Afghanistan’s Human Security Crisis: Understanding Violence as a Health Epidemic

Ayesha Quraishi

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Afghanistan’s Human Security Crisis: Understanding Violence as a Health Epidemic

Abstract
After the Soviet invasion of Afghanistan, Afghanistan experienced new forms of conflict that the models of state behavior during the Cold War could not entirely explain. The (in)security observed in Afghanistan and other underdeveloped countries inspired scholars to de-militarize security studies and explore different paradigms of security. Human security, unlike national security, conceives violence as a threat to the individual. In public health studies, violence is a disease that behaves like an infectious disease. Freedom of health is essential to human security because the paradigm is centered on protection and empowerment of human beings. In this thesis, I demonstrate how the environment of violence in Afghanistan affects the health of Afghan people and behaves like a disease itself.

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LAKE FOREST COLLEGE

Senior Thesis

Afghanistan’s Human Security Crisis: Understanding Violence as a Health Epidemic

by

Ayesha Quraishi

April 19, 2019

The report of the investigation undertaken as a Senior Thesis, to carry two courses of credit in the International Relations Program

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ABSTRACT

After the Soviet invasion of Afghanistan, Afghanistan experienced new forms of conflict that the models of state behavior during the Cold War could not entirely explain. The (in)security observed in Afghanistan and other underdeveloped countries inspired scholars to de-militarize security studies and explore different paradigms of security. Human security, unlike national security, conceives violence as a threat to the individual. In public health studies, violence is a disease that behaves like an infectious disease. Freedom of health is essential to human security because the paradigm is centered on protection and empowerment of human beings. In this thesis, I demonstrate how the environment of violence in Afghanistan affects the health of Afghan people and behaves like a disease itself.
To my family, for their unwavering support and love. They instilled in me their values and principles that have kept me grounded in my faith, culture, and education.

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To the people of Afghanistan, who embody resilience, strength, and steadfastness amidst calamitous circumstances. I wrote this thesis under a roof of peace and security I am prescribed to as an Afghan-American. I hope I can contribute to the healing of this inspiring population who make me proud to call Afghanistan my motherland.
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# TABLE OF CONTENTS

Chapter 1: Introduction to senior thesis in international relations ............... p. 1

Chapter 2: Sociopolitical history of violence in Afghanistan ...................... p. 4

Chapter 3: Human security of Afghanistan .............................................. p. 39

Chapter 4: Afghanistan’s health and human security ............................... p. 62

Chapter 5: Infectious disease model of violence in Afghanistan ................. p. 85

Conclusion .............................................................................................. p. 107

References .............................................................................................. p. 108
Chapter 1: Introduction to undergraduate senior thesis in international relations

This thesis explores the relationship between Afghanistan’s environment of violence and how it affects the population health of Afghans. The relationship is determined using the human security paradigm of security studies in international relations. After the Soviet Union withdrew from Afghanistan in 1989, Afghanistan emerged as an underdeveloped country with new forms of violence that traditional paradigms of security studies could not describe. Figure 1 illustrates the sociopolitical history of violence in Afghanistan and how violence has caused generations of Afghans to live in an environment of insecurity.

Figure 1. Contagion of violence in Afghanistan through images obtained from the International Committee of Red Cross archives. (A) The Samarkhel refugee camp in Jalalabad during the 1992-1996 Civil War between ethnic factions. The photo was taken in 1994. During the Civil War, there was an atrocious level of violence between the different Mujahideen factions and thousands of Kabul inhabitants were displaced to Jalalabad because of the violence. Samarkhel was the largest refugee camp, housing nearly 30,000 internally displaced Afghans from Kabul. (B) When the Taliban regime was taken down by U.S. led NATO forces, refugees in neighboring countries, namely Pakistan, came back to Afghanistan after decades of being displaced. They came back to a land that was completely different to what they left, and in Kabul, they set out to rebuild their homes. Photo was taken in 2002. (C) Amputated boy in front of Buddhas of Bamiyan in 1995. Civilians are often caught between infighting and, as a result, become disabled. The Buddha statues were some of the greatest archaeological treasures in the world, originating in the 4th or 5th century. In 2001, they were blasted by the Taliban as revenge from the West for refusing to recognize their government. (D) Widowed women
are lined up in front of an ICRC distribution center to receive services. The photo was taken in 1998, which was during the Taliban regime. During the Taliban regime, the support for widows and disabled people was left entirely on the shoulders of NGO’s like ICRC. (E) U.S. C-Company searching a village in Zabul province for Taliban in 2004. The U.S. invaded Afghanistan in 2001 to overthrow the Taliban government and establish security in the region. Adapted from: Picture section. (2011). International Review of the Red Cross, 93(881), 161–171. Retrieved from http://10.0.3.249/S1816383111000178

The human security paradigm emerged during the post-Cold War period because of scholars’ realization that social, political, environmental, and cultural developments must be considered with the same weight as military power. Health is one such phenomena; emerging infectious diseases like HIV/AIDS and Ebola during the post-Cold War period forced the international community to consider disease as a national security threat. After the Taliban regime, Afghanistan had some of the worst mortality rates in the world (maternal: 16%; infant: 16.5%; child: 25.7%) (Newbrander et al., 2014). Most haunting is that access to healthcare services was limited to 10% of the population (Newbrander et al., 2014). According to Acerra et al. (2009), there are only 6,000 physicians and 14,000 nurses in a population of 28 million people.

In 1996, the 49th World Health Assembly (WHA) adapted Resolution WHA49.25, which recognized violence as a major and growing public health problem across the world (Krug et al., 2002). The WHA assigned the World Health Organization (WHO) the responsibility for leading and guiding states to develop programs that prevented self-inflicted and violence against others. Public health is an interdisciplinary and science-based study that requires cooperation between various structures to develop solutions for emerging diseases, conditions, and structural disparities affecting population health. At the international level, non-governmental organizations (NGOs) play a significant role in underdeveloped countries. For example, Afghanistan’s Basic Package of Healthcare
Services (BPHS) relies on NGO’s like the World Bank and International Committee of the Red Cross for funding and services. Further, rapid regime changes and conflicts in Afghanistan forced NGOs to work independent from the government until recently, which led to an uncoordinated and unfocused health sector.

I argue that disease is also a human security threat. More specifically, violence is a human security threat because it is an infectious disease. For the past four decades, Afghanistan has been plagued by violence and it has deteriorated the human security of the population by impacting their health and spreading more violence over time. My research questions that helped me develop this argument are the following:

Why is a human security approach appropriate in Afghanistan? How does violence spread?

How does violence affect the population health of Afghans?

How does human security theory ameliorate the contagion of violence in Afghanistan?

By answering these questions, this senior thesis in international relations demonstrates that violence is a preponderant threat to human security in Afghanistan.
Chapter 2: Sociopolitical history of violence in modern Afghanistan

“There is nothing the community can do. We are caught between both sides. And so we pick sides. Half of us support the government, half of us support the Taliban. The middle people will not survive. You have to pick a side or you will be the first to suffer and you will not have anyone to help you. The people in the middle are in danger from both sides.”

—Male, 48 years, cook and farmer, from Dasht-e-Archi district, Kunduz province (Carthaigh et al., 2015).

Abstract

Afghanistan has historically been a highly decentralized and tribal nation-state. The first sense of unity among Afghan people came during the Anglo-Afghan wars of the 19th century, during which the fragmented, tribal society joined hands and actively participated in the defeat of a foreign power. This period also marked the onset of the Durand Line dispute between Afghanistan and Pakistan, which has divided indigenous Pashtun tribes and set the geographical domain of insurgent operations in the late 20th and early 21st century. Afghanistan experienced relative peace after the Anglo-Afghan wars until the Soviet invasion of Afghanistan in 1979. Rubin (2013) argues the Soviet-Afghan war brought an intensity and scope of violence that was not seen since the 19th century. This proxy war between the United States and Soviet Union produced a power vacuum in Afghanistan that is an ongoing legacy of the Cold War. Between 1992 and 1996, insurgent groups thrived and a most abhorrent, ethnically-driven form of violence occurred. Further, the geography of war in Afghanistan transformed from the countryside into major urban centers. This period of civil war ended in 1996 by the Taliban, a southern movement of Pashtun men who sanctioned an austere version of Islamic law onto the Afghan population. Although they successfully centralized the Afghan government after decades of conflict, their regime was notorious for human rights abuses and hosting al Qaeda while Osama bin Laden planned the September 11, 2001 attacks
against the United States. In response to the September 11 attacks, the United States invaded Afghanistan and started their ongoing War on Terror. Operation Enduring Freedom was fully implemented when U.S.-led N.A.T.O. forces signed the Bonn Agreement in 2001. This chapter provides a historical background on the sociopolitical events crucial to understanding the epidemic of violence in Afghanistan.

**Figure 1.** Map of modern-day Afghanistan and its geopolitical position. Geographically, Afghanistan is in Turko-Persia, acting as a buffer state between the Middle East, South Asia, and East Asia. Politically, its position has juggled between South Asia and the Middle East in because of events discussed further in this chapter. Notably, Afghanistan has historically acted as the gateway to the Indian subcontinent for Russia. The four major urban centers of Afghanistan characterize the geopolitical regions and sociocultural areas within the nation-state. The proximity of these major urban areas to international borders is important when considering the exodus of Afghans to neighboring countries during war and conflict (see Fig. 2). Adapted from: Barfield, T. J. 1950-. (2010). Afghanistan: a cultural and political history. Princeton: Princeton University Press.

**Introduction**
The security situation in Afghanistan today requires a thorough understanding of both international and internal events that have taken place in the 19th, 20th, and 21st centuries. Since the 19th century, international wars between Russia and other great powers took advantage of the geopolitical position of landlocked Afghanistan (Figure 1). The legacy of these wars has worsened the internal security situation of Afghanistan, although Western and regional powers have gained relative power over the destabilized state and over each other. Afghanistan’s distinctive location in Turko-Persia reflects its historical experience as a landlocked country caught between dueling empires’ imperial pursuits. According to David Seddon (2003), Afghanistan today is divided into three geographical areas, the central highlands (e.g. Hindu Kush mountains), fertile northern plains, and desolate plateau in the southwest (p. 176). Southcentral Asia is the crossroad between East and West, where great powers such as Alexander the Great and Russia have attempted to conquer the region to ensure their access to China, India, or Persia. By the end of the sixteenth century, there were at least twenty languages spoken in Afghanistan which is the direct result of the many peoples from different linguistic groups that have passed through and settled in the region (Seddon, 2003, p. 177). Afghanistan’s rich cultural, social, and economic history is often ignored in today’s discourse about its status as a failed state.

For example, most refugee crises across the Islamic world stem from extremist terrorism, but assuming that all underdeveloped Muslim societies have fundamentally similar cultural, religious, and political history is deceptive and removes Afghans from their own rich history (Barfield, 2010). In addition to insurgent and U.S.-led operations in southern Afghanistan, the recent droughts affecting that region has displaced hundreds of thousands of rural Afghans and forced many farmers to cultivate opium, which finances
the Taliban insurgency prominent in that region. The Afghan refugee crisis today has a mixture of causes, including, but not limited to, Islamic insurgency, climate change, and lack of economic opportunities. Contextualizing the refugee crisis within the history of Afghanistan sheds light onto the interconnectedness of institutions and regimes, as political institutions are deeply rooted in Afghan cultural norms and social organizations (Barfield, 2010, p. 17).

In order to understand how violence has spread in Afghanistan, one must understand how international and domestic events have disrupted Afghan society. Further, how violence directly and indirectly impacted the health and well-being of Afghans requires recognition of the cultural norms and values that also impact the health of this population. A brief historical account of the Anglo-Afghan wars, Russo-Afghan war, post-Cold War political violence, and the U.S. invasion of Afghanistan will offer insight into the violence and communal distress the Afghan population has experienced in recent history.

![Map of Afghan refugee movement after September 11, 2001.](image)

**Figure 2.** Map of Afghan refugee movement after September 11, 2001. This map represents refugee movement before the U.S. invasion and dissemination of the Taliban
regime. A large proportion of Afghan refugees are in the North West Frontier Province of Pakistan. After the U.S. invasion, there was a significant returnee movement of Afghan refugees in Iran. Adapted from: UNHCR. (2001). Afghanistan Emergency Situation, Afghan refugees in neighboring countries.

**Anglo-Afghan Wars**

Although the Anglo-Afghan wars that occurred between 1839-1842 and 1878-1880 are not directly related to the sociopolitical phenomena we observe today (e.g. refugee crisis, Islamic fundamentalism, and political violence), the conflicts manifest Afghan civilian’s endeavor to preserve their state’s sovereignty and legitimacy against the encroachments of foreign powers. Various political phenomena that occurred during this period evidently repeated themselves in recent history, and today’s political events in Afghanistan are a legacy of the political dynamics that occurred during these earlier periods.

Before the First Anglo-Afghan War, Britain helped the Kingdom of Kabul defend Herat, a city in north western Afghanistan, from the Persians who, with support from Russia, sought to expand into the region. In southern Afghanistan, the Sikhs conquered Peshawar and the Afghans were unable to restore their control; the Sikhs later became part of the British Commonwealth. Ranjit Singh, the Sikh leader, took advantage of the struggle for control of Kabul between Sadozai and Barakzai clans of the Durrani tribe (Seddon, 2003). In 1831, the Sikhs secured Peshawar; in 1837, the Sikhs appointed a governor from Lahore to govern Peshawar. During this pre-war period, Afghanistan acted as a buffer state between two rival empires: Russia and Britain.

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1 For background on the Anglo-Afghan Wars during the 19th century, see:
In 1839, Lord Auckland, governor general of India, embarked on a quest to conquer Afghanistan by overthrowing Dost Muhammad, the emir and leader of the Muhammadzai faction. Lord Auckland sought to install Shah Shuja of the Sadozai faction in Dost Muhammad’s place. Having defeated the Sikhs in Peshawar, the British deployed many thousands of troops and invaded Afghanistan. Dost Muhammad surrendered and fled to Bukhara (Uzbekistan) until 1840 when he would return and join the rebellions. Between 1839 and 1842, the Afghan state was controlled by Britain with Shah Shuja as emir. British occupation of Afghanistan faced great opposition from Afghan civilians who were adversely affected by inflation and presence of British troops. Marginalized tribes, such as the Kohistani Tajiks in northern Afghanistan and Ghilzai Pashtuns in eastern Afghanistan, banded together under the leadership of Muhammad Akbar, Dost Muhammad’s son, to fight against the British. Faced with overwhelming internal dissent against their direct rule, the British withdrew their troops in January of 1842. On their way back to Peshawar through the Gandamak Pass they were wiped out by Ghilzai warriors. Sixteen thousand British soldiers were killed and only one British survivor arrived safely in Jalalabad.

In 1843, the British Army of Retribution attempted to relieve their garrisons at Jalalabad and Kandahar; they destroyed the homes of Afghan troops and razed Kabul (Seddon, 2003) Still, they were unsuccessful in their mission and suffered major losses again. During this time, Dost Mohammed was restored to the throne. The failure of British forces to directly rule Afghanistan markedly labeled the state as uniquely violent, a place European powers should avoid in their colonial conquests. More important, though, is that the First Anglo-Afghan War demonstrated how Afghans in the margins of the sociopolitical framework were powerful enough to overthrow a foreign power that the
Afghan central government could not. This phenomenon is a theme throughout the later history of Afghanistan.

After Dost Muhammad passed away in 1863, his son Sher Ali became emir of Afghanistan. During his rule, Russian and British tensions intensified, and Afghanistan was again caught in the middle of the great powers’ quest for hegemony. According to Seddon (2017): “In April 1878, three large Russian military columns formed at Tashkent, Aleksandrovsk, and in the Ferghana Valley, preparing to move towards Afghanistan” (p. 185). Because Afghanistan was within Britain’s sphere of influence, Sher Ali established terms with Britain regarding Afghanistan’s sovereignty. However, British forces violated these terms when they took control of Quetta in southwestern Afghanistan in 1876. This prompted Sher Ali to travel north and seek aid from Russia. Russian officials denied his request and Sher Ali died shortly thereafter in 1879. His successor, Yaqub, subsequently conceded to the British. Britain now had full control of Afghanistan’s foreign affairs and established a permanent mission in Afghanistan. This political development marked the onset of the Second-Anglo Afghan War.²

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British presence in Afghanistan prompted great hostilities among the Afghan people, as it had done in the First Anglo-Afghan War. The Ghilzai Pashtuns and Kohistani Tajiks led the tribal resistance against Britain’s direct rule, which prompted Britain to assign an emir who would respect their interests after they left. Abdur Rahman became emir of Northern Afghanistan, a much smaller area of Afghanistan, and the British finally evacuated Afghanistan after defeating Ayyub Khan’s rebellion in the Battle of Kandahar in 1880.3

Nevertheless, Abdur Rahman faced internal challenges trying to reclaim the other areas of Afghanistan controlled by governors who opposed his rule, as they supported Ayyub Khan’s bidding for emir. Although Britain recognized the sovereignty of his government, they did not provide aid for Abdur Rahman’s quest. Abdur Rahman allied with the Ghilzai Pashtuns and Kohistani Tajiks, who helped reclaim all regions of
Afghanistan and dismantle the old state structure (Barfield, 2010, p. 147). With their help, he successfully brought together the major urban centers and tribal regions, uniting the Afghan population.

In the international context, Abdur Rahman and the Afghan people had little influence over treaties and agreements that impacted their country. Indirectly ruling Afghanistan from India, Britain focused its strategy on preventing Russian expansion. They assigned the northern and western borders of Afghanistan, and in exchange offered arms and ammunition for Abdur Rahman’s allegiance. This dependence on Western aid is another pattern in Afghan history that we see today, which is largely a legacy of the most contentious international agreement the British imposed among the Afghan people: the 1893 Durand Line. This agreement split Pashtun tribes between British India and Afghanistan and blocked access to the Arabian Sea. The territory annexed from Afghanistan became the North West Frontier Province (NWFP) of British India (Seddon, 2003). After the British left India, the arbitrary border remained despite pleas to the international community for revision. When Pakistan was established in 1947, inhabitants of NWFP were presented two options for their state membership: India or Pakistan. They were not offered the option to once again become part of Afghanistan (Seddon, 2003, p. 189). Today, Pakistan claims control over the disputed land, which contains more Pashtuns, indigenous Afghan people, than Afghanistan itself (Barfield, 2010, p. 54).

According to Barfield (2010), no Afghan government has ever accepted the Durand line between Afghanistan and the North-West Frontier Province (Khyber Pakhtunkhwa) as legitimate (p. 48).

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Decades later, emir Aminullah Khan initiated the Third Anglo-Afghan War, which resulted in British concession of their indirect rule. The Treaty of Rawalpindi in 1919 confirmed Afghanistan’s full control of their domestic and foreign policies (Seddon, 2003). Afghanistan was recognized as an independent state at the Paris Peace Conference in 1919 (Seddon, 2003). Aminullah Khan’s objective was a confederation of Afghanistan and Central Asia, dominated by Kabul. On the other hand, Soviet Russia wanted Afghanistan to become part of its empire; they supported Aminullah Khan’s regime financially and militarily when it was faced with rebels, such as during the 1925 Khost rebellion (Seddon, 2003). Nevertheless, Aminullah Khan’s modernization policies, paralleling Iran and Turkey’s, was met with internal dissent and he was deposed in 1929, replaced by Nader Shah who reversed his policies (Seddon, 2003, p. 188). Meanwhile, Soviet Russia continued to support the Afghan government. By 1950, Afghanistan was completely dependent on the Soviet Union for arms and 90% dependent for petroleum products (Seddon, 2003, p. 189). Under prime minister Daud Khan, Afghanistan’s dependence on the Soviet Union was intensified and it is what led to the most violent conflict in Afghanistan since the Anglo-Afghan wars.

