan of allowing its territory in Balochistan to be used to destabilise the Sistan-Baluchestan region in Iran though the

Iranians usually make the connection to foreign (read Western) intelligence services operating in the Balochistan and southern Afghanistan region. Yet, the problem is much wider than what Iran often claims and not necessarily uni-directional. The porous Iran-Pakistan border that runs over 900km is a magnet for smugglers of humans, drugs and petroleum products criminal elements and even militants. While Iran has invested more than Pakistan in shoring up its border controls, security officials here have privately over the years suggested that Iran is not above interfering in Balochistan and southern Afghanistan, especially given the Shia Hazara population in the region.

Identifying the problem though does not mean that either side has been particularly keen on solving it not that cross-border movements in remote regions can ever really be fully eliminated, especially when there is a significant financial incentive. But surely, given the alarming potential for friction that exists on the Pak-Iran border, it is in the interests of both sides to go beyond diplomatic barbs and systematically diminish the threat. The Pak-Iran relationship has over the years been characterised by coolness towards each other, not just because of Pakistan's closeness to Saudi Arabia and its relationship with the US, but also because neither country's leadership has been willing to think in creative or innovative ways to improve ties. The physical links that the IP gas pipeline, surplus electricity supply from Iran to Pakistan and higher volumes of official trade would create could help make ties mutually beneficial and move them away from the present security-centric character. But for that to happen the leadership on both sides would need to show greater vision.

Afghanistan is the world's largest cultivator and supplier of opium (93 percent of the global opiates market). According to the

Afghanistan Opium Survey 2008 by the UN Office on Drugs and Crime, opium cultivation in the country is no longer associated with poverty. The report notes 98 percent of all Afghanistan's opium is grown in the seven provinces in the southwest where there are permanent Taliban settlements, and where organized crime groups profit from the instability. "Since drugs and insurgency are caused by, and effect, each other, they need to be dealt with at the same time--and urgently," it asserts. The Pashtuns and Balochi's gain much of their income from cross-border smuggling, says the USIP paper. Thanks to the largely porous border and people from similar ethnic groups straddling both its sides, "the borderlands already have become a land bridge for the criminal (drugs) and criminalized (transit trade) economies of the region." The trans-border political and military networks between the two countries are reinforced as well as funded and armed by criminal activities such as trafficking in drugs, arms, and even people. "The long history of each state offering sanctuary to the other's opponents has built bitterness and mistrust." - United States Institute of Peace.

Conclusion

Government officials, international agencies and others in the three countries involved are investing considerable efforts to improve the health and well-being of people in the marginalized communities in the AIP border area. Little progress, however, has been observed so far regarding improvements in gender equality and reducing health and social disparities in particularly vulnerable sub-populations living in this disadvantaged region. There is a need to study the impacts of underlying socio-cultural and environmental determinants, i.e. gender, language, ethnicity, residential status, and socio-economic status (SES), on sub-populations social and health disparities in the AIP region,

in order to better designsustainable and effective programs. Broadly speaking, the objectives of programs aiming to improve the health and social status of vulnerable groups in this region should fall into the following four categories: Health Care establishing and operating affordable primary and emergency health care services, accessible by vulnerable people, primarily women and children. This will minimize the burden of morbidity and mortality from both communicable and non-communicable diseases among marginalized populations. Education and Empowerment: supporting school and other literacy programs for all, particularly for women and young girls, to reduce illiteracy in the region. This would empower young women to build sustainable livelihoods and could narrow the gender inequality in the region. Awareness: conducting local campaigns and forums to build community capacity and to increase public awareness on community health, human rights, and relevant issues. More familiar and appropriate language(s) and culturally sensitive and accepted methods must be applied. Sustainable Development: planning and conducting longer-term programs to build and strengthen the community infrastructure in the region. Addressing the impacts of the environmental, social, economical, and cultural determinants of health would facilitate community development in the region. Particular attention should be paid to the factors affecting women and children's health and the traditional practices that may promote gender inequality in terms of health, education, wealth, and decision-making. In conclusion, the people in the AIP borders need health care services and culturally appropriate awareness campaigns to improve women and children's health and programs to help children, especially young girls, to find new opportunities for education. More research is

needed to determine and measure the impacts of underlying cultural and traditional factors that can be modified to promote the empowerment of women and facilitate sustainable changes needed to support health.

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