Soviet Invasion of Afghanistan (1979-1989)

In 1973, King Zahir Shah of Afghanistan was ousted by his cousin and former Prime Minister, Muhammad Daoud Khan, in a bloodless coup. Zahir Shah, a Durrani Pashtun, was undergoing medical treatment in Italy when Daud Khan took over the Afghan government and established a republic. Shah introduced legislation ten years earlier that restricted family of the monarchy to hold ministry positions, and Daoud Khan had to resign from his Prime Minister position. Under Zahir Shah (r. 1933-1973), Afghanistan prospered in its Golden Age, achieving a balanced and secular legal system deemed
legitimate by its citizens (Malejacq, 2017). According to Barfield (2010), in the eyes of ordinary Afghans, each regime after Zahir Shah was less legitimate than its predecessor (p. 165). The year 1973 marked the beginning of Afghanistan’s future legacy of conflict over ideologies few of its people shared.

Daoud Khan led a republic, the National Revolutionary Party of Afghanistan, which suppressed the Islamist opposition and the secularist party PDPA that supported a closer relationship between Afghanistan and the Soviet Union. During this pre-war period, “a gradually expanding, foreign-supported state coexisted with a rural sector based on subsistence agriculture and pastoralism” (Rubin, 2013, p. 53). Nur Muhammad Taraki, a Ghilzai Pashtun who would later view himself as another Lenin (Dimitrakis, 2012), was Daud Khan’s secretary general and helped consolidate communist seats in the lower house of parliament in 1966. Due to personal conflict between Taraki and Babrak Karmal, another influential leader of the communist party, the group was split into the predominantly Pashtun Khalq and predominantly Tajik Parcham factions. Daud Khan, a Pashtun himself, had mostly Parchami ministers. Unsuccessful in bringing down his opposition, Daoud Khan was assassinated in 1978 after a coup by the Khalq faction of the People’s Democratic Party of Afghanistan (PDPA). This Marxist party is characterized as “Kabul-based modernists [who] pressed secular reforms onto the conservative rural majority” (Maqljacq, 2017).

The PDPA promoted social policies at odds with the Afghan tribal system; for example, the PDPA mandated compulsory literacy programs that demanded attendance of young, unmarried men and women together in mixed classes. According to Seddon (2003), “Their ambitious social and economic reforms, directly challenging dominant Islamic values and the power of the clergy, led to opposition and revolt; within six
months there was widespread opposition. This rapidly developed into a jihad, partly fueled by international trends of Islamic radical movements, but quickly co-opted and financed and armed by the United States through its Pakistan allies” (p. 190). These policies did not represent the majority rural population, and so the subsequent collapse and loss of legitimacy of the Afghan state also meant weakening of institutions that support civil rights like women’s public roles (Rubin, 2013, p. 54). This response from the rural population of Afghanistan was also observed during Aminullah Khan’s modernization period. These social policies led to nationwide insurgency supported by Pakistan (Dimitarkis, 2012), and the communist regime began to deteriorate.

Taraki and Hafizullah Amin, his protégé, asked the U.S.S.R. for assistance against the tribal rebellion, and were rejected on multiple accounts because of their refusal to bring the Parchamists (the rival communist party led by Babrak Karmal) and Islamists into their government. Internal dissent also brought the PDPA regime to nearly collapse, as Amin led a coup against Taraki and murdered him. In March 1979, Amin assumed presidency of the Revolutionary Council (Seddon, 2003). Leonid Brezhnev, the Soviet Union Secretary General, believed Amin was working for the CIA and became actively interested in Afghanistan (Dimitrakis, 2012, p. 513). He also intercepted CIA reports claiming the United States’ intention to make a “new Great Ottoman Empire” composed of the Muslim population in Central Asia (Dimitrakis, 2012, p. 513), and his office feared Iranian-Pakistani intervention in Afghanistan for the rich uranium deposits that would supply their nuclear regimes (Dimitrakis, 2012, p. 513). Thus, on December 12, 1979, the Soviet Union ousted Amin and appointed Babrak Karmal to lead the PDPA. On December 27, 1979, approximately 75,000-80,000 troops invaded Afghanistan in what would be the beginning of an inveterate conflict.
The United States condemned the Soviet invasion of Afghanistan, portraying the Soviet Union as an enemy to the Muslim world and calling the international community “to condemn such blatant military interference into the internal affairs of an independent sovereign state” (Dimitrakis, 2012, p. 514). President Jimmy Carter made it clear that the transformation of Afghanistan into the Soviet’s puppet state had strategic consequences for the region and the leaders of the free world had to stop them. The UN General Assembly’s Security Council received a letter calling the Soviet invasion as a threat to international peace and security, and the Security Council deliberated between January 5th to 9th, 1980 (Dimitrakis, 2012, p. 520). Because the Soviet Union was a permanent member of the Security Council, the resolution condemning the invasion, calling for immediate withdrawal of troops, and respecting the sovereignty of the Afghan people was vetoed. Thus, the Soviet war continued, leaving over a million Afghan casualties and creating three million refugees before, in the face of mounting opposition, the Soviets finally withdrew in 1989 after having suffered high casualties (Barfield, 2010, p. 171).

Barnett Rubin, former Senior Advisor to the US Special Representative for Afghanistan and Pakistan, describes the Soviet invasion of Afghanistan as follows:

During the Soviet occupation, hundreds of thousands of civilians, possibly a million or more, lost their lives in the indiscriminate bombing and shelling of villages thought to be sheltering the resistance. Populated areas by roadsides were razed. Millions became refugees. Irrigation systems, orchards, and grain and seed storage were destroyed. Torture became part of an intelligence effort and hence more systematic, with the aid of Soviet and East German advisers. A diplomat of the regime once estimated to me that 150,000 people had been arrested in Kabul by his government, and virtually all prisoners were tortured. Gradually, especially after 1986, torture decreased, to be replaced by skilled interrogation. Indiscriminate bombing decreased, to be replaced by indiscriminate bribing (Rubin, 2013, p. 134).

Rubin (2013) also chronicles insurgents’ tactics, such as the skinning of Soviet soldiers while alive. During this conflict, the USSR deployed more than 350,000 troops to
Afghanistan, (but there were never more than 120,000 in Afghanistan at the same time), and lost 85,000 (Seddon, 2003, p. 191). The ensuing resistance to the Soviet invasion was led by the Mujahedeen, Islamic “freedom fighters” financed by the United States, China, Iran, Pakistan, and Gulf states (Seddon, 2003, p. 191). Approximately 1.3 million Mujahedeen died during the Soviet occupation (Seddon, 2003). Rubin (2013) recounts the atrocities of the Soviet-installed Parchami regime:

From April 1978 to December 1979, the Khalqi faction’s communist regime attempted to eradicate its enemies through mass arrests and executions. The regime subsequently installed by the Soviet Union, dominated by the Parchami faction, published a list of about twelve thousand people said to have disappeared in Pul-i-Charkhi prison under Khalqi rule. Others put the actual figure higher. Throughout the country, the Khalqi regime, at times with the apparent complicity of Soviet advisers, executed an unknown number – probably in the tens of thousands—of religious, tribal, and clan leaders. In a few cases, people were buried or burned alive. After a military mutiny led by Captains Ismail Khan and Alauddin Khan, the city of Herat was bombed indiscriminately, with thousands of casualties (Rubin, 2013, p. 134).

The Soviet invasion of Afghanistan (1979-1989) presented disturbing political phenomena that have contributed to the failure of the state (Rubin, 2013, p. 55). Namely, the opposing flows of politically motivated military assistance to state and non-state actors (e.g. Soviet-backed PDPA and U.S.-backed Mujahedeen). The subsistence of the Afghan population, too, is dependent on politically motivated humanitarian aid (e.g. U.S., Soviet Union, and Pakistan aid):

By the Soviet withdrawal, nearly all of Kabul’s food and fuel was donated by the USSR and distributed by the government through coupons…Food production fell by half to two-thirds as Soviet counterinsurgency devastated the rural economy. This destruction not only impoverished the rural populations but weakened the elites whose power depended on control of rural resources. Much of the rural population fled to Pakistan and Iran, where it entered monetary economies (Rubin, 2013, p. 55).
Because counterinsurgency destroyed the rural subsistence economy, Afghan cities were forced into urbanization to meet the economic needs of internally displaced Afghans. In addition, millions of rural Afghans became refugees in camps and cities in Pakistan and Iran, where most insurgent operations are planned. Rubin (2013) calls them “refugee-warrior communities” (p. 55).

Afghanistan experienced relative stability after the withdrawal of Soviet forces in 1989. The PDPA was led by Najibullah and remained in power until 1992, right after the Soviet Union collapsed. During this period, Najibullah focused on disentangling militias constituted by ethnic minorities, such as Dostum’s Uzbek ‘Jawzjani’ militia (Johnson, 2007, p. 183). In response to Dostum’s self-proclaimed autonomous region in northern Afghanistan, Najibullah renamed the PDPA to Hezb-e Watan (Party of the Nation) and emphasized his resistance to foreign intervention – even from the Soviet Union. For example, Pakistan supported Gulbuddin Hekmatyar’s Hizb-e-Islami faction, even claiming Hekmatyar was responsible for the successful capture of Khost in 1991 when he wasn’t, so that he can attract Afghan popular support (Johnson, 2007, p. 184). Najibullah also tried to reintegrate his power by prescribing Islam as legitimacy for his rule: “only practicing Muslims could serve in the ‘new’ government. In fact, places to non-PDPA members were limited, and when Khalqis criticized his move in December 1989, he had 100 leading members of the faction arrested” (Johnson, 2007, p. 183).

The resistance against Najibullah was intense, but it was exceptionally divided. According to Johnson (2007): “Without the common cause of defeating foreign Soviet forces, factionalism prevented concerted action” (p. 184). Nevertheless, when Najibullah replaced several of his personnel from other ethnic groups with Pashtuns (like himself), his regime began to crumble. The Tajiks helped Dostum take Mazar-e-Sharif in northern
Afghanistan, which consequently led Najibullah to resign in 1992 (Johnson, 2007). The Interim Government, represented by Tajik leaders Rabbani and Mojadiddi, rejected the United Nation’s proposals for the new establishment; thus, the UN was unable to secure central authority after Najibullah’s resignation. In fact, Najibullah had to flee to UN headquarters for safety from Dostum, Massoud, and Hekmatyar’s forces that entered Kabul during the UN negotiations (Johnson, 2007, p. 186). This created a power vacuum among the various Mujahedeen factions, who were originally bonded because of their jihad against the communist infidels.

According to Rubin (2013), Afghanistan entered a period of virtual statelessness, where Afghan society divided multilaterally because of ethnic animosity towards each other (p. 135). The factions were predominantly Pashtun and Tajik, and each faction was representative of a certain region or tribe. Although the United States was disengaged during this period and the Soviet Union dissolved, each faction found a regional foreign financier (e.g. Pakistan, Iran, Saudi Arabia) that supported their guerrilla-like operations (Rubin, 2013). While the Soviet Union destroyed Afghanistan’s countryside, the ensuing civil war among the mujahideen and militias destroyed the capital (Rubin, 2013, p. 135).

**Civil War (1992-1996)**

The most heinous of crimes were committed during the civil war. Rape became a regular feature of the conflict. Factions killed their enemies by plunging spikes through their heads. The opium economy thrived. In the hot summers, factions captured their enemies and sealed them in shipping containers, where they suffocated (Rubin, 2013, p. 135). Returning refugees found their country destroyed and highly fragmented with no effective central state. The United Nations and international humanitarian agencies
supplied food to Afghanistan’s vulnerable population, but at only half the amount that the Soviet Union had offered (e.g. 120,000 tons of wheat/year versus 250,000 tons by the USSR) (Rubin, 2013, p. 57).

When Najibullah’s regime collapsed, Tajik factions from northern Afghanistan entered Kabul to secure their rule. Led by Ahmad Shah Masoud, the establishment of the Islamic State of Afghanistan failed because of attacks on Kabul by militias and mujahideen supported by Pakistan (Rubin, 2013, p. 55). According to Rubin (2013), these attacks and the majority Pashtun’s ethnic animosity towards Tajik rule prevented Masoud’s faction from expanding their control beyond Kabul and their ethnic base. In April 1992, a 51-person delegation signed the Peshawar Accord that delineated Mojadiddi as President for two months and Rabbani for four months afterwards. A presidential election organized by the Council of Supreme Popular Settlement would occur 18 months later. This delegation excluded Hekmatyar, who responded to Rabbani’s arrival after the Peshawar Accords with a rocket attack on the capital (Johnson, 2007, p. 186). Johnson states: “It was clear from this episode that force, rather than compromise, was still the option most favoured by the various factions” (2007, p. 186). Kabul became divided between the key factions: Massoud’s Shura-i-Nazar in the north, Sayyaf’s Saudi-backed Ittehad-e-Islami in the Paghman suburbs, Dostum’s Jumbesh-e-Meli Islami in the center, and Abdul Ali Mazari’s Shiite Hezb-e-Wahdat in the west (Johnson, 2007, p. 187).

Between 1992 and 1995, a conservative estimate claims that approximately 9,800 Afghan civilians and fighters were killed and 56,000 were wounded (Johnson, 2007, p. 187). Per Johnson (2007), this is a conservative estimate. The Afshar massacre on February 11th, 1993 is considered one of the worst atrocities to occur during the civil war.
Winterbotham et al. (2011) conducted research for the Afghanistan Research and Evaluation Unit on wartime suffering. They interviewed Afghans in the Afshar district of Kabul province, shedding light on the severity of the human rights violations that occurred during the civil war. Controlled by Hizb-i-Wahdat, the Shiite and Hazara faction, it was the target of attack by predominantly Pashtun and Tajik troops (Winterbotham et al., 2011, p. 5). One interviewee, Zafar, a young Hazara male from Afshar stated: “My four brothers along with my father were captured during this time. They were imprisoned for about nine months by Sayyaf. One of my brothers was captured twice but he managed to escape. We were in Kabul up till late 1373 [1994] and we were completely looted in this area…There was war every day” (Winterbotham et al., 2011, p. 6). Hazara men were frequently imprisoned by Itthiad-i-Islami and Jamiat-i-Islami, and there were significant instances of female rape when Afshar was invaded by militia forces.

Outside of Kabul, warlords increased their influence over their rural populations through “taxing,” which is “a euphemism for expropriating any material wealth from the people, proved vital to buy loyalties and assert a sort of baronial legitimacy to rule” (Johnson, 2007, p. 188). Haji Abdul Qadir, governor of Jalalabad, notably allowed Arab extremists, such as Osama bin Laden, to establish their operations in his province. Further, Qadir tolerated opium cultivation and sustained relationships with Rabbani and Hekmatyar (Johnson, 2007, p. 188). This was politically strategic for Qadir, as he had the support of both the Tajik and Pashtun forces. Indirectly, his operations would be supported by Pakistan’s ISI, who supported Hekmatyar.

In 1995, the Taliban attempted to enter Kabul; however, they were unsuccessful after Massoud and Sayyaf’s counter-attack. In 1996, the Taliban and Hekmatyar’s forces
increased their resistance against Rabbani’s government, which subsequently led to Rabbani offering Hekmatyar the position of Prime Minister to bring the Tajik and Pashtun factions together. Hekmatyar accepted the offer, and the Taliban responded by shelling Kabul and launching rockets in its center (Johnson, 2007, p. 188). Furthermore, Pakistan’s ISI was also upset at Hekmatyar’s appointment, convinced that Hekmatyar would not bring a pro-Pakistan authority in Kabul. Pakistan shifted its support to the Taliban and aided their attack on Kabul in September of that year. The Taliban first seized Jalalabad on September 11th, 1996, which was followed by Massoud’s withdrawal of his forces from Kabul on September 26th, 1996 back to his ethnic base in the North. The next day, the Taliban claimed their rule of Afghanistan.

**Taliban (1996-2001)**

According to Rubin (2013), the Taliban are an “indigenous southern Pashtun response to warlordism and an instrument of Pakistani policy” (p. 135). The militaristic organization imposed a strict interpretation of the Quran, which they felt were justified by the harsh abuses during the civil war. By 2000, the Taliban centralized their control over the main roads, cities, airports, and custom posts in Afghanistan. Further, they transitioned the countryside from local warlord rule to a weak rentier state (Rubin, 2013, p. 58). After winning the civil war in 1996, only three states recognized it as Afghanistan’s government: Pakistan, Saudi Arabia, and the United Arab Emirates (Kleiner, 2014, p. 708).

Johnson (2007) identifies two versions of the origins of the Taliban. The first states that the Taliban emerged as disciples of Mullah Mohammed Omar, who envisioned a pure Islamist movement to cleanse Afghanistan of war, corruption, and iniquity. The second version argues the Taliban was formed by Pakistan’s military, the ISI, to fulfill
their desire to form a pro-Pakistan government in Kabul. Such a force would secure Pakistan’s western borders if they were to be at war with India. Furthermore, if Afghanistan formed an oil pipeline with its fellow Central Asian countries, Pakistan would reap the economic benefits of oil trade because of their Indian Ocean coastline. The Durand Line conflict would also subside, as the Taliban represented a trans-Pashtun movement that would bring all Pashtuns in Afghanistan: “Instead of such a state [Pashtunistan] being built at the expense of Pakistan, the new state would be superimposed on Afghanistan, thus diverting or satisfying Islamist and Pashtun aspirations at home” (Johnson, 2007, p. 190). The majority of the 80,000 Taliban recruits were indigenous and displaced Pashtuns from the contested North West Frontier Province, and Pakistan helped raise their funds and equipped them with weaponry (Johnson, 2007, p. 189). Between these two versions of how the Taliban was born, the latter has greater evidence and demonstrates the pattern of foreign involvement in Afghanistan’s sociopolitical history.

By 1996, Afghan communities and institutions were disintegrated or destroyed because of the Soviet invasion and civil war. The mass exodus of Afghan refugees to Pakistan’s NWFP provided extremists a vulnerable population of young men who grew up in war. According to Baitenmann (1990),

When the USSR invaded Afghanistan in December 1979 the trickle of refugees became a steady flow, adding another half a million refugees in the first six months of 1980, 1.4 million by the end of the year, two million within three years, and an estimated 3.5 million by 1989 (p. 63). Conservative rural uluma, Islamic teachers, in southern Afghanistan and the NWFP provided the only education available to Afghan refugees at their madrasas (Islamic schools). These madrasas were also funded by Wahabi Pakistani and Saudi donors
The Taliban mobilized the social capital they had at these madrasas to recruit young Pashtun men into their organization.

The Taliban’s main opposition were the non-Pashtuns, led by Ahmed Shah Massoud (of the Tajiks), in the North. With their prominent ally, Al-Qaeda, the Taliban turned Massoud’s region into a wasteland, committed mass executions, destroyed their orchards and vineyards, and displaced the population. Similarly, the opposition factions murdered thousands of Taliban prisoners in June 1997 during the battle for Mazar-I-Sharif, which was responded by the Taliban’s execution of thousands of civilians (mostly Hazaras) in August 1998, as well as Iranian diplomats living there (Rubin, 2013, p. 136). Per Johnson (2007),

Survivors state that the killing went on for three days and was led by foreign Taliban fighters under the direction of Mullah Omar’s associate, Mullah Abdul Manan Niazi. Several were boiled or asphyxiated by being locked in metal containers in the sun. Thirty patients in a hospital were murdered in their beds… (p. 192).

The Mazar-i-Sharif massacre was one of many offensives against the Hazara people committed by the Taliban, such as the infamous Bamyan raid on September 13, 1998.

There is no compulsion on belief in Islam, but the Taliban strictly enforced their laws through their Department for the Promotion of Virtue and Suppression of Vice, otherwise known as their religious police. They banned television, music, dancing, and even destroyed non-Islamic archeological artifacts in Afghanistan (e.g. the Bamyan Buddhas) (Johnson, 2007, p. 193). Women were denied employment at a time when many were widowed because of the decades of conflict; thus, these women had no source of monetary income. When the United Nations protested against their practices, the Taliban responded by saying their law was derived from Allah (God) (Johnson, 2007, p. 193).
The Taliban created a hub for religious extremists, such as Arab Afghan fighters like Osama bin Laden. The term “Arab Afghan” was used during the Soviet Invasion of Afghanistan for Arab fighters who joined the Mujahideen in their jihad against the communists. Osama bin Laden fought with the Mujahideen, and after the Soviet withdrawal, he founded al-Qaeda. Enraged at the U.S. base on Saudi soil during the Gulf War, he began plotting his retaliation against the West. He believed he could use the same guerrilla tactics against the United States that he used against the Soviet Union, Afghanistan’s former occupiers. Johnson (2007) states: “[H]is paradigmatic views were based entirely on the assumption that religious zealotry alone could bring down a superpower” (p. 194). He returned to Afghanistan in 1996 to orchestrate his campaign against the West. The Taliban felt obligated to host bin Laden because of the Pashtun tribal custom (pakhtunwali), bin Laden’s service to Afghanistan during the Soviet war, and al Qaeda’s role as the major benefactors of the Taliban (Johnson, 2007, p. 194).

Osama bin Laden and his “foreign Taliban” members were also responsible for the murder of Massoud. According to Johnson (2007): “On 9 September [2001] a group of al-Qaeda, posing as journalists, packed a camera with explosives, and, during an interview with Massoud, they detonated it. Massoud died in the blast” (p. 195). This event occurred two days before the September 11 attacks on the United States, for which 2,893 people died in New York, 233 died in the Pentagon, and 93 died on United Airlines Flight 93 in western Pennsylvania. Al Qaeda was responsible for this attack on the United States, which resulted in a U.S.-led world coalition against terrorism. Members of the North Atlantic Treaty Organization supported the United States’ military action against Al Qaeda, in which the U.S. invaded Afghanistan to neutralize Osama bin Laden (Johnson, 2007, p. 196) and topple the Taliban. Rubin (2010) describes this event given
his own experience being involved in the negotiations that produce the Bonn agreement:

“Taliban rule ended with the military campaign of the United States and its allies after
the attack of September 11, 2001 – itself a crime against humanity, and the only one of
these that I witnessed personally, but one in which no Afghans were directly involved”
(Rubin, 2013, p. 136).

**United States Invasion of Afghanistan – Present**

The War on Terror, also known as Operation Enduring Freedom, was in full effect on
October 7th, 2001. According to Kleiner (2014), the United States, Britain, and the
Northern Alliance secured Kabul on November 13th, 2001, and Kandahar, the Taliban’s
capital city, on December 9th, 2001. This war involved the cooperation of international
security services to track al-Qaeda members and their associates. Furthermore, the United
States pioneered a coalition of nation-states that would force countries harboring
extremists to close down their organizations. The United States’ Special Forces also
cooperated with Massoud’s Northern Alliance, which aided in the domestic offensive
against the Taliban (Johnson, 2007, p. 197). At this point, Pakistan became fully
supportive of U.S. efforts to dismantle the Taliban in order to neutralize Osama bin
Laden’s operation against the West. According to Johnson (2007): “Musharaff
[Pakistan’s president] must have realized that Pakistan’s policy of creating a friendly
power on the western border had failed spectacularly” (p. 196). Nevertheless, the United
States, Afghanistan, and NATO allies later suspected Pakistan’s Inter-Services
Intelligence (ISI) of supporting Taliban insurgency against Karzai’s administration and
ISAF forces: “A draft State Department paper of 19 September 2006 pointed to ongoing
ISI support ‘though the nature and amount of this support and the degree to which it
reflects official GOP (Government of Pakistan) policy is not always clear” (Kleiner, 2014, p. 716).

Without Pakistan’s support, the Taliban also lost a major military and financial backing. Their human rights violations proved them to be no different from the communists and insurgents that terrorized Afghan civilians’ lives for two decades. Within four days in November 2001, the United States helped secure all the major urban centers. On December 9th, 2001, Hamid Karzai arrived in Kabul and confirmed the end of the war as interim head of government (Johnson, 2007, p. 198). In 2004, he was elected president of Afghanistan. Nonetheless, the Taliban was (and continues to be) active in Afghanistan and in the NWFP of Pakistan.

At the onset of the invasion, the U.S. bombarded training camps, radar installations, and Taliban areas with B52 and B1 “Stealth” bombers (Johnson, 2007, p. 197). The international community, led by the United States, significantly afflicted the Taliban’s ability to fight on the ground. President George W. Bush stated that the U.S. invasion “aimed at driving al-Qaeda operatives out of Afghanistan, bringing them to justice, and disrupting ‘the use of Afghanistan as a terrorist base’” (Kleiner, 2014, p. 709). In 1999, the UN Security Council determined that al-Qaeda and the Taliban were equally threatening, which led to sanctions of the same level on both organizations (Kleiner, 2014, p. 709). Although al-Qaeda and the Taliban are both extremist organizations, the sanctions against al-Qaeda did not impact the political economy of an entire country. Al Qaeda is an international terrorist network aimed at emancipating Muslim countries from Western involvement, especially the United States. The Taliban, however, are an organization of predominantly Pashtun and Sunni Afghans who practice a most austere interpretation of Islam; they were never under al-Qaeda’s command
because they are a regional organization focused on bringing peace to Afghanistan in their own version. Rubin (2013) admits that the beliefs and practices of the Taliban were an effect, not a cause, of decades of war:

The young men fighting in Afghanistan in 2001, twenty-three years after the Sawr revolution, had known nothing but war and conflict their whole lives. They had been raised on and lived an ideology of jihad; they had never known a united Afghanistan where competing groups did not resort to arms; they had little education and few skills; and in the economy they had known bearing arms, growing opium, and smuggling seemed the only relatively lucrative professions. They might long for peace, but they also feared it. Peace might seem, if anything, less secure than war (Rubin, 2013, p. 139).

After the overthrow of the Taliban government, the Bonn Agreement was signed by Afghan leaders in December of 2001. According to Jones et al. (2006), “The Bonn Agreement established a timetable for achieving peace and security, reestablishing key government institutions, and rebuilding Afghanistan” (p. 89). Executing the lead nation approach, the United States, Germany, United Kingdom, Italy, and Japan contributed financial assistance and coordination of reconstruction efforts in Afghanistan. The U.S. was tasked with repairing the internal security of Afghanistan through the Afghan National Army, for which the new government did not have full control of after the overthrow (Jones et al., 2006, p. 91). Insurgent groups, warlords, and narco-leaders were the most serious security threats the Karzai administration faced.

Despite the legal and constitutional structures created by this agreement, power was still in the hands of factional commanders armed by the United States in 2001 (Rubin, 2013, p. 142-143). Rubin (2013) argues that peace in Afghanistan would only occur through the creation of institutions that control non-state actors and make the government “law-bound” (p. 143). The Bonn Agreement marked the period of Afghanistan’s “transitional justice,” defined as the “measures by which a society
accounts for past abuses as it moves from a condition of dictatorship or conflict, where the perpetrators of violence enjoy impunity, to one of civil peace, where the state seeks to provide justice and security to its citizens” (Rubin, 2013, p. 133). Peace and justice, Rubin (2013) argues, are not separate ideals – they are interdependent. For example, the United States’ policy of demobilization, disarmament, and reintegration (DDR) potentially allows war criminals to walk while international authorities are busy breaking up these groups (Rubin, 2013, p. 144). Nevertheless, in order to bring justice, security in the control of NATO forces and the Afghan government must be obtained.

Insurgent groups like the Taliban and Hizb-i-Islami follow a loosely hierarchical organization structure that allows considerable autonomy to guerrilla units. These units act as “franchises” who conduct military operations (Jones et al., 2006, p. 92). Foreign jihadists in Afghanistan also act as franchises who receive guidance from their al Qaeda or ISIS commanders (Jones et al., 2006, p. 93). In comparison to the domestic insurgent groups, the foreign jihadists are non-state actors that are professional fighters. They have broader objectives, such as jihad against the United States, and are better equipped than the domestic groups. According to Jones et al. (2006), Taliban and Hezb-i-Islami insurgents have civilian jobs and are “part-time” insurgents, while foreign jihadists are working full-time to dismantle the U.S.-backed Afghan government and other institutions against their extreme beliefs. The presence of these foreign jihadists in Afghanistan date back to 1979 when the Soviet Union invaded Afghanistan and “Arab Afghans” joined the Mujahedeen to fight against the communist infidels. Between 2002 and 2006, insurgent groups primarily performed attacks against the Afghan government, followed by Afghan civilians. Figure 3 illustrates the various targets of these groups.

Warlords and regional commanders are leaders of the various tribes constituting the organizational fabric of Afghan society. It is because of the Ghilzai and Kohistani tribes that the British failed to directly rule Afghanistan, and why Amir Abdul Rahman Khan could not centralize state power when the British left. Language, ethnicity, patrilineal descent, and geography are among the binding factors that balkanize the Pashtuns, Tajiks, Hazaras, and Uzbeks, as well as within these respective groups (e.g. Durani and Ghilzai Pashtuns). Today, the Khost province of southern Afghanistan is controlled by the Pasha Khan Zadran, a Pashtun warlord who has hundreds of militias (Jones et al., 2006, p. 95). The leaders of the northern United Front factions, Abdul Rashid Dostum and Atta Mohammad, were affiliated with the Karzai administration, and the U.S. assisted southern and eastern warlords during Operation Enduring Freedom.
Jones et al., 2006, p. 95). Security in Afghanistan after 2001 could only be achieved when the central government and U.S. preserved the power of the warlords.

The United States’ counterterrorism initiative was led by the U.S. Office of the Coordinator for Counterterrorism. They introduced a vetting process and developed a VIP protection program that was implemented in the Afghanistan Presidential Protection Service. The Office also helped establish the counterterrorism finance programs that helped Afghans draft anti-terrorist-financing legislation and prosecute financial crimes linked to terrorism (Jones et al., 2006, p. 100). Notably, the Office’s Terrorist Interdiction Program introduced a database system of suspected terrorist; this database was used to identify and track high risk individuals entering and leaving Afghanistan. While the counterterrorism efforts were successful at the onset of their invasion, by 2004 there was a sharp increase in insurgent attacks (Figure 4).

According to Kleiner (2014), the Taliban waged their first attacks in 2003 and became significantly stronger in 2006 when they gained control of provinces bordering Pakistan’s tribal areas. They also increased attacks in the scattered Pashtun provinces of the North, such as Kunduz, as well as recruiting non-Pashtuns into their organization. Although the northwestern provinces of Afghanistan were relatively peaceful compared to the south and east, the peace was at the cost of corruption, drug trafficking, and criminality (Kleiner, 2014, p. 710). Using improvised explosive devices, small arms, rocket grenades, and suicide bombings, the Taliban attacked Afghan security forces, U.S. forces, and Afghan government officials. According to Kleiner (2014), they even appointed commanders for IED units and established a separate chain of command for this mode of warfare (p. 712). This mode of violence not only disrupted the state structure, but also the cultural framework of Afghan society, as they undermined the traditional authority of elders (Kleiner, 2014, p. 711). In 2004 and 2005, the U.S. found a decrease in the number of terrorist attacks against their forces, while there was an increase in suicide attacks targeting civilians during this period (Jones et al., 2006, p. 104-105). Furthermore, in southern and eastern Afghanistan, government authority did not exist: “People turned to the Taliban to administer justice, which they performed in a rapid, though rigorous way” (Kleiner, 2014, p. 711). By 2012, the Taliban established shadow governors in almost all provinces of Afghanistan, as well as provincial and district-level commissions (Kleiner, 2014, p. 713).

Although Germany was assigned police rebuilding and the United Kingdom counter-narcotics in the Bonn Agreement, the U.S. provides the bulk of assistance in these security areas. U.S. officials believed the Germans’ approach was too slow and underfunded; one U.S. official stated, “When it became clear that they [Germans] were
not going to provide training to lower-level police officers, and were moving too slowly with too few resources, we decided to intervene to save the program from failing” (Jones et al., 2006, p. 97). The U.S. provided training and equipment through DynCorp (a private contractor), and aided reconstruction of the battered police infrastructure after the Taliban regime. The Combined Security Transition Command-Afghanistan program focused on vetting senior Ministry of Interior officials and changing the culture within the ministry (Jones et al., 2006, p.98-99).

Likewise, the U.S. assisted the U.K. in their counter-narcotics initiatives. The U.S. facilitated the creation of a deputy minister for counter-narcotics in the Ministry of Interior during the Karzai administration, and the U.S.’s Office of Drug Control oversees all U.S. counter-narcotics activities, such as poppy field eradication. Despite the U.S.’s efforts to weaken the illicit drug economy, poppy cultivation contributes to 40 percent of the gross domestic product and Afghanistan produces 87 percent of the world’s total (Jones et al., 2006, p. 109).

The greatest security threat facing Afghanistan today are the narco-leaders controlling the illicit drug economy. According to Rubin (2013), Afghanistan has the highest yield of opium harvests in the world:

Opium provides cash not only through sale but through credit and demand for labor. Farmers sell the crop to wholesale traders. When faced with cash flow problems or food deficits, especially in the winter months before the harvest, they can obtain loans from traders under a system of futures contracts called salaam. Finally, the opium harvest requires intensive labor, which provides many landless or land-poor young men with earning opportunities (Rubin, 2013, p. 57).

Criminal networks benefit from the post-conflict phase of Afghanistan because of the fragile security conditions they can manipulate; in fact, 80 percent of the employees working in the Ministry of the Interior benefit from the production of opioids (Quraishi,
2018). Further, narco-leaders maintain preponderance over other actors, such as the Taliban and the central government, since non-compliance becomes an informal norm when the income earned from drug trade is ten-fold greater than government salaries (Quraishi, 2018). The Taliban aids narco-leaders by controlling the arable areas of Afghanistan in the West and South, forcing farmers via sharecropping methods to harvest poppy plants (Quraishi, 2018). Narco-leaders benefit the greatest in this economy, for which one hectare of opium is valued at over $4,500 USD (Quraishi, 2018).

According to Rubin (2013), since the onset of the War on Terror in Afghanistan, “hundreds, perhaps thousands, of civilians have died in U.S. bombing raids, without public investigations or payment of compensation. The only trial – of pilots who accidentally killed Canadian soldiers, not Afghan civilians – resulted in an acquittal” (p.136). In 2010, the UN Assistance Mission in Afghanistan (UNAMA) reported 2,777 Afghan civilians killed, 75% by the Taliban and insurgents and 25% by U.S.-led forces. In 2013, this number rose to 2,959 reported civilian deaths, 75% of which was due to militant groups. Nevertheless, it should be noted that there have not been any public investigations regarding the deaths due to U.S.-led forces (Rubin, 2013), and the ISAF database of civilian death and injury (from the Civilian Casualty Tracking Cell started in 2008) is not consistently made public (Crawford, 2016, p. 2). the conclusions made by the UNAMA report should be understood with this in mind. In a Costs of War report by the Watson Institute for International Studies, Crawford (2015) states about 26,270 civilians have died from direct war-related violence and 29,900 civilians were injured in Afghanistan. In Pakistan, 21,500 civilians have died because of direct violence from the U.S. War on Terror, as the war in Afghanistan spilled into Pakistan due to insurgent activities in the NWFP.
Using UNAMA data and other sources, Crawford (2016) estimated that greater than 31,000 civilians have been killed from direct war violence between 2001 and mid-2016 (Figure 5). Figure 3 demonstrates how more civilian deaths occurred after 2007. While there was a steady rise in the numbers of civilians killed in the war by all parties during this period – anti-government elements or pro-government forces — civilian war deaths are significantly attributed to anti-government insurgent organizations (Crawford, 2015, p. 3). In 2009, ISAF and the US reduced the number of air strikes by making the criteria for a strike more restrictive, which decreased the portion of civilians killed by pro-government forces. Nevertheless, the number of civilians killed by improvised explosive devices (IEDs) has increased since 2009, which is paralleled by the increased killing of Afghan officials by the Taliban (Figure 6). Starting in 2013, there has been a steady rise in pro-government N.A.T.O. and Afghan forces. In 2014, the International Committee of the Red Cross (ICRC) markedly noticed pro-government and anti-government forces unable to distinguish between civilians and combatant (Crawford, 2015, p. 3).

Figure 5. Afghanistan direct civilian war deaths, 2001-2015.
Adapted from:
Figure 6. Causes and numbers of direct civilian deaths in Afghanistan between 2009 and 2014. In addition to the causes of civilian deaths in Afghanistan, the graph illustrates the trends of targeted killings and aerial operations by anti-government elements (AGE) and pro-government forces (PGF).

Adapted from:

For the last four decades, violence in Afghanistan has displaced millions of Afghans. The repatriation of 5.8 million Afghan since March 2002 is the “largest ongoing repatriation operation in the world” (Crawford, 2015, p. 5). While Afghans are returning to Afghanistan, the intensified conflict in recent years has caused people to flee violence or fear returning home. In 2014, there was about 2.7 million Afghan refugees, and greater than 701,900 internally displaced people. Likewise, 13,000 Pashtuns from the North Waziristan district of Pakistan (in the NWFP) were also displaced into southern Afghanistan because of the Pakistani military operation Zarb-e-Azb (Crawford, 2015, p. 6).

Human rights abuses in Afghanistan have increased since 2001; the Afghanistan Independent Human Rights Commission argued:
Mass bombardment of villages, arbitrary detention, summary execution of prisoners, torture, rape of women and children, looting of public and civilian property, forced disappearance of civilians and massacres have created an atmosphere that has cast a dark shadow on the psychology of the whole nation (Jones et al., 2006, p. 113).

Jones et al. (2006) states there is little known evidence that the U.S. and its allies committed major human rights abuses; however, warlords and insurgents have been (and continue to) be involved in abuses against women, extortion, torture, human trafficking, and more. According to Jones et al. (2006), “During the September 2005 parliamentary election campaign, there were numerous reports of intimidation by warlord militias to force people to vote for or against specific candidates” (p. 115).

According to Jones et al. (2006), “most Afghans believe that security is the biggest problem facing the country. They are particularly concerned about threats from warlords, insurgent attacks, and other violence such as crime” (p. 107). Medicins sans Frontiere withdrew from Afghanistan in July of 2004 because of the deteriorating security situation. Five of their workers were murdered in the Badghis province of northern Afghanistan (Jones et al., 2006, p. 107). Moreover, 29 percent of Afghans interviewed in an International Republican Institute poll were in favor of extremist leaders (Jones et al., 2006, p. 107). This poll also indicated that 85 percent of Afghans interviewed had a favorable view of President Karzai, and 67 percent had a favorable view of the U.S. military (Jones et al., 2006 p. 107).

**Conclusion**

Modern Afghanistan is a violent place. Each foreign power that attempted to conquer Afghanistan, from Alexander the Great to the Soviet Union, was unsuccessful. Nonetheless, each has left a mark on modern Afghanistan. This chapter gave an historical
overview of modern Afghanistan, illuminating the violent past that has shaped its violent present, and, most likely, future. The Anglo-Afghan wars unified the decentralized Afghan population because of the threat to their state’s sovereignty. This conflict also introduced the Durand Line conflict, a post-colonial legacy of the British Raj that divided indigenous Pashtun tribes in southern/eastern Afghanistan and the NWFP (also known as Khyber Pakhtunkhwa) in Pakistan. The contested border is still not accepted by the government of Afghanistan and remains one of the most dangerous areas of the world, where opium trade, terrorism, and arms distribution is robust.

During the Soviet-Afghan war, the NWFP was the base for Mujahideen and insurgent operations against the PDPA and Soviets. The United States supported the Mujahideen during this period, including “Arab Afghans” like Osama bin Laden. The power vacuum that resulted after Soviet withdrawal in 1989 caused a gruesome civil war between mujahideen factions in the major urban centers of Afghanistan. The civil war was ended in 1996 by the Taliban, a group of Pashtun men who used a strict interpretation of Islam to reunify the fragmented country after decades of war; their regime, however, practiced major human rights violations. It was during their regime that terrorist organizations like al Qaeda ran their operations in Afghanistan, such as the September 11 attacks on the United States. The September 11 attacks resulted in the U.S. War on Terror, also known as Operation Enduring Freedom, in which the U.S. and its allies dismantled the Taliban regime and set the framework for the rebuilding of Afghanistan’s government. Although the U.S. successfully dismantled the Taliban regime and established a democratic government, the rise in insurgent operations in Afghanistan since 2001 is worth noting. The Afghan population continues to experience an environment of violence that impacts their health and well-being.
Chapter 3: Human security in Afghanistan

“The world has become so linked, that no threat to human security is unconnected to our own”

– Barnett R. Rubin

Abstract

In this chapter, security studies in international relations is defined to establish the framework for which human security is based on. The human security paradigm is further elaborated on to help readers understand the security situation of Afghanistan. Understanding human security will prepare readers for the ensuing chapters focusing on health security of the Afghan population and its relationship with violence. Rather than viewing violence as a national security threat, this chapter will demonstrate to readers for the argument that it is also a human security threat; specifically, it threatens the health and well-being of an entire population.

Introduction

Although the fall of the Berlin Wall in November 1991 symbolized the end of the Cold War (1947-1991) for the Great Powers, to Afghans, the withdrawal of Soviet troops from Afghanistan in 1989 demarcated the end of their involvement in the East-West proxy war. The year 1991 also delineates the onset of a brief, unipolar international order. As the Soviet Union quickly disintegrated, the United States enjoyed its advantageous power differential in the international system as a hegemon. Meanwhile, other states around the world (e.g. Afghanistan) experienced new forms of conflict that the models of state behavior during the Cold War could not entirely explain. Notably, scholars observed that the security of the state could not be sustained by their military power alone. Many developing countries emerged out of the Cold War with unresolved social, economic, and cultural conflicts that were instigated by the power war between the United States and the
Soviet Union (Waisova, 2003, p. 69). In addition to these new state actors, many non-state actors arose during the post-conflict period (e.g. Taliban). Today, governments of the developing world are either in conflict with internal adversaries or hosting terrorist organizations (e.g. Pakistan) (Schweller, 2014, p. 55). These non-state actors are the subject of today’s most contentious international relations issues like the refugee crisis and Islamic extremism. Schweller (2014) refers to this current phenomenon as the “hybrid world,” one that favors guerrilla tactics, sabotage, cyber warfare, and terrorism in an anarchical world were global webs of networks override traditional power bases (p. 100-104).

This chapter discusses the following phenomena to contrive the utility of human security in Afghanistan today. These elements will be referred to throughout this thesis to demonstrate how violence is a health epidemic in Afghanistan.

- Security studies in international relations
- Defining human security
- Debate between human security and national security analysis
- Afghanistan’s security situation today

This thesis explores an individual or community’s freedom of health under the human security paradigm, as it relates to violence during conflict. Rather than focusing on infectious disease as a trans-border issue, the relationship between chronic illness and the spread of violence will be understood. In this respect, violence is treated as an infectious disease; how violence fits in the infectious disease model will be explained later in this thesis. Freedom of health is essential to human security because the locus of this theory is protection of human beings. Accordingly, preventive measures in human security are emphasized over reactive efforts (Matthew, 2009, p. 59), which is similar to how chronic
illnesses such as hypertension and diabetes are treated in medicine. Disease leads to poverty, and poverty leads to further ill-health; thus, conflict adversely impacts the conditions of living for those already living in poverty: “War itself is a significant cause of livelihood contraction: violence tends to escalate in part because it generates new causes of grievance and increased impoverishment” (Matthew, 2009, p. 126). The spread of violence is also demonstrated by the observation that countries recently emerging from civil war have a forty percent chance of entering another conflict (Matthew, 2009, p. 131). While poverty is certainly an endogenous factor in the prevalence of disease and conflict, it is not the only social determinant of health being explored in this thesis. Health literacy, access to education, and gender relations are examples of other factors that occur with conflict and exacerbate prevalence of chronic disease. Therefore, this thesis demonstrates how health insecurity is a threat to human security.

Security studies in international relations

According to Walt’s praised essay on security studies, security analysis is defined as “the study of the threat, use, and control of military force” (1991, p. 212). Rubin, however, argues using force to create security is a political claim that makes the act of violence legitimate (2013, p. 197). Interstate conflict is always a threat and endangers both the state and society. Still, military power does not entirely guarantee national security; poverty, education, and health are also involved in well-being. The aforementioned non-military threats are considered “statecraft” as they either characterize or implicate war (Walt, 1991, p. 213). Walt (1991) cautions against expanding security studies. He believes “Defining the field in this way would destroy its intellectual coherence and make it more difficult to devise solutions to any of these important problems” (p. 213).
While health security or poverty may threaten a state, collective violence has greater consequences to the evolution of human society and prospects for peace (Walt, 1991, p. 213).

The nuclear revolution in the mid-20th century intensified security studies, prompting analysts to ask the central question: “how could states use weapons of mass destruction as instruments of policy, given the risk of any nuclear exchange?” (Walt, 1991, p. 214). During this “Golden Age” of security studies, scholars answered this question using a focus on military balances. This period reached a roadblock in the 1960s, as remaining issues required new conceptual approaches or more advanced analytical tools. Further, there was the failure of a large successor generation of scholars in academia. The Vietnam War also challenged the methodology of security studies, such as systems analysis and bargaining theory. Other non-state and state actors involved in the conflict neglected the security studies of the United States, and the study became unfashionable in many U.S. universities (Walt, 1991, p. 216). The improved relations between the U.S. and Soviet Union made security analysis of war seem less important and more pertinent issues like the international political economy more interesting.

Security studies overcame this dead end of scholarship in the mid-1970s. The Renaissance period retained security analysis’ interdisciplinary character and connection to real-world events while introducing different approaches. Scholars began to rely more on history to generate, test, and refine theories: “the method of ‘structured, focused comparison’ refined by Alexander George and his associates encouraged scholars to use the historical record in a more disciplined fashion” (Walt, 1991, p. 217). Historical analysis made security studies more policy-relevant and exposed the limitations of existing theories through comparative case studies. Moreover, history brought a debate
on the “requirements of deterrence, the utility of the rational deterrence framework, and the appropriate strategies for evaluating it” (Walt, 1991, p. 217). This renaissance also showed the combination of organization theory and careful empirical research in deterrence theory. For example, scholars examined nuclear strategy as it relates to communication between civilian authorities and commands of national authorities. They found civilian authorities’ knowledge of and control over U.S. nuclear operations was limited and nuclear balance in the international system did not have a large effect on international politics or crisis behavior (Walt, 1991, p. 218).

The renaissance also introduced new theoretical approaches and propositions about conventional warfare, as the Vietnam War sparked interest in the role of conventional military power (Walt, 1991, p. 218). This produced a shift in focus from nuclear weapons policy to conventional warfare. According to Walt (1991), Kenneth Waltz’s Theory of International Politics of 1979 reformulated the applicability of realism within the international political economy, during a time when liberal theory was popular. Anarchy and war as constraints to state behavior was debated among scholars in a host of areas that addressed specific policy problems, such as alliances, “expected utility” theory of war, and cooperation (Walt, 1991, p. 219). Moreover, the field of study adopted the norms and objectives of social science. Scholars became engaged in theory creation, theory testing, and theory application (Walt, 1991, p.221). Policy analysis requires theory application to illuminate specific policy problems (Walt, 1991, p. 221). The renaissance also experienced increased access to information, which resulted in civilian analysis of contemporary defense issues (Walt, 1991, p. 220-222).

Kolodziej (1992) argues Walt (1991) takes a neo-realist approach in his essay and undermines the contributions of other scholars in security studies. He focuses on
American national security rather than international security and gives policy makers too much credit for advancing the field of security studies. Further, Kolodziej (1992) states Walt (1991) portrays the methodology of security studies to “a highly selective and largely traditional array of disciplinary and interdisciplinary approaches” (p. 421). Walt (1991) negates the significant amount of research challenging realist theory, the evolving interdisciplinary approach because of the Cold War, the debate between academics and policymakers, and innovative research being performed to update security studies from its traditionalist approach (Kolodziej, 1992, p. 36).

Kolodziej (1992) argues alternative definitions of security are not proposed by Walt (1991): “Security is simply stipulated [by Walt] as the study of war and diplomacy and confined essentially to state-centric analysis” (p. 422). Notably, Walt (1991) does not review the literature about the “armed pursuits, strategies, and claims” of non-state actors (Kolodziej, 1992, p. 422). The prevalence of ethnic and nationality wars in the Middle East and Southwest Asia demonstrate Kolodziej’s notion. These international civil wars transcend national borders and threaten multiple states, suggesting how first-image analysis is flawed when the state is a source of insecurity (Kolodziej, 1992, p. 422-423). Forcing armed conflicts that arise from ideological and ethnic differences into the nation-state unit of second-image analysis dismisses the qualitative distinctions between armed conflicts and interstate wars (Kolodziej, 1992, p. 423). Furthermore, this prevents scholars from asking paramount questions and applying relevant theory to answer these questions (Kolodziej, 1992, p. 423). Accordingly, the primary level of analysis will become more realistic in security studies regarding internal wars: “As the society of states moves gradually toward a world society of peoples, the issue of the legitimacy of a particular regime’s rule becomes increasingly difficult to ignore as a critical security
issue” (Kolodziej, 1992, p. 423). Scholars may even understand interstate wars as a “long chain of civil strifes” (p. 423) in an emerging global system.

Kolodziej (1992) also states that Walt (1991) overlooks prominent security studies theories, like Robert Axelrod, and new methodology that integrates the levels of analysis. Walt’s theory (1991) is highly egoistical, using war between states as the most important element in finding solutions for security equations. On the other hand, Axelrod argues cooperation cannot occur in a world of egoists without central authority (Kolodziej, 1992, p. 424). Schweller (2014) notes that today’s major actors are still egoistic, but not in the traditional military sense: “the major actors in the system are primarily egoistic: they remain quite competitive due to social and material scarcity” (Schweller, 2014, p. 84). In addition, Kolodziej’s (1992) argument demonstrates Hobbes’ observation that security issues derive from the insatiable and incompatible needs of individuals and groups (Kolodziej, 1992, p. 424). Kolodziej (1992) posits that Walt (1991) fails to consider the rudimentary characteristics of realism and reformulate the types of questions that should be asked to solve security problems today.

For example, Walt’s (1991) focus on military force cannot explain the end of the Cold War; the Soviet Union’s military establishment, expansive foreign empire, and the Warsaw pact inhibited the state’s economic growth and development. The Cold War system collapsed because Soviet leaders failed to uphold the three security systems stabilizing the international system: “the bipolar balance in Europe and its sprawling and irregular extension to the developing world; the coercive undergirding of the Soviet Union’s economic production and distribution system; and the Soviet state” (Kolodziej, 1992, p. 424). Kolodziej (1992) states that Renaissance scholars failed to anticipate the end of the Cold War because they assumed that the state and anarchical system could be
discerned as separate levels of causation (p. 425). Rather, the anarchical nature of the international system and nation-states depend on each other as “imperative of logic and observed behavior” (Kolodziej, 1992, p. 426).

After the Cold War, international relations scholars expanded the definition of security to understand hegemony and the behavior of actors in this new system. Rather than viewing security as an objective of states, it started to be viewed as an objective of individuals and groups. This shift in approach has moved “security away from states and an emphasis on military force and war, toward people and the multitudinous risks they must manage” (Matthew, 2009, p. 8). The predominating state-centered, military sense of security was a result of the world wars, increasing military strength, and nuclear arms (Waisova, 2003, p. 58-59). According to Matthew (2009), the meaning of security under the national security model did not recognize the advances in communication technologies, globalization, and environmental change that were occurring after the Cold War (p. 7). Looking at security outside of the interest of state actors and in terms of the individual, such as studying the role of citizens and non-citizens, has led scholars to the paradigm of human security.

**Post-Cold War revival in security studies**

Before the seventeenth century, the state was conceived as an instrument for producing security for its citizens; however, since the establishment of the state-system, it is the subject of security studies (Bilgin, 2003, p. 203). Students of Third World security believe that the Western-oriented and state based national security paradigm could not address the security needs and interests of states and nonstate actors in the Third World (Bilgin, 2003, p. 205), such as Afghanistan and the Taliban. Traditionally, the national
security paradigm issued states the responsibility to establish security by enhancing their military power. This causes other states to increase their military power, which makes the original state more insecure than it was at the onset, otherwise known as the security dilemma (Bilgin, 2003, p. 204). Johan Galtung, an international relations scholar, calls this unstable peace: “peace maintained through threatening mutual annihilation, namely nuclear deterrence” (Bilgin, 2003, p. 205). During the Cold War, the threat of global nuclear catastrophe encouraged Mikhail Gorbachev, leader of the Soviet Union, to practice common security: “Common security is based on the notion that security must be sought and maintained not against one’s adversaries but with them” (Bilgin, 2003, p. 204). This practice set the path for the end of the Cold War, as the reduction of arms in S.U. led to the reduction of arms by the U.S..

Johan Galtung introduced the maximal approach that defined peace as both the absence of war and establishment of conditions for social justice (Bilgin, 2003, p. 204). In his approach, he distinguished personal and structural violence; violence is “avoidable insults to basic human needs, and more generally to life, lowering the real level of needs satisfaction below what is potentially possible” (Bilgin, 2003, p. 205). Structural violence is defined as “socioeconomic institutions and relations that oppress human beings by preventing them from realizing their potential” (Bilgin, 2003, p. 204). In addition to structural and personal violence, cultural violence is defined as mechanisms that render direction violence and structural violence acceptable (Bilgin, 2003, p. 205). In this framework, Galtung shifted the focus of peace research away from the national security approach to individuals and social groups (Bilgin, 2003, p. 205). In the absence of war and establishment of social justice, states may achieve positive peace, where there is the “absence of both direct (physical) violence and indirect (structural and cultural)
violence” (Bilgin, 2003, p. 205). Existing institutions must enhance dialogue, cooperation, and solidarity among people.

Galtung’s structural focus on insecurity complemented students of Third World security approaches. The Third World approach to security included, economic, political, and environmental issues in their security agendas; unlike the Western world’s approach of maintenance and militarization, the Third World focuses on state-building and establishing secure systems for food, health, money, and trade – as secure as their militaries (Bilgin, 2003, p. 206). During the Cold War, the bottom-up views of security by non-state actors in the Third World were not recognized unless they involved violence. For example, the Islamic Salvation Front (FIS) in Algeria during the 1980s set up a myriad of medical clinics and charities to serve the underserved, but their message was not heard until they took up violent practices to be recognized (Bilgin, 2003, p. 206). Not all nonstate actors took up violence, though (e.g. Gandhi, Zapatistas, Chiapas, etc.) (Bilgin, 2003, p. 206). The bottom-up issues of security where largely ignored during the national security-driven Cold War period. After the Cold War, these issues have revived.

Academics have argued to drop the traditional interstate framework of security. According to Bilgin (2003), the paradigm of human security was a result of developments in economic disparities within and between states, hardships of people in the developing world in the margins of globalized world economy, diminishing nonrenewable resources forcing displacement of people, rising anti-foreigner feelings and violence to migration from developing world to developed world, and proliferation of intrastate conflicts that increases pressure for humanitarian intervention (Bilgin, 2003, p. 207). The advent of human security is largely attributable to the costs incurred by national security.
Human security places individuals as the primary referents of security. States can make large portions of their population within their territory insecure by securing themselves, such as states that violate human rights to keep government official in power. States may also fail to meet the needs of their citizens (Bilgin, 2003, p. 208). The differences between states in character and capacity makes a comprehensive approach to security difficult (Bilgin, 2003, p. 208). State-based approaches also ignore other populations of the world, such as refugees or non-citizens. Bill McSweeney argues that a reflexive theory of social order can make security studies a dynamic process where identities and interests are “mutually constituted by social agents in search of security” (Bilgin, 2003, p. 209). Further, McSweeney demonstrates that security studies can look at people and communities as agents that seek to enhance their own and others’ security (Bilgin, 2003, p. 209). For example, Europe is divided by various ethnicities and religion; however, the identity of being European has led to the formation of the European Union.

Brian Job introduced the concept of the “insecurity dilemma”, where weak states are facing internal security threats rather than external, which is guaranteed to last in an anarchic international system. A human security approach would allow security studies to delineate how security issues of the Third World are created by the developed world and sustained by the norms and institutions of international society (Bilgin, 2003, p. 210). Human security emerged from the recognition that “individuals and communities’ security does not necessarily follow from the security of the state in which they are citizens” (Bilgin, 2003, p. 213). Robert Jackson eloquently articulates that while the international society gives national security of states precedence, they don’t recognize that protection from external threats is not converted to domestic security for the citizens of the states (Bilgin, 2003, p. 213). During the Cold War, the United Nations was unable
to direct attention to humanitarian crises or intervene in interstate conflicts because of the high-risk it would pose to the superpower rivalry between the Soviet Union and United States. After the Cold War, however, the United Nations made it clear whose security they were interested in:

the Secretary General of the United Nations, Kofi Annan (1999), also embraced human security as a strategic guide to action and pointed to the existing conception of state sovereignty and the narrow and often self-centered definition of national interest as obstacles to effective action for human rights in humanitarian crises (Bilgin, 2003, p. 214).

**Defining human security**

To this date, human security doesn’t have a standardized definition in the international relations community. The United Nation’s 1994 Human Development Report defined human security as “a concern with human life and dignity” (Matthew, 2009, p. 8) and identified various components of human security, including health, community, economy, and political elements. The International Commission on Human Security further elaborated on this definition, emphasizing human dignity and human development: “‘[human security] protect[s] the vital core of all human lives in ways that enhance human freedoms and human fulfilment’ and which encompasses ‘human rights, good governance, access to education and health care…’” (Matthew, 2009, p. 9).

According to Bilgin (2003), the 1994 UNDP report underscored two ways the concept of security could be revised: “(1) the stress put on territorial security should be shifted toward people’s security, and (2) security should be sought not through armaments but through sustainable development” (p. 214). Human security is a universal concern relative to all people, and globalization has created an underdeveloped “Third World” that is connected to the developed “First World”. Thus, distress in the
underdeveloped world is distress in the developed world, and vice versa. Human security can be ensured through preventative methods and security studies should place people as the referents (Bilgin, 2003, p. 214). The United Nations’ human security approach urges a people-centric understanding of security that seeks peace through change, instead of peace through stability (Bilgin, 2003, p. 214).

Nevertheless, human security has several elements and principles that are widely agreed on. A nonbinding document by the UN General Assembly in 2005 outlines several of these common elements: “We stress the right of people to live in freedom and dignity, free from poverty and despair. We recognize that all individuals, in particular vulnerable people, are entitled to freedom from fear and freedom from want, with an equal opportunity to enjoy all their rights and fully develop their human potential” (Neack, 2017, p. 161-162). Freedom from fear is an immediate freedom that is protected by the state, or in the states’ absence, the international community. The freedom from want and freedom of dignity are primary freedoms upheld by the empowerment of individuals (Neack, 2017, p. 162).

States have a primary responsibility to protect their civilians’ freedom from fear, as well as empower these individuals to exercise their freedom from want and freedom of upholding human dignity. These three responsibilities are foundational elements of the human security paradigm. For example, in 2016, the United Nations stated there were approximately sixty-five million forcibly displaced people, twenty-one million of them were refugees, and forty million were internally displaced people (Neack, 2017, p. 160). In a nonbinding draft agreement on refugees and migrants at the United Nations that year, the United Nations suggested including a phrase about the detention of children; this document is called the New York Declaration for Refugees and Migrants. The
declaration illustrates a common purpose between states: “Large movements of refugees and migrants have political, economic, social, developmental, humanitarian, and human rights ramifications, which cross all borders. These are global phenomena that call for global approaches and global solutions” (Neack, 2017, p. 161). Economic development, education, and participation in decision-making processes are forms of empowerment that nourish people’s resilience under stressful conditions and give them dignity (Neack, 2017, p. 162).

Since the advent of the Geneva Conventions in 1864, states have focused their efforts on the freedom from fear of violence. The Geneva Conventions provided specific agreements on the etiquette of war or conflict, and states agreed to these conventions mostly because they were about the protection of soldiers (Neack, 2017, p. 163). Protecting their military assets during a time when national security measures defined their sovereignty, states willingly exercise these conventions during war or conflict. While protection of the freedom of fear has actively been practiced by states, the freedom from want and freedom to live in dignity hasn’t had similar measures. The benefit of the Geneva Convention for the latter is the distinction between civilians and combatants. According to the Geneva Conventions, a combatant is a member of the armed forces involved in conflict, while civilians are people who do not belong to the armed forces, militias, rebel groups, or occupied residents who take up arms (Neack, 2017, p. 164). Most importantly, in the context of human security, Protocol I, Article 50, Section 3 states: “The presence within the civilian population of individuals who do not come within the definition of civilians does not deprive the population of its civilian character” (Neack, 2017, p. 164). In a period of war, the distinction between civilians and
combatants allow states and the international community to implement preventative measures for the security of the state.

By indicating that political actors have individuals defined as combatants should not deprive these populations of their civilian character; this allows the international community to not only empower individuals, but communities. The Global Environmental Change and Human Security definition of human security includes communities in their definition: “individuals and communities have the options necessary to end, mitigate, or adapt to threats to their human, environmental, and social rights; have the capacity and freedom to exercise these options; and actively participate in pursuing these options” (Matthew, 2009, p. 18). When human beings are given freedoms by the state or international community, they are in effect capable of gathering the resources necessary to achieve the interests of their communities.

According to Narasimhan & Chen (2003), international humanitarian law was built on this principle of civilian distinctiveness. Rational military preference supports civilian protection (p. 16) and state actors must commit to these laws: “such conventions, and behaviors respectful of them, depend on a high degree of human connectivity and perceived equality of trust and risk of reprisal” (Narasimhan & Chen, 2003, p. 16). Nevertheless, the regional and civilian conflicts after the Cold War expose the growing role of non-state actors in state security. While state actors abide by these humanitarian laws based on the Geneva Conventions, non-state actors do not have to. Human security de-militarizes security analysis and considers the role other phenomena, such as social constructs (i.e. race, religion, tribal system), public health, and education, have on a state’s security. In a globalized world, trans-border problems like the refugee crisis cannot be solved by international humanitarian law that uses state actors as their unit of
analysis. International humanitarian law should extend on its principle of civilian distinctiveness and consider communities, such as non-citizens and child traffickers across borders; transborder problems are increasingly threats to states’ security in the post-Cold War period. Moreover, international humanitarian law should provide the framework for protection of individual and communities’ freedom from want and freedom to live in dignity, in addition to their freedom from fear.

In Afghanistan, internal divisions between the various ethnic and religious groups helped ignite the civil war between the Mujahedeen armies (1992-1996). The fall of the Soviet Union in 1991 prompted Mujahedeen warlords (based in NWFP, Pakistan) to overthrow the communist Afghan president, Mohammad Najibullah in 1992. The ensuing conflict between these guerrilla forces lasted until 1996 when the Taliban took control of Kabul. According to Narasimhan & Chen (2003), “Such conflicts usually provoke massive flows of people, both international refugees and internally displaced people; gross violations of human rights; and tragically, genocide, including the use of rape as a weapon of war” (p. 6). Before the Syrian War, Afghanistan had the largest number of internationally displaced people. Afghans who returned to Afghanistan after taking refuge in neighboring countries during the Soviet Invasion were forced to escape Afghanistan again. During this conflict, civilians were both “collateral damage” and the intended targets of attacks. The Hazara tribe of Afghanistan was particularly persecuted by the warlords because of their Shiite beliefs and Mongol ancestry. This post-Cold War period of Afghanistan marked the beginning of the inter-ethnic and inter-religious conflict that simultaneously occurs in Afghanistan today amidst international combat.

**Debate between human security and national security analysis**
National security interests and human security interests are widely contested in the international relations community. Human security demands the state to “serve and support the people from which it draws its legitimacy” (Fakiolas, 2009, p. 369). This paradigm is both a policy tool and a set of values and norms that involves three forms of agenda: advancing human rights and well-being of individuals and communities within states, establishing a human security organizational system of global governance, and creating policies that extend power relations between states to facilitate securitization of world politics (Fakiolas, 2009, p. 369). National security, in contrast, argues security comes from the state and the state must protects its population from external and internal threats: “without the state there is no protection for people and property: people make a contract to create the basis for their own safe and good life” (Waisova, 2003, p. 60). Further, national security ensures gains that can be achieved in a zero-sum international anarchy. States share a belief that they are in an international society for which they are the principal actors and bearers of rights and duties; in this society, they share a struggle for survival and seek to have more relative power (Fakiolas, 2009, p. 377).

Although national security and human security have stark differences, Fakiolas (2009) argues human and national security is neither separate nor identical: “They are made by humans for humans and for human purposes.” He views the state as collectively human and inter-subjectively constituted, a material product of interaction and consciousness (Fakiolas, 2009, p. 376). It is an agent of social power because it embodies social relations in society within “territorially ordered institutional confines” (Fakiolas, 2009, p. 376-377). Further, it is an agent of structural power because it protects its territory from external force in an environment of international anarchy. The main objective of a state, then, is “to realize the freedom from threats and wants for its human
beings that are the bearers of society and constitutive of the state within a territorially confined space” (Fakiolas, 2009, p. 379).

The national security model assumes the insecurity of an individual is only secured with tangible resources, such as the state’s military. Ironically, the securitization of an individual, particularly in military terms, decreases human security because the chance of conflict increases (Waisova, 2003, p. 69). Further, when developed states are strengthening their national security, they are simultaneously weakening the national and human security of underdeveloped states (Waisova, 2003, p. 69). This phenomenon is called the boomerang effect, an idea of mutual dependence between the securities of states in an interconnected post-Cold War world. A prime example of the boomerang effect is the September 11, 2001 attack on the United States by non-state actors from Middle Eastern allies of the United States facing civil war and economic depression after the Cold War.

The human security approach ensures states and the international community provides the minimum material and survival inputs for security, human development, and conflict prevention (Narasimhan & Chen, 2003, p. 14). Further, human security recognizes human beings’ core attachments to home, community, and the future; these core attachments facilitate participation of individuals and the nation-state in society (Narasimhan & Chen, 2003, p. 14). When they are broken, Narasimhan & Chen (2003) argue violence and disorder in the international system arises:

These attachments are often undone when populations are uprooted and dislocated, when families are dispersed and communities are destroyed, and when arbitrary violence and discrimination render the future distant and unpredictable. People turn to other sources for participation, recognition, and empowerment, and credible dispute resolution becomes unlikely and the paths to violence and disorder are manifold (p. 14).
Afghanistan’s Security Situation Today

In the case of Afghanistan, it is difficult to understand how its behavior in the international system conforms to national security analysis. Afghanistan’s insecurity today stems from domestic insecurity that indirectly involves multiple state and non-state actors in the East and West. In this sense, national security cannot protect its territory from external forces since the armed conflict is a domestic issue. Individuals are threatened more by the state’s institutions (or their non-existence) than by external threats (Waisova, 2003, p. 61). In the national security paradigm, war is waged against external challengers using the state’s military institution (Fakiolas, 2009, p. 378). Afghanistan’s military strength is largely attributable to the North Atlantic Treaty Organization (NATO), an international alliance between the United States and European powers who commanded the international security assistance force (ISAF) in Afghanistan between 2001 and 2014 (Rubin, 2013).

The first parliamentary elections in 2010 did not unify the fragmented society, and the exorbitant violence present in last October’s parliamentary elections illuminates the deteriorating security in Afghanistan: “156 were killed and 340 wounded in 152 election-related security incidents” (Dadabaev, 2019, p. 115). At the onset of the U.S. invasion of Afghanistan, the conflict consistently involved two major actors, the pro-government forces (e.g. U.S.-led N.A.T.O. forces, ISAF, Afghan government) and anti-government elements (e.g. Taliban, al Qaeda). Today, a third side has emerged in the conflict: the Islamic State. It worth noting that the “Islamic State” is generally referred as “Daesh” amongst Afghans, and “Daesh” directly translates to those who crush things; this difference in language is important when looking through the human security lens, as it separates the religion of a population from the actions of a non-state actor. Although it
is an anti-government element, it is also anti-Taliban (Dadabaev, 2019, p. 115). Further, the Islamic State force is 70% Pakistani, 6% Uzbek, 4% Chechen, 3% Arab, 1% Chinese, and 14% Afghan (Dadabaev, 2019, p. 115). The involvement of Pakistani nationals in Afghanistan’s deteriorating security situation is an ever-present theme in Afghanistan’s modern history. The Taliban aims to fight infidels and occupational forces, while the Islamic State is less selective on its targets and conducts large scale attacks that cause many casualties (Dadabaev, 2019, p. 116).

Afghanistan experienced the highest rate of civilian casualties within the last decade last year: “According to the UN assistance Mission in Afghanistan, 1,692 civilians were killed and 3,430 injured between January and July 2018, the highest rate in 10 years” (Dadabaev, 2019, p. 116). A significant portion of the Afghan population either lives in provinces completely controlled by insurgents or in contested areas. Dadabaev (2019) found that Taliban-controlled territories have an equal or greater degree of order compared to the government. In addition, drug trafficking in Afghanistan threatens its Central Asian neighbors by turning the region into a transit route to Europe (Dadabaev, 2019, p. 118).

In addition to the anti-government elements, the pro-government forces in Afghanistan has contributed greatly to the insecurity of the state today. When the International Criminal Court (ICC) indicated their intention to investigate and prosecute U.S. troops in Afghanistan for war crimes, John Bolt, the U.S. national security advisor, threatened to arrest the ICC judges (Dadabaev, 2019, p. 120). In the July 30th quarterly report of the Special Inspector General for Afghanistan Reconstruction to the U.S. Congress, the Special Inspector General claimed there was no direct discussion of stabilization strategy and programs in Afghanistan, as they collectively had disappointing
results, and the U.S. will unlikely pursue future stabilization programs in Afghanistan (Dadabaev, 2019, p. 120). U.S. President Donald Trump’s administration has begun direct negotiations with the Taliban by establishing a State Department team including Trump’s special advisor on Afghanistan, Zalmay Khalilzad (Dadabaev, 2019, p. 120-121). In December of 2018, the Trump administration announced the withdrawal of 7,000 troops in Afghanistan, signaling an impending overall U.S. withdrawal from Afghanistan (Dadabaev, 2019, p. 121). Interestingly, China recently expressed its interest in establishing a military base in Afghanistan (Dadabaev, 2019, p. 121); the timing of this announcement signifies a looming shift in the regional balance of power when the U.S. withdraws from Afghanistan.

**Conclusion**

The current (in)security situation of Afghanistan reveals how state and international efforts to rebuild a centralized Afghan government has failed to produce security. The international community has spent billions of dollars to rebuild the national security institutions of Afghanistan, a cost unsustainable by the donor states and the government of Afghanistan in the long term (Shahrani, 2018, p. 44). The Cold War-like security measures enacted by U.S.-led N.A.T.O. forces and the Afghan government are ineffective and demonstrate the need for a human security approach in rebuilding the state institutions of Afghanistan. The failure of a national security approach to “repairing” Afghanistan demonstrates Matthew’s (2009) argument that the national security model does not recognize the advances in communication technologies, globalization, and environmental change after the Cold War. As Kolodziej (1992) argues, analyzing armed conflicts that arise from ideological and ethnic differences into the
nation-state unit of second-image analysis dismisses the qualitative distinctions between armed conflicts and interstate wars. A human security approach to restoring security in Afghanistan will allow scholars to perform research at the primary level of analysis and identify the Afghan government as illegitimate and a critical security issue. Further, the primary level of analysis will place pro-government forces and anti-government elements on the same playing field. War between U.S.-led N.A.T.O. forces (state actors) and insurgent forces (non-state actors) does not even meet the foundational requirements of national security approach, that states are the unit of analysis; in this respect, the war between a state actor and non-state would not provide a solution to the insecurity in Afghanistan.

Human security theory is a promising approach to security studies regarding Afghanistan. Instead of focusing on state security, international policy should be driven towards securing the population, controlling trans-border opium trade, improving the education sector, developing the health sector, etc. Violence in Afghanistan is not only a national security threat, but also a human security threat. It not only threatens the state’s military power, but also its domestic institutions, fostering greater intrastate conflict. Galtung (1990) articulated the relationship between different forms of violence that affect the securitization of an individual very well: “Direct violence is an event; structural violence is a process with ups and downs; cultural violence is an invariant, a ‘permanence’, remaining essentially the same for long periods, given the slow transformations of basic culture” (p. 295). Cultural violence normalizes exploitation and repression, which is engrained in the structure of a state, and direct violence is the response to the structure.
A human security approach in Afghanistan can address the trauma that incurs upon individuals experiencing these forms of violence. According to Galtung (1990): “When it [direct and structural violence] happens to a group, a collectivity, we have the collective trauma that can sediment into the collective subconscious and become raw material for major historical processes and events” (p. 295). Thus, cultural peace causes structural peace, which causes direct peace in a state. In this respect, a state become secured. The human security approach allows for this formulation of violence, which broadens the agenda for peace studies by considering the structural and cultural phenomena involved in violence, rather than its direct forms (studied in national security studies). Afghanistan, as evidenced by its sociopolitical history of violence, has experienced cultural, direct, and structural violence. Perhaps, security studies of Afghanistan that considered Galtung’s argument can bring positive peace to Afghanistan.
Chapter 4: Afghanistan’s health & human security

“We live in the mountains in Samangan province. It's far away from here [Kunduz city]. It took us more than half a day to get here. We walked, travelled by donkey and then took a taxi, but the majority of the journey was on foot. My relative couldn't afford [the transport] to bring his injured son here. So I borrowed the money from people I knew and travelled with him instead. To pay back the money, I will have to sell many more nuts. And our family will have to eat less. There is no other way.”

- Male, 43 years, farmer, Khuram Wa Sarbagh district, Samangan province

(Carthaigh et al., 2015)

Abstract

This chapter discusses the “post-conflict” public health sector of Afghanistan and its relationship to human security. Further, the relationship between international law and security studies in global health governance is briefly explored. Public health is an international institution that has only recently started formulating laws through the Universal Declaration of Human Rights (UDHR) and International Health Regulations (IHR). Public health institutions protect states from external threats (much like national security), but they also protect the individual from internal threats (as in human security).

The chapter goes over developments in Afghanistan’s public health sector, specifically through the Ministry of Public Health. Furthermore, the prevalence of non-communicable diseases in Afghanistan is discussed.

Introduction

The right to attain an adequate standard of physical and mental health is an inherent and universal right. Every nation-state should have a secure health system as it is fundamental to a healthy and equitable society. While this right is universal in nature, most disadvantaged and vulnerable populations do not have the resources or security to benefit from this right. Social determinants of health are the exogenous circumstances humans are born into and experience life by, including the condition of institutions that prevent disease and treat illness when it occurs. The social, economic, cultural, and political forces that shape these circumstances affect the health status of populations to a
great degree (Bell, 2010). Such social determinants of health include armed conflict, employment, empowerment, environment, finance, human rights, poverty, sanitation, social policies, trade, and water supply (Hoffman et al., 2016). In fact, studies demonstrate how these factors are equally important to the somatic factors determining the health status of populations. Non-state actors, such as human rights organizations, follow human rights norms to address social determinants of health and promote health outcomes and access in underserved and vulnerable populations (Chapman, 2009).

The Universal Declaration of Human Rights (UDHR) has a foundational role in international human rights law and is universally agreed-upon by the United Nations General Assembly as international goals. Unlike a treaty, the UDHR is a resolution that is nonbinding; thus, not all members of the United Nations must adhere to its goals. Nevertheless, the language has been used by many nations and incorporated in their constitutions (Malik, 2010, p. 1093). Generally, international human rights proclaim the Kantian precept to treat human beings as an end and not as a means; this is illustrated through the prominent efforts of international institutions in developing countries. Protection of dignity and equal worth requires protection of political, social, and economic rights, including health (Malik, 2010, p. 1093). Article 25 of UDHR (1948) broadly defines health and the various social determinants that determine health outcomes:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The institution of public health is limited in the international sphere because international humanitarian law has been built on the assumption that military preference supports
civilian protection (Narasimhan and Chen, 2003, p. 16). Protection of civilians in a national security-driven framework of international humanitarian law depends on human connectivity and trust, which are phenomena human the human security paradigm explicitly considers.

Based off the UDHR, the International Covenant on Civil and Political Rights was ratified in 1992. Article 6 of this legally binding covenant enumerated the right to life, which was further expanded in 1982 by the Human Rights Committee in General Comment 6. The committee expanded the vague language of the ICCPR to require states to reduce infant mortality and increase life expectancy (Malik, 2010, p. 1092-1093). In addition to the ICCPR, the International Covenant on Economic, Social, and Cultural Rights further delineates the right to health. Unlike the ICCPR, the ICESCR has not yet been ratified. Article 12 of the ICESCR outlines the metrics used to assess the standard of health, such as “the prevention, treatment and control of epidemic, endemic, occupational, and other diseases” and “the improvement of all aspects of environment and industrial hygiene” (Malik, 2010, p. 1094). Further, the ICESCR considers the individual differences between countries and adjusts the measures of each requirement according to the countries’ baseline health status, development, economic status, and social conditions.

Because of the human rights norms the UDHR and subsequent covenants circumscribe, governments are obligated to respect, protect, and fulfill the right to health. According to Malik (2010), the obligations today are in the “respect” or “protect” stage and have yet to reach the “fulfill” stage. States refrain from interfering with people’s ability to enjoy their freedom of health, and they also protect their people from having
their rights compromised by third parties. Generally, implementation of the right to
health through resource allocation has not been achieved. Recent international health
laws that “embraces human rights as inextricably linked to health” (Malik, 2010, p. 1098)
like the International Health Regulations (IHR) provides a policy framework for
implementation of this right. Further, this framework is predicated upon a model of
global governance (Malik, 2010, p. 1099) that achieves human security, international
environmental improvement, and optimal population benefit in global trade (Malik, 2010,
p. 1099).

Article 12 of the International Covenant on Economic, Social, and Cultural Rights
(ICESCR) mandates the right to obtain the “highest attainable standard of physical and
mental health” by countries part of the Covenant. These countries must enforce laws and
programs that promote “the reduction of infant mortality and for the healthy development
of the child, the improvement of all aspects of environmental and industrial hygiene, the
prevention treatment and control of epidemic, endemic, occupational and other disease,
and the creation of conditions which would assure medical service and medical attention
to all” (Chapman, 2009). The United Nations Committee on Economic, Social, and
Cultural Rights updated the ICESCR in 2000 to include more social determinants of
health, such as access to safe and potable water and sanitation, food security, and health
education. Also, the revisions emphasized nondiscrimination and equal treatment in
access to health care across all member states. Afghanistan, United States, Pakistan, Iran,
and the United Kingdom are some of the 166 signatories following this covenant.

Hongxi, emperor of the Ming Dynasty in China, stated, “We must treat poverty
like we would treat drowning. There is no time to lose.” He elucidated the urgency
governments must have to address social determinants of health. According to Foege
poverty is the leading factor involved in adverse health outcomes, but the public health field has only started considering social determinants of health in the last sixty years. International relations scholars like Andrew Price-Smith perceive the spread of infectious disease, like HIV/AIDS, to threaten state survival greater than warfare and civil conflict: “‘Rapid negative change in the health status of a population and pathogen-induced demographic collapse may...figure in the destabilization of states’” (Upton, 2004, p. 73). Communicable diseases do not recognize international borders and thus they become trans-border threats the international community must distinguish. For example, when the international community learned about China’s outbreak of Severe Acute Respiratory Syndrome (SARS) in 2002 and China’s efforts to hide the epidemic from the public, the World Health Organization (WHO) was commissioned to stop its spread (Upton, 2004, p. 76).

According to the public health scholar Nicholas King, public health institutions protect their citizens from external threats, making public health an international discipline that has similarities with the national security paradigm (King, 2002, p. 764). Today, the emerging diseases worldview is predominant in the West and illustrates how Americans are no longer insulated from diseases thought to be of the developing world (King, 2002, p. 767). In this framework, there are certain nations acting as reservoirs of infection; moreover, there are boundaries between races, classes, and nation-states that protect great powers from infection. The emerging diseases worldview also considers globalization as “an irresponsible source of geographic transgression, rendering the ideal of territoriality moot” (King, 2002, p. 773). Western scientific discovery can be used to eradicate these diseases in the developing world through the establishment of a global surveillance network that detects, tracks, and intervenes against disease outbreaks (King,
2002, p. 774). In a globalized world, great powers must de-territorialize their public health efforts and realize that a sick person in Afghanistan can become a sick person in the United States. As leaders in medicinal science, this approach will not only protect the U.S. from disease but also improve the health of the international community.

Traditionally, international health has focused on intervention when disease transmission occurs between humans or non-humans. Today, though, control of infectious diseases must be achieved through biomedical technology. This is difficult because of the commodification of pharmaceuticals and vaccines in developed and newly industrialized countries. Introducing multi-tiered pricing schemes, synchronization of regulatory standards regarding safety, quality control, intellectual property, and piracy, and education and training of health professionals from developing nations would protect and incentivize Western biomedical science (King, 2002, p. 776-777). Putting the emerging diseases worldview into effect could substantially improve the global health of developing nations like Afghanistan. Proponents may argue that this Eurocentric worldview does not consider the traditional healing practices of indigenous people that may equally benefit developing nations. However, this worldview does not challenge the beliefs of non-Western nations but envisions equal access to health technologies. Using global health to foster international development, underdeveloped nations can integrate into the world capitalist economy through participation in this framework. In the World Bank’s 1993 World Development Report, the international institution recommended simultaneously expanding health and economic development because poor health is an obstacle to economic development. Investment in education, redirecting government spending from specialized healthcare to prevention, and promoting cost-effective
healthcare and competition among providers are some strategies that can achieve international development (King, 2002, p. 781).

Health development in Afghanistan has significantly changed since the establishment of former-president Hamid Karzai’s administration. At the onset of Karzai’s administration, the Ministry of Public Health (MOPH) identified delivery of sustainable, quality, and accessible healthcare, especially for women, as its top priority. Their other goal was to successfully implement the Basic Package of Health Services (BPHS), a nationwide health system that contracts non-governmental organizations for provision of services. According to Sabri et al. (2007), the World Bank, United States Agency for International Development (USAID), and the European Commission are the three major donors to the BPHS. Afghanistan is dependent on non-governmental organizations (NGOs) to fund greater than 80% of health facilities (public and private) in the developing country (Peters et al., 2007). Per Acerra et al. (2009), it costs ~$4.30 – $5.12 USD per capita to begin a program rebuilding the health sector in Afghanistan.

Afghanistan’s health trajectory after decades of violence took a vital turn during the Karzai administration; nonetheless, it still has much to improve as violence is reemerging at rates higher than ten years ago.

**Afghanistan’s Public Health Institutions**

There are many lessons to be learned from Afghanistan’s efforts to develop their health sector amidst violence, insecurity, and deep poverty. After the collapse of the Taliban in 2001, Afghanistan had some of the worst mortality rates in the world (maternal: 16%; infant: 16.5%; child: 25.7%) (Newbrander et al., 2014). According to Loevinsohn & Sayed (2008), the maternal mortality ratio in northern Badakhshan province was 6,507
deaths per 100,000 live births – 15 times higher than in Kabul. Moreover, access to healthcare services was limited to 10% of the population (Newbrander et al., 2014). Acerra et al. (2009) found there are only 6,000 physicians and 14,000 nurses in a population of 28 million people. During the Soviet-Afghan and civil wars, non-governmental organizations (NGOs) predominantly led healthcare services in rural Afghanistan, where 80% of the population lives; their services were limited, though, as there was approximately 1 primary health care clinic per 50,000 people (Loevinsohn & Sayed, 2008). Furthermore, rapid regime changes and conflict necessitated NGOs to work independently from the government, which led to uncoordinated and unfocused activities in the health sector.

Because there was not a system to collect information on health services, the MOPH began monitoring health outcomes through surveys and using a balanced scorecard (BSC) to benchmark their progress (Peters et al., 2007). Afghanistan is the first developing country to implement BSC as the method for monitoring health services (Peters et al., 2007). The MOPH conducts an annual assessment of service provision and patient perspective, the National Health Services Performance Assessment, which is used for the BSC.

Analyzing the MOPH’s BSC in 2004, Peters et al. (2007) found variation within each indicator across provinces, demonstrating different needs for each province. The differences across provinces are probably due to the different levels of violence they face. Similarly, drought is another condition that likely influences the BSC indicators. Despite the variation across provinces, the 2004 BSC showed improvement at the national level, especially in the MOPH’s vision for greater delivery of sustainable, quality, and accessible healthcare for the female population (Peters et al., 2007). There were also
more poor people making outpatient visits than other income level groups; however, lower levels of satisfaction from healthcare services was reported from the poor (Peters et al., 2007). The MOPH’s implementation of *shura-e-sehie*, community health forums in each province that plan and monitor local health activities, are nationally unsuccessful given that a median of 34% *shura-e-sehie* are active across Afghanistan (Peters et al., 2007). The MOPH’s implementation of *shura-e-sehie*, community health forums in each province that plan and monitor local health activities, are nationally unsuccessful given that a median of 34% *shura-e-sehie* are active across Afghanistan (Peters et al., 2007). The BSC has helped the MOPH and its stakeholders focus on specific provinces and general areas for improvement: “the MOPH, donors, and implementing agencies made it a priority to improve tuberculosis care and record keeping, health-worker training and knowledge, *shura-e-sehie* activities, drug availability, laboratory capacity, and use of clinical guidelines” (Peters, 2007, p. 149). In addition to the national implementation of BSC, provincial practice of BSC helps provincial health directors to address low-performing domains in their areas. NGOs contracted with MOPH in the same provinces, however, do not coordinate their health service delivery function with the provincial directorates, leading to duplication, inefficiency, and neglect of government-sponsored programs (Sabri et al., 2007). The BSC should also assess the role of NGOs in health outcomes, which would also organize provincial management of health programs. According to Peters (2007), BSC allows the MOPH to develop the “groundwork for the continued development of a well-balanced health sector that reflects patient and staff perspectives, capacity for service provision, technical quality, financial systems and the vision and values of the ministry” (p. 150).

Between 2002 and 2007, there has been a 136% increase in the number of primary health care facilities, also characterized by a 58.2% increase in female physicians, nurses, and midwives (Loevinsohn & Sayed, 2008). Likewise, there are better health outcomes in Afghanistan since the implementation of BPHS: “The 2006 household
survey found that the infant mortality rate was 129 per 1000 live births and the under 5-year mortality rate was 191 per 1000 live births. The United Nations estimates for these indicators in 2002 were 165 and 257, respectively, which represents a 22% and 26% decline, respectively, in these rates” (Loevinsohn & Sayed, 2008).

However, this improvement in healthcare services soon after the onset of BPHS implementation was short-lived. Although Afghanistan is now in its final phase of US-led NATO military intervention, it is experiencing an unprecedented level of violence since 2001. According to Carthaigh et al. (2015), civilian casualties increased 13.5% in 2013 compared to 2012, and of the 630,000 internally displaced Afghans, 124,000 of them were displaced in 2013 alone. While much progress was made by the BPHS, donor support to the health sector is influenced by political goals, like state building, which could potentially cause a bias in healthcare provisions (Carthaigh et al., 2015). For example, patients fear using public health services because of insurgents who are anti-government. Carthaigh et al. (2015) also argues that aid provision is often threat-based instead of needs-based, and aid providers are often concentrated in areas where US-led NATO troops are present.

Data collected in four Medecins Sans Frontieres (MSF) hospitals (Kunduz, Helmand, Kabul, and Khost) showed patients perceived the “free” public system as deceiving. Carthaigh et al. (2015) found 56.2% of respondents who visited a public facility ended up paying for medications. Further, they also spoke of healthcare providers encouraging patients to visit their private practices: “Even if you can see the doctor for free, when you need medicines or tests, the doctors push you towards their own private clinics (male, 40, mullah from Gharmsher district, Helmand province)” (Carthaigh et al., 2015). One in ten patients went abroad for treatment for an illness of someone in their
household within three months of their interview, often to Pakistan, and this puts a financial burden on families.

Furthermore, active fighting between armed groups and impossibility of night travel due to insecurity on the roads were leading barriers to reaching the MSF hospital for treatment. Figure 1 illustrates the types of barriers patients interviewed experienced. Patients experience great danger in their journey for health care amenities; often, those who live in rural Afghanistan are caught in the middle of insurgency and international or national military forces:

In the last years violence has blocked us coming to health centres and hospitals more than 100 times I think. There is constant violence around my village. We never know how much fighting each week will bring. The fighting doesn't stop when there are injured people, so we can't get them to a doctor. So we wait, and then they die, and the fighting continues. Even if you are able to move with your wounded you still have to get through roadblocks, checkpoints, questioning and harassment before you can reach the hospital (male, 25 years, school principal, from Baghlan province) (Carthaigh et al., 2015).

Public health services are perceived as inadequate because of long waiting times, unavailability or low quality of drugs, and lack of qualified staff (Carthaigh et al., 2015). Hansen et al. (2008) found that there was no difference in service quality between public and NGO health facilities, but NGO’s provided greater equitable quality of care to the poor than government facilities. Sabri et al. (2007) argue NGO’s have “short-term contracts and lack long-term vision in healthcare delivery”; this leaves the Afghan health sector unlikely to develop a self-sustaining, independent healthcare system. The conflict impacts health infrastructure and availability of healthcare professionals in insecure areas of Afghanistan. NGO’s are often funded externally, and their contracts are closely monitored for quality and equity (Hansen et al., 2008), so it makes sense that their facilities are better than the latter. Moreover, Carthaigh et al. (2015) states medical staff
and ambulance drivers are often scared to travel to the most insecure zones, especially female health workers. Among the four MSF clinics, one in five people had a close one that died the last year because of inadequate access to healthcare, and conflict served as a major cause for this discrepancy (Carthaigh et al., 2015); pregnant women are especially vulnerable because untreated postpartum bleeding often leads to death:

A few months ago a woman in my village was pregnant. She had problems and needed to get to a hospital to deliver. There was fighting at night so we couldn't bring her here. She and her baby died that night (female, 28 years, from Bak district, Khost province) (Carthaigh et al., 2015).


The MOPH’s implementation of BPHS is not meeting the population’s medical and emergency needs. According to Acerra et al. (2009), “In 2004, more than 40 health and reconstruction workers were killed, including 5 who were murdered specifically for being health care workers. Due to this violence, at least 300,000 people lost access to primary care services…” (p. 79). In addition to the domestic population, Afghanistan’s
increasingly dangerous environment impacts the NGOs contracted with the MOPH, as the number of aid workers killed in Afghanistan increases every year (Carthaigh et al., 2015). For the long term, the MOPH must determine how to become less dependent on NGOs for the basic health care services outlined in the BPHS.

While the BPHS addressed important health needs for a country that lacked an adequate healthcare system for decades, it did not address another pressing issue in post-conflict Afghanistan. In general, communicable diseases have dominated the global health and disease agenda (Feroz, 2015). Non-communicable diseases (NCD’s), such as heart disease and diabetes, are major challenges to international development; until 2015, Afghanistan did not have a national policy or strategy for non-communicable disease prevention. A post-conflict environment increases the risk of NCD’s, as psychological distress and rapid urbanization lead to unhealthy behaviors. Physiologically, the thrifty phenotype hypothesis finds adults’ metabolism to be affected by the nutritional conditions of their pre- or early post-natal periods of development (Roberts et al., 2012).

In September 2011, the United Nations General Assembly encouraged member states to tackle NCD’s in their respective states. However, the general assembly failed to mention the greater issue of NCD’s in developing countries (Akbulut-Yuksel, 2017). Despite the ignorance towards NCDs in the international community, the Ministry of Health in Afghanistan considered the high mortality rates due to NCDs in the Afghan population and established a Noncommunicable Diseases Department in 2012 (Feroz, 2015). Figure 2 illustrates the organization of the NCDs department.

Non-communicable diseases in Afghanistan

In Mokdad et al.’s (2016) population study of the Eastern Mediterranean Region, there was a shift in the main causes of death from communicable diseases to non-communicable diseases as the leading cause of death between 1990 and 2013. The leading cause of death in 2013 was ischemic heart disease, which was also the leading cause for the DALY change in males in 2013. Disability-Adjusted Life Years (DALYs) measure the gap between current health status and an ideal health situation in which the population lives longer and is free of disease and disability. DALYs are the sum of the Years of Life Lost (YLL) due to premature mortality and Years Lost due to Disability (YLD). YLL’s are equal to the product of number of deaths (N) and the standard life expectancy at age of death in years (L). Additionally, YLD’s are equal to the product of the number of incident cases (I), disability weight (DW), and average duration of the case until remission or death (L) ("Metrics: Disability-Adjusted Life Year (DALY)").
For females in the EMR, lower respiratory infection was the leading cause of DALYs; hypertension was the leading risk factor for both sexes. In low-income countries, such as Afghanistan, childhood wasting (acute malnutrition) was the common cause for population-wide change in DALYs. The findings of this study demonstrated how the public health of the EMR is affected by conflict, ageing, and population growth (Mokdad et al., 2016, p. e705).

Afghanistan had the lowest life expectancy and healthy life expectancy since 1990 (Men: 56.5 years vs 49.0 years; Women: 56.0 years vs 48.8 years). The Syrian war contributed to 38.1% of YLLs in Syria during 2013; Mokdad et al. (2016) states:

Between 1990 and 2013 life expectancy for Syria would have been 6 years higher than observed for males and 5 years higher for females had the crisis not happened….in Syria the annualized rate of reduction in infant mortality between 2010 to 2013 was -9.1%, in sharp contrast with the rate of decrease of 6.0% before 2010 (p. e710). Furthermore, the lack of stable infrastructure during war has drawn in environmental challenges to the low-income countries in the Eastern Mediterranean Region; the depletion of water and sanitation resources has increased the rate of disease outbreaks. Nevertheless, for civilians from low-income countries internally and externally displaced because of conflict, survival is a larger challenge than improving their health.

Non-communicable diseases (NCDs) are non-infectious medical conditions like high blood pressure, diabetes, and chronic respiratory diseases. The four main groups of NCDs are diabetes, cancer, chronic vascular disease, and chronic obstructive pulmonary diseases; they also share four major risk factors: tobacco use, unhealthy diet, harmful alcohol consumption, and insufficient physical activity (Ferozuddin, 2015). These risk factors are further exasperated by stress due to violence. The World Health Assembly made reducing avoidable mortality from NCDs by 25% as a health goal to be achieved by
2025 (Saeed, 2013). The global economic burden of NCDs is estimated to rise to $13 trillion by 2030, a sharp increase from the $6.3 trillion spent on NCDs in 2010 (Saeed, 2013). Hypertension (high blood pressure) is predicted to increase to 1.5 billion by 2025 and the prevalence of this disease in the Eastern Mediterranean Region (EMR) is significant – 29% of about 125 million individuals are affected (Saeed, 2013). The 2010 Afghanistan Mortality Survey found that 33.3% of all deaths are due to non-communicable diseases while 42.6% of deaths are due to communicable, maternal, perinatal, and nutritional conditions (Saeed, 2013). Kabul city, the capital of Afghanistan, is substantially affected by low ambient air quality due to pollution. Saeed (2013) states smoking among men older than 15 years in Kabul is 35%, which worsens the burden of respiratory diseases and cancer among inhabitants of the city.

In a cross-sectional study of residents 40 years and older in Kabul, Saeed (2013) found high prevalence of obesity (31.2%), hypertension (46.3%), and diabetes (13.3%). Furthermore, 60% of participants consumed about three servings of fruit and vegetables per week (Saeed, 2013). Comparatively, U.S. federal guidelines recommend adults have at least 1-2 servings of fruit and 2-3 servings of vegetable per day (“Only 1 in 10 Adults Get Enough Fruits or Vegetables”, 2017). Saeed (2013) found a significant association between fruit consumption and hypertension: as fruit consumption decreased, hypertension increased. Although two thirds of the population is overweight, it should be considered that being overweight or obsess is perceived as beautiful, even healthy, in Afghan culture. Saeed (2013) argues that Afghanistan is experiencing an epidemic of non-communicable diseases.

The Ministry of Public Health must address the outbreak of NCDs in Afghanistan, as the BPHS did not lay out a framework for ameliorating NCDs. Although Saeed’s
(2013) study was in Kabul, one urban center in a highly rural country, there is an increasing number of internally displaced people coming to Kabul because of insurgency and drought in their respective regions since 2001. According to Engelgau et al. (2011), non-communicable disease surveillance in Afghanistan is very limited. This is largely due to the decentralized treatment provisions; for example, hypertension treatment is offered at district hospitals, but diabetes and ischemic heart disease are only treated at provincial hospitals (p. 115). This is problematic for patients who have multiple conditions, which is often the case. In 2011, there were 3,000-4,000 physicians in Afghanistan, but they are located in mostly urban centers (Engelgau et al., 2011, p. 116). Furthermore, Afghanistan has a severe shortage of specialists in non-communicable diseases, especially psychiatry. Afghanistan’s agenda for new health projects is based on the Millennium Development Goals (MDGs), such as maternal and child health, family planning, and communicable diseases. MDG was developed by the United Nations with the focus of meeting the needs of the world’s poorest. In 2018, the UN launched the Sustainable Development Goals, which are 17 goals that are focused on promoting prosperity while protecting the planet. How Afghanistan’s MOPH will address the United Nation’s Sustainable Development Goals while still working on Millennium Development Goals is uncertain, and there is insufficient literature to draw logical conclusions regarding this phenomenon.

In 2015, the Ministry of Public Health introduced the National Noncommunicable Diseases control and Prevention Strategy 2015-2020, the nation’s first national strategy for NCD prevention. According to Dr. Ferozuddin Feroz, Minister of Public Health in Afghanistan, “Whilst effective treatment for NCDs is essential, early action towards prevention is critical. Otherwise we are in danger of having a sickness or ill-health
system rather than a health system” (Ferozuddin, 2015). Moreover, the communal nature of Afghan society makes community-intervention a positive approach towards promoting and encouraging healthy behaviors.

Before 2015, Afghanistan’s development projects in health were largely based on the United Nation’s Millennium Development Goals, which did not recognize NCDs as a development issue, and the uncoordinated goals of donor agencies and non-governmental organizations contracted with the MOPH (Ferozuddin, 2015). Rural regions of Afghanistan experience a shortage of healthcare professionals and have low capacity for primary and secondary control and management of NCDs (Ferozuddin, 2015). Pro-government forces and anti-government elements “block relief convoys, obstruct ambulance passage, invade hospitals, destroy clinics, and harass and terrorize national and international medical and other humanitarian workers” (Narasimhan and Chen, 2003, p. 18). BPHS facilities do not consider NCDs in their capacity building trainings, either, and the NCDs surveillance system – the World Health Organization’s STEPwise approach to Surveillance (STEPS)—has yet to be established to monitor the NCD epidemic. In addition, there is no death registration or cause of death recording in Afghanistan. Since the MOPH established their NCDs prevention strategy, they focused on prevention and management of NCDS at various levels in Afghanistan’s health care facilities.

The goal of the National Noncommunicable Diseases control and Prevention Strategy 2015-2020 is to “Prevent or delay the onset of non-communicable diseases (including road injuries) and their related complications, and improve their management, thus enhancing the quality of life of the Afghan population, leading to longer and more productive lives” (Ferozuddin, 2015, p. 10). The MOPH’s six objectives are to (1)
advocate for and raise NCDS priority as well as integrate NCD in the development work at national level, (2) introduce interventions through which the main shared, modifiable risk factors for NCDs and road injuries are reduced, (3) strengthen national health systems response to address NCDs including road injuries prevention, (4) strengthen the evidence base for the prevention and control of NCDs, (5) promote partnerships for the prevention and control of NCDs, and (6) monitor implementation of the NCDs prevention and control interventions and evaluate progress at the national level (Ferozuddin, 2015). They are approaching these objectives by (1) advocacy work with decision makers for NCDs control and prevention, (2) prevention and promotion of NCDs, (3) strengthening health systems at different levels to address control of NCD and road traffic injuries, (4) strengthening evidence for enhanced control of NCDs, (5) securing support of NCDs control from all partners, and (6) monitoring for better results (Ferozuddin, 2015).

At the national level, the MOPH’s Noncommunicable Diseases Control Directorate maintains close coordination with their subordinate departments and collaborate with other ministries, international organizations, and government agencies (Ferozuddin, 2015). The provincial level is essential for implementation of the NCDs prevention strategy, for which regional officers are primarily responsible (Ferozuddin, 2015). At the community level, community health workers are in charge of community mobilization and education on NCDs (Ferozuddin, 2015). Table 1 illustrates the various indicators being used to assess the objectives of the MOPH in addressing NCDs in Afghanistan.
Table 1. Comprehensive set of indicators at for different objectives of the National Noncommunicable Diseases control and Prevention Strategy 2015-2020. The MOPH did not provide any baseline or target goals for their objectives. Since this is the first national program for NCDs prevention, data collected between 2015-2020 will probably provide the baseline needed to determine future targets. Adapted from: Feroz, F. National Strategy for Prevention and Control of Non-Communicable Diseases 2015 -2020 (2015). Afghanistan: Ministry of Public Health.

The MOPH’s national strategy for NCDs is a historical event because it is addressing a major threat to human security in Afghanistan. The Basic Package of Health Services (BPHS) largely depended on contracted non-governmental organizations for implementation of their goals. The National Strategy for Prevention and Control of Non-Communicable Diseases, however, is a MOPH-headed effort, illustrating a strengthened
health sector since 2001. Currently, there is no public assessment of this strategy, so it is uncertain whether the MOPH has successfully implemented this strategy and if it was successful. The WHO representative in Afghanistan, Dr. Richard Peeperkorn, suggested in 2018 that NCD management in Afghanistan is not yet covered in public health facilities (“Addressing the escalating burden of noncommunicable diseases in Afghanistan”, 2018). Because of this, the Eastern Mediterranean W.H.O. office developed an NCD emergency kit that they are sending to Afghan Red Crescent Society – managed primary health care facilities. Figure 3 depicts a 4-day training for 26 health care workers in Afghanistan conducted by WHO.

**Figure 3.** Dr. Sadiq (left) practicing the examination of feet for diabetic patients on Mr. Dauod (right) during a 4-day WHO training aimed to help medical staff understand and use medicine and equipment for management of NCD. Adapted from: Addressing the escalating burden of noncommunicable diseases in Afghanistan. (2018). Retrieved from http://www.emro.who.int/afg/afghanistan-news/addressing-the-escalating-burden-of-non-communicable-diseases-in-afghanistan.html

In addition to access and quality of healthcare, mental health also has a relationship with high prevalence of NCDs in Afghanistan. According to Hamrah et al. (2018), who performed the first study in Afghanistan on the prevalence of anxiety,
depression, and NCDs, there is a strong association between hypertension and anxiety and depression. According to Hamrah et al. (2018), the Afghan population faces major stressors due to ongoing conflict and there are no provincial statistics on the prevalence of mental disorders. Hamra et al. (2016) performed a cross-sectional study in an outpatient clinic in Andkhoy, Afghanistan treating hypertensive patients. 42.3% of the 234 patients had anxiety disorders and 58.1% exhibited depressive disorders; their findings were supported by similar findings in other countries by the World Health Organization and World Organization of Family Doctors (Hamra et al., 2016). They also found that older patients had significantly higher rates of anxiety; if this small sample represented the entire Afghanistan, it would demonstrate the importance of mental health services because of the growing ageing population. Patients with additional chronic diseases were also more likely to have comorbid depression-anxiety than other subjects (Hamra et al., 2016). Hamra et al. (2016)’s study demonstrated the need for a nation-wide study on mental health status and NCDs in Afghanistan to determine strategies for prevention and control.

**Conclusion**

In human security, health is no longer treated as a form of consumption that determines economic growth. Rather, health can be a threat that determines basic survival and involves a human being’s core attachments to home, community, and future. Human security captures the extended impact of health crises, as conflict, epidemics, and catastrophic illness produces immense economic, social, and political disturbances (Narasimhan and Chen, 2003, p. 11). Health security requires surveillance, control, and response, which can be prescribed by international humanitarian law. Although the
distinction between combatants and non-combatants in IHL protects individuals, IHL
does not address the social and psychological repercussions of conflict. In order to
provide greater health security to individuals, IHL must adapt laws the empower
individuals and communities to address the physical, social, and psychological affects of
health insecurity. Protection from fear of ill-health cannot determine overall human
security as it is written in IHL today.

This chapter discussed Afghanistan’s current health sector and described the
initiatives of the public health sector. Afghanistan’s Ministry of Public Health has taken
great measures to improve the overall well-being of the Afghan population. Nevertheless,
vigilence has posed a great threat to the health of the Afghan population, as insecurity
from fighting/conflict poses a major barrier to healthcare. In the next chapter, the
infectious disease model of violence will be explicated. Violence will be shown as a
communicable disease the promotes the occurrence of non-communicable disease. Given
the content of this chapter, readers must recognize that violence and non-communicable
diseases are major threats to human security in Afghanistan.
Chapter 5: Infectious disease model of violence

“In these wars, no one could be trusted to take care of you; social contracts were shattered; the state, the army, and your neighbors betrayed your trust; your sense of right and wrong was violated by daily events; and you were helpless against the full assault of conflict. Survival was the best that could be achieved. Survival with meaning was too much to ask for” (Narasimhan and Chen, 2003, p. 20).

Abstract

In the latter half of the 20th century, international relations scholars started to understand communicable diseases as major threats to national security. The behavior of violence as an infectious disease is discussed and related to the contagion of violence in Afghanistan. In underdeveloped countries, like Afghanistan, violence has a higher prevalence in the population. An environment of war contributes to the physical, emotional, and mental symptoms, but also the transmission of this infectious agent to more people.

Introduction

A person’s freedom to obtain and sustain good health is a universal freedom that the human security paradigm of international relations aims to protect. Disease is a trans-border problem that impacts individuals’ welfare, for which the international community must intervene to address and redress the problem (Glasgow, 2008). Human security ascertains the depth and impact of health crises, such as conflict, epidemics, and catastrophic illness, on a state’s economic, social and political institutions (Narasimhan & Chen, 2003, p. 11). The anthrax bioterrorism attacks in the United States and the HIV/AIDs pandemic were two critical events after the Cold War that demonstrated the extent to which health can jeopardize a state’s security.

According to Narasimhan and Chen (2003), bioterrorism generates public fear and increases a society’s sense of vulnerability (p. 8-9). For example, the anthrax attacks also exposed the underinvestment of public health infrastructure in the world’s most
powerful nation-state: “Political leaders were warned and began to recognize that public health protection, like fire and police forces, remains an essential public good that must be provided by government” (Narasimhan & Chen, p. 8-9). Not to mention, the attacks occurred a week after the September 11th attacks, sparking great concern over the status of the United States’ position in the international system. In addition to bioterrorism, the natural spread of infectious diseases across borders received great attention in the 1980s. An epidemic occurs when the occurrence of disease is higher than the expected rate in a population. The HIV/AIDS epidemic is recognized as the greatest human security threat in all of human history, constituting a death toll greater than the Black Death in the 14th century (Narasimhan & Chen, 2003). The pandemic especially affected sub-Saharan Africa: “Two decades after its discovery and global spread, the UN security council in 1999 declared HIV/AIDS a threat to national security, especially in heavily infected, economically weak, and politically fragile countries in sub-Saharan Africa” (Narasimhan & Chen, 2003, p. 9). The HIV/AIDS epidemic illustrated the health linkages to poverty and the ineffectiveness of military institutions securing national borders for trans-border threats. These two events convinced the international community that people’s insecurities are interdependent (Narasimhan & Chen, 2003, p. 13).

Infectious disease has been the focus of scholarly research in health security since the end of the Cold War (Glasgow, 2008). The infectious disease model explains how an agent initiates a specific biological pathway leading to symptoms of disease and infectivity. Infectious diseases comprise of a foreign species proliferating within a host (e.g. the human body), combatting the host’s defense mechanisms. Often, the hosts’ immune system is unable to subdue the host, which results in death because the body’s organs cannot function. Innate immunity is the defense mechanisms against foreign
pathogens coded by genetic information. This system offers immediate protection against foreign species, but only for a short term. This form of immunity also lacks the molecular specificity to distinguish itself from pathogens, potentially fighting against itself even after the pathogen is eradicated (Yatim & Lakkis, 2015). Over time, though, the adaptive immune system is turned on and provides more long-term protection against the pathogen. This system has specific cells (lymphocytes) that recognize foreign species with high specificity. Adaptive immunity becomes more intricate when these cells differentiate into subsets that attack the foreign species with even greater specificity (Yatim & Lakkis, 2015). Although most of the cells that fight off the pathogen die, the ones that remain become memory cells. These memory cells “ensure that a second encounter with the same invader is dealt with swiftly and effectively because of the many advantages they have over their inexperienced (naïve) predecessors” (Yatim & Lakkis, 2015). The innate and adaptive immune systems are bridged through these memory cells, as they can recognize the pathogen and assemble the cells of the innate immune system to combat the intruder. The adaptive immune system uses this method to quickly eradicate the infection at minimal cost to the host (Yatim & Lakkis, 2015).

Human security’s focus on communicable diseases is easier to analyze as a political science phenomenon because they are literally “threats” that can be understood like traditional national security threats. However, non-communicable diseases are predicted to be a greater threat by 2030 (Glasgow, 2008) - mostly affecting developing countries - and understanding how to diffuse their impact on human beings is of importance to the international community. Examples of these non-communicable diseases are hypertension, diabetes, or depression. If the aforementioned chronic
conditions will impact individual’s health ownership at a greater level, the international community must shift its attention towards diffusing non-communicable diseases.

Nevertheless, Glasgow (2008) and the international community have a narrow understanding of what infectious diseases are. One communicable disease human security academics have not adequately studied is violence, and this chapter will illustrate how violence acts as an infectious disease. Recognizing violence as a health epidemic and interrupting the spread of violence, the threat of non-communicable diseases on a person’s health ownership is reduced. Further, violence equally impacts the security of a human being at the unit level and the security of a state; it is as much a health issue as it is a national security issue. Public health scholars use an interdisciplinary, science-based approach to study the spread of violence from the person to the community and community to person: “like an infectious disease, violence is a product of the interactions between people and the world around them” (Scott, 2008).

**Violence as a disease**

According to the Scott (2008), violence is “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivement” (p. 22). Violence is categorized into interpersonal violence, self-directed violence, and collective violence. In this thesis, the impact of collective violence on a group’s health ownership is being explored. Collective violence is the instrumental use of violence by groups “to achieve political, economic, ideological, or social objectives” (Scott, 2008). This includes armed conflict, state-sponsored violence, and organized crime; the consequences of all forms of violence,
particularly collective violence in the form of war, are transnational and transgenerational.

In Afghanistan, for example, there are generations of Afghans born and raised in the environment of war since the onset of the Soviet Invasion of Afghanistan in 1979. Collective violence destroys families, communities, and culture; it reduces resources that promote and protect health services to vulnerable populations. It plagues the physical environment and instills in people and nations to believe that violence is the solution to conflicts (Scott, 2008). In the infectious disease model, a person’s level of resilience is considered their immunity towards the violence, and their resilience depends on the concepts of culture, place, religion, family, and law. Levy et al. (2017) define community resilience as: “(a) the functionality of the built environment after an event (physical resilience); (b) the physical and psychological health of people (individual resilience); and (c) the governance structure, networks of trust and communication, flexibility, and redundancy of the community (organizational resilience)” (Levy et al., 2017).

Increasing investment in human security through violence prevention will have lifelong benefits, decreasing the prevalence of longer-term health conditions, disability, and high-risk behavior. Preventing violence adversely affecting the health of people will also secure the states they are in. According to the Scott (2008), violence is the leading cause of death and disability for people aged 15-59, and the impact of violence moves farther than immediate death: “...resultant injuries that are often lifelong, hospitalizations, political instability, and stagnation of economic growth for families, communities, and nations.” Furthermore, adverse childhood experiences (ACEs) have detrimental impact on one’s health. According to Hughes et al. (2017), ACEs are events during childhood or adolescence that negatively impact a person’s physical and mental health (e.g. war).
ACEs are both direct and indirect: “ACEs include harms that affect children directly (eg, abuse and neglect) and indirectly through their living environments (eg. parental conflict, substance abuse, or mental illness)” (Hughes et al., 2017). These events lead to chronic stress that impacts the nervous, endocrine, and immune systems, causing diminished cognitive, social, emotional, and physiological functioning (Hughes et al., 2017). High risk behaviors as a result of a traumatic event contribute to chronic, non-communicable diseases that Glasgow (2008) argues should be of greater importance to the international community than infectious diseases.

Akbulut-Yuksel (2017) found that individuals exposed to WWII violence during the prenatal and early postnatal periods exhibited higher body mass indices (BMI’s) and increased propensity for obesity as adults. During periods of conflict there is decreased access to economic resources and health care (Figure 1), resulting in food shortages and decreased quality of food; thus, during war there is an increased rate of childhood malnutrition. Childhood malnutrition during the prenatal and early postnatal periods can leave people more susceptible to both obesity and chronic diseases like hypertension and diabetes (Akbulut-Yuksel, 2017, p. 117). The thrifty phenotype hypothesis argues adults’ metabolism is affected by the nutritional conditions of their pre- or early post-natal periods. Akbulut-Yuksel’s (2017) finding demonstrates how children who have lived in an environment of war are more likely to develop obesity, diabetes, and heart disease because of environmental conditions affecting their metabolism. His study found wartime children from the most destructed German cities are 0.23 standard deviations more likely to have chronic disease than their counterparts (Akbulut-Yuksel, 2017, p. 118). His findings support the theory that adverse childhood experiences lead to long-term effects

Figure 1. Destruction of hospitals by overall destruction intensity of German city. At the 95% confidence interval, this graph illustrates how cities affected by more violence experience greater destruction of their hospitals. German cities that experienced greater destruction were determined by their rubble per capita. Destroyed hospitals and cities lead to decreased access to health care due to dysfunctionality of hospitals and departure of doctors. This graph further explains why wartime children have higher prevalence of malnourishment, leading to decreased metabolism and higher prevalence of chronic diseases and obesity. Adapted from: Akbulut-Yuksel, M. (2017). War during childhood: The long run effects of warfare on health. Journal of Health Economics, 53, 117–130. https://doi.org/10.1016/j.jhealeco.2017.02.005

In underdeveloped countries, like Afghanistan, violence has a higher prevalence in the population. An environment of war contributes to the physical, emotional, and mental symptoms, but also the transmission of this infectious agent to more people. According to Eric Dubow from Bowling Green State University, ethno-political violence is a higher-level stressor that increases other forms of violence, such as family, community and school violence (Patel et al., 2013). In fact, the internal divisions between
ethnic or religious communities drive armed conflict, for which civilians are both collateral damage and the intended target of violence: “Such conflicts usually provoke massive flows of people, both international refugees and internally displaced people; gross violations of human rights; and, tragically, genocide, including the use of rape as a weapon of war” (Narasimhan & Chen, 2003, p. 6).

Similar to different strains of a virus, there are different manifestations of violence whose processes are harder to decipher. For example, how does domestic violence arise from ethno-political violence? Why do we transmit the violence we fear outside into our homes against our loved ones? Accordingly, Dr. Dubow states, “the more ethno-political violence to which children are exposed, the greater the occurrences of community, school, and family violence, and individual aggressive behavior” (Patel et al., 2013). Moreover, ethno-political violence obstructs a child’s development both physically and mentally, but also emotionally. For example, Native American children struggle with identity formation because the violence they live under displaces them from cultural practices and traditions. In most cases, innate immunity towards ethno-political violence is impossible because of the systemic effects on a person’s culture, place, religion, family, and law; however, the international community has a duty to use its institutions and, like a targeted drug, develop resilience among inflicted populations.

Of the twenty-two countries in the Eastern Mediterranean Region, Afghanistan has the lowest per capita gross national product (GNP) at $2,000 (GBD 2015 Eastern Mediterranean Region Collaborators, 2017). According to the Global Burden of Disease 2015 study, 36% of the population lives below the national poverty line and 34% of the population is food-insecure. Like its Eastern Mediterranean Region (EMR) counterparts, the pattern of wars, civil strife, and economic changes have strained Afghanistan’s
limited resource and impacted its population’s health (GBD 2015 Eastern Mediterranean Region Collaborators, 2018). According to GBD 2015 EMR Collaborators, the GBD 2015 utilized a “systematic and simultaneous estimation of disease incidence, prevalence, exposure to risks, and injuries; and statistical models to pool data, adjust for bias, and incorporate covariates” (2018). Notably, their socio-demographic index was based on income per capita, average education for people ages 15 or older, and fertility rate; they also looked at trends in diseases, population growth, and risk exposure to delineate the drivers of change (GBD 2015 Eastern Mediterranean Region Collaborators, 2018).

The collaborators found ischemic heart disease and cerebrovascular disease were the leading causes of death in EMR. Ischemic heart disease was also the leading cause of disease burden between 2005 and 2015, determined by the disability-adjusted life years (DALYs) measure. Accordingly, “Collective violence and legal intervention increased by 847% during this time period” (GBD 2015 Eastern Mediterranean Region Collaborators, 2018). Figure 2 illustrates the thirty causes of death due to population growth, population ageing, and changes in age-specific mortality rates between 2005 and 2015. Furthermore, war and legal intervention was the fifth leading cause of disease burden over time in 2015, having ranked 32 in 1990 and 55 in 2005 (GBD 2015 Eastern Mediterranean Region Collaborators, 2018). In this measurement, violence is categorized as an injury, and the other causes of DALYs are either non-communicable or communicable diseases.
As violence increased in the EMR, injuries related to collective violence contributed to both deaths and decreased quality of life. This is an interesting observation because while chronic, non-communicable diseases attributed to greater deaths during this time period, communicable diseases caused greater DALYs. Moreover, the top six leading risk factors for DALYs in 2015 were high blood pressure, childhood undernutrition, high body-mass index, high fasting plasma glucose, ambient particulate matter, and high total cholesterol. In contrast, the top six leading risk factors for DALYs in 1990 were childhood undernutrition, unsafe water, suboptimal breastfeeding, unsafe sanitation, handwashing, and ambient particulate matter (GBD 2015 Eastern Mediterranean Region Collaborators, 2018). There was a strong shift from mostly
environmental risk factors to mostly metabolic risk factors. The only leading environmental risk factor was ambient particulate matter (air pollution). Moreover, the metabolic risk factors are highly involved in non-communicable diseases, while the environmental risk factors play a large role in transmission of communicable diseases (GBD 2015 Eastern Mediterranean Region Collaborators, 2018). The more recent DALY risk factors indicate non-communicable disease burden will trump communicable diseases in the near future. To note, the study categorized communicable, maternal, and neonatal/nutritional causes together. Thus, DALY’s due to “communicable” diseases my very well be the result of the latter. During this time period, violence increased dramatically, likely extinguishing the healthcare institutions in the region that would prevent these risk factors and diseases. The collaborators state that these health challenges “exist at the nexus of human health, environmental resilience, and social and economic equity” (GBD 2015 Eastern Mediterranean Region Collaborators, 2018). Health education and training will ensure policies are developed, implemented, and enforced (GBD 2015 Eastern Mediterranean Region Collaborators, 2018). Additionally, the best health intervention plan for this region would be an international agenda to stabilize the region from its wars (GBD 2015 Eastern Mediterranean Region Collaborators, 2018).

According to the 2015 Global Burden of Disease EMR study (2017), intentional injuries are a “combination of self-harm (including suicide), interpersonal violence (such as homicide and physical and sexual assault), collective violence (or war), and legal intervention (such as police enforcement)” (GBD 2015 Eastern Mediterranean Region Intentional Injuries Collaborators, 2017). Unlike other injuries and diseases, intentional injuries can be avoided by human beings; however, 30% of global deaths were from
intentional injuries in 2015 (GBD 2015 Eastern Mediterranean Region Intentional Injuries Collaborators, 2017). In the EMR alone, 28,695 people died from self-harm, 35,626 people died from interpersonal violence, and 143,858 people died from collective violence/legal intervention. Compared to 1990, collective violence/legal intervention has increased 1027% in 2015 (Figure 3 and 4). Figure 3 illustrates the age-standardized death rates from different forms of violence among the respective World Health Organization regions in 2015. The EMR distribution has much greater collective violence/legal intervention than the other regions. Figure 4 illustrates the number of deaths due to intentional injuries over time, which further supports the study’s claim that the EMR has significant collective violence/legal intervention in recent times. Conflicts and social unrest in the EMR have increased the prevalence of intentional injuries in the last decade, which is also underreported because of cultural and religious norms in the region (GBD 2015 Eastern Mediterranean Region Intentional Injuries Collaborators, 2017). In this study, collective violence included wars, terrorism, other forms of violent political conflict, state-perpetrated violence, and organized violent crime.
Figure 3. Age-standardized death rates from different forms of violence among the W.H.O. regions in 2015.

Collective Violence is a Disease in Afghanistan

Violence is a central threat to human security and manifests in three major forms: self-directed, interpersonal, and collective violence. According to Meddings et al. (2003), self-directed violence is violence towards oneself, interpersonal violence is violence inflicted by one person on another or small group, and collective violence is violence inflicted by large groups like states or non-state actors (p. 161). Meddings et al. (2003) makes five major assertions regarding violence:

- Violence is a central threat to human security under all widely prevailing concepts of human security.
- The types of violence constituting this threat include both collective violence and interpersonal violence.
- These types of violence share determinants that are inextricably linked with some of the major issues underlying the increased attention that human security has received over the last decade.
- Coherent policy recommendations to prevent violence would have cross-cutting benefits in terms of reducing a number of threats to human security.
- Violence, as a human security threat, constitutes a core public health issue.

The physical changes occurring in the environment of a human being during conflict, or collective violence, has striking effects. There are both short-term and long-term effects, and the short-term effects occur almost immediately – violence has a small incubation period much shorter than the incubation period of HIV or Ebola. Violence affects the vital core of human beings, preventing them from having basic survival, livelihood, or dignity.
Meddings et al. (2003) argues collective violence creates population displacement and destruction of social infrastructures. Furthermore, they found that the total disability adjusted life-years (DALYs) lost in 1999 due to the indirect impact of collective violence from 1991 to 1997 was nearly the same as the DALYs lost directly from collective violence in 1999 (p. 168). Weak economic development, inequalities in access to economic, political, and social resources, weak governance, and globalization influence the vulnerability of populations to collective violence (Meddings et al., 2003). Collective violence also exploits the global economic system in order to support war economies, causing an uncontrollable and widespread availability of weapons that only increase the level of violence (Meddings et al., 2003, p. 173).

The GBD 2015 study found Afghan men to have one of the highest age-sex distributions (ASDR) of deaths due to self-harm. Afghanistan has the highest ASDR for interpersonal violence and second highest ADR for collective violence/legal intervention. The collaborators of this study argue that while unrest and conflicts are causing intentional injuries through collective violence in the EMR, the environment of war is also correlated with increased burden from self-harm and other diseases (GBD 2015 Eastern Mediterranean Region Intentional Injuries Collaborators, 2017). Moreover, they found that children under 5 years old are a large part of total deaths due to collective violence: “while the general mortality rate of children under 5 is around ten times that of individuals over 5 in pre-conflict states, it decreases to around double during a conflict state” (GBD 2015 Eastern Mediterranean Region Intentional Injuries Collaborators, 2017). War doesn’t just impact individuals while it occurs; it also indirectly causes death and disability after the war:
“Previous studies show that several years after termination of wars, people are at higher risk of death due to its consequences such as remaining land mines. In addition, some people suffer from the long-term complications of injuries such as amputations and spinal cord injury for years after war and are at risk of premature death for the same reasons” (GBD 2015 Eastern Mediterranean Region Intentional Injuries Collaborators, 2017).

The authors of this paper note that delineating interpersonal violence from collective violence is difficult during civil war, as access to firearms isn’t difficult in countries like Afghanistan and Iraq, and firearms were found to majorly contribute to total deaths from interpersonal injuries (GBD 2015 Eastern Mediterranean Region Intentional Injuries Collaborators, 2017).

Afghanistan was involved in an International Committee of the Red Cross survey of 12,000 people exposed to wars that yielded insight on the psychosocial dimension of war trauma. The study demonstrated the societal dimension of violence and loss: “an ecology of suffering that affects all aspects of collective life, of being and acting together. The narratives of suffering are always related by ‘we’ and articulated as collective experience and collective fate. Violence has changed their entire world” (Narasimhan and Chen, 2003, p. 18). The people of Afghanistan in particular describe the war to bring a lot of physical destruction: “Everything beautiful, everything productive, everything that links people to their past or supports a path to the future has been broken or crushed” (Narasimhan and Chen, 2003, p. 19). Internal conflict causes deterioration of social trust, which commits all actors involved in the conflict to greater hatred and brutality.

Although the ICRC data suggests people in areas of conflict have high expectations from the international community, they also believe the external world does not have the authority to address the psychological and social issues of collective shame
and demoralization their experience: “The respondents note the fragmented approach of the many different organizations competing for visibility, purveying goods and services ill designed to address the continuum of suffering in their communities” (Narasimhan and Chen, 2003, p. 20). Rather, people in conflict zones expects the principles of international humanitarian law to be endorsed by the international community to “prevent wars from getting worse” (Narasimhan and Chen, 2003, p. 21). According to Narasimhan and Chen (2003), global health recognizes multiple actors in the production of health, including non-state actors and the national government.

**Violence and Climate Change**

Levy et al. (2017) explored the relationship between climate change and collective violence, demonstrating the health consequences of these phenomena. The indirect health effects of climate change are of particular interest because of their association with collective violence, forced migration, and food insecurity, factors that are prevalent in Afghanistan today. Malnutrition occurs from increasing temperatures and extreme precipitation that cause droughts and floods, decreasing agricultural resources (Levy et al., 2017). Cropland damage, sea-level rise, and food and water shortages might force communities to become refugees in other countries or internally displaced people within their own (Levy et al., 2017). Collective violence arises from political, economic, and social instability stemming from the aforementioned events. Levy et al. (2017) defines violence as the “the instrumental use of violence by people who identify themselves as members of a group…against another group or set of individuals, in order to achieve political, economic or social objectives.” Violence indirectly damages the
healthcare infrastructure, as well as health-supporting institutions like safe food and water, transportation, and communication.

Drought leads to increased conflict because of the competition for scarce natural resources, causing food price shocks (Levy et al., 2017). Levy et al. (2017) argues hot temperatures are associated with collective violence and interpersonal violence. Water-related conflicts have greatly increased since the 1960s: “there were 38 water-related conflicts throughout the world between 1960 and 1989 (on average, 1.3 per year) and 83 such conflicts between 1990 and 2007 (on average, 4.6 per year)” (Levy et al., 2017). In the case of Afghanistan, though, Levy et al. (2017) argue there is not a strong association between drought and development of conflict. Studying the narco-economy of Afghanistan challenges their argument, as higher crop yields of opium in drought-ridden Afghanistan finances the war economy, which increases collective violence in the population. It may also increase interpersonal violence since the illegal distribution of arms is prominent and anyone can have access to weaponry. Climate change is one of several causative factors to collective violence in Afghanistan, however, the multiple droughts that occurred since the War on Terror and their relation to opium production should be considered.

**Violence and Displacement**

The contagion of violence is also an issue for the displaced Afghan population. For example, within Afghanistan, non-communicable diseases are a pertinent human security threat actively being mitigated by the MOPH. For Afghan refugees and asylum seekers, though, NCD are a neglected threat. During the Soviet occupation, 5 million refugees fled to Iran and Pakistan, and 2 million Afghans were internally
displaced. Macksoud et al. (1993) states displacement, forced immigration, and refugee status are linked to traumatic stress reactions in Asian children and adolescents. Further, they demonstrate the impact on the development of children who witness parental panic reactions; observing their parents in distress affects their psychopathology. Nevertheless, in periods of war, children are better off staying with their parents because of the “buffering effect” parents have when they face destruction and deprivation (pg. 631). Macksoud et al. (1993) found several accounts of young children that appeared mute and withdrawn after a traumatic experience (pg. 627). Children under 4 years old demonstrate regressive, anxious attachment behavior, and younger children have a complicated mourning process because they haven’t fully yet developed the mental processes that help them work through the traumatic death before grieving their loss (pg. 627). Adolescents demonstrate rebellious and antisocial behavior, as well as “decreased ability to concentrate because of intrusions of traumatic memories or by the depressed effect on the child’s mental processes” (pg. 627).

41% of the refugees in the world in 2016 came from only 3 war-torn countries (Syria, Afghanistan, and Somalia) and only 6 countries host these refugees (Levy et al., 2017). These refugees are displaced from state-based conflict, non-state conflict, or both. The infection of violence ruptures the ties humans have with their home, tearing the social fabric and community people belong to. Furthermore, displacement exposes women and girls to sexual violence and prostitution (Narasimhan and Chen, 2003, p. 17).

Meiqari et al. (2017) used data from a Medecins Sans Frontieres (MSF) operation center in northern Syria between 2013 and 2016 to study the impact of Syrian war on children’s health. This center provided primary and secondary healthcare during this period. Because of violence that has damaged health systems and displaced healthcare
professionals in Syria, there is an increasing healthcare demand for refugees in neighboring countries. MSF officials were challenged by the dire security situation in the region, as some areas were impossible to reach and management of care was difficult due to the nature of a population always on the move. Furthermore, children 6-59 months old exhibited anemia, a micronutrient deficiency (Meiqari et al., 2017) known to affect the development of children.

According to Pumariega et al. (2005), first and second-generation immigrant children are the most rapidly growing segment of the American population. Refugee children are the most vulnerable in situations of displacement; traumatic experiences of pre- and post-migration from their homeland are more easily triggered in this population of refugees and are especially influenced by their parent’s response: “Later psychological stressors can often re-activate the emotions and memories associated with these events, especially for children and adolescents” (Pumariega et al. 583). Examples of such memories include criminal activity and lawlessness in refugee camps. Further, refugee settlements in host countries has a common “cycle of poverty, coupled with inferior levels of education” (Pumariega et al. 584). This causes a consistent declining of financial opportunity among refugees and immigrants. Pumariega et al. (2005) demonstrates how cultural transition is a psychological process, there are behavioral consequences from immigrating from one country to another. Post-traumatic stress disorders are particularly prominent, and risk factors include poverty, education, financial insecurity, and poor physical health (pg. 588). Pumariega et al. (2005) states “There are other dysfunctional behavioral consequences from the impact of traumas and losses suffered by immigrants and refugees, including domestic violence and gambling (pg. 588). Additionally, second geeneration immigrants are more predisposed for
behavioral conditions, such as substance abuse, conduct disturbance, and eating disorders, than first generation immigrants (pg. 588). This may be due to chronic stress from financial security, marginalization, and discrimination; second generation immigrants do not have a secure identity or traditional values like their parents, but also do not have a secure cultural identity with the country they are in. Nevertheless, older adult immigrants have the highest risk for mental health problems, due to cultural inflexibility, isolated behavior, and physical health risk factors.

Pumariega et al. (2005) argues for community-based mental health services for immigrant/refugee populations in the U.S. Culturally competent professionals provide better care because they are accustomed to the cultural and linguistic characteristics of the group. They argue psychotherapy, providing means of integration (such as housing and employment), and offering options for social services and mental health services can help immigrant families function in their new environment and empower families in their overall adaptation and management of their children’s behavioral needs. The violence in Afghanistan that began during the Soviet Invasion is responsible for a myriad of mental and physical health concerns in the Afghan population. According to Wardak (1993), war “affects the entire culture of a country and has transgenerational consequences” (pg. 349). Social, political, cultural, and economic factors of refugee life have damaged traditional values and functions within Afghan sociocultural networks. Afghan refugees’ separation from their fatherland places them in a moral conflict because of the “opposing needs to defend their country and protect themselves and their families” (Wardak, 1993). Community-based mental (and physical) health services that are conscious of the social, political, cultural, and economic factors Afghan refugees face can alleviate the stress of resettlement and integration for Afghan refugee families.
Conclusion

The human security paradigm of international relations focuses on the individual’s security. For this reason, understanding violence as a disease is incredibly useful for analyzing the effect of this threat on an individual. By ameliorating violence as disease, the external security of state can also improve. Unlike human security, the traditional national security approach external security at the cost of destabilizing the internal security of the state. This bottom-up approach to ameliorating violence will decrease the prevalence of disease, improve the behavioral health of a population, and restore the social institutions that promote the health of a population (e.g. education, culture, economy).
Conclusion

This senior thesis demonstrates why human security is a valuable approach for understanding Afghanistan’s (in)security. Violence is conceived as threat to individual Afghans – contrary to the traditional security studies. Violence affects many dimensions of the individual; this thesis focuses on the individual’s health. Using a public health approach, international relations scholars can study violence as an infectious disease and bring international solutions that will distinguish the disease (or contain it) as it has for AIDS and Ebola. While epidemiological techniques are useful, we must also consider how violence does not entirely behave like an infectious disease. For example, it is not a biological agent that can be treated with medicine. Defining violence as a disease also has a metaphorical component to it that must be discerned from its material meaning as a disease. People have agency over its transmittance – we can refuse to be part of the contagion, unlike Ebola or measles. Treatment of violence requires an integrated approach that considers the different areas of international relations its dynamic behavior is involved in. When using the human security approach, scholars can better understand why states are unable to protect their population from violent threats, as well as understand emerging political phenomena occurring in the 21st century. During the Cold War, nuclear arms were the greatest threat to state and individuals’ security. Today, climate change, cyber warfare, refugee displacement, and other new phenomena have proved states’ incapability to protect their citizens. An international solution is required, and the human security paradigm of security studies has significant potential to ameliorate violence.
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