April 2017

On the brink of conflict: the people of South Asia deserve better

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Countries must work together for enduring peace and wellbeing in the region

Nearly two decades ago, coinciding with overt nuclear tests conducted by Pakistan and India, we highlighted in *The BMJ* the huge risks of beginning a nuclear race in the subcontinent[1] and its massive costs.[2] Today, South Asia is once again at the brink of conflict, with massive deployment of armies on the borders between Pakistan and India. Insurgency and unrest affect major regions in Kashmir, Baluchistan, Assam, and the tribal and Maoist controlled areas in both India and Pakistan.[3] Afghanistan has seen incessant conflict and suffering since the Soviet invasion in 1979. Nepal has emerged from decades of a debilitating Maoist insurgency, and Sri Lanka has just begun rebuilding the north after years of war and devastation.

Terrorism, which had been relatively rare, is now a daily threat affecting the lives and livelihoods of millions in South Asian states. Conflict, civic unrest, and insurgency have cost the region dearly. Despite continued economic growth and development, South Asia remains one of the poorest and most unequal regions of the world. Alarmingly, poor social determinants and development have fuelled grassroots rebellions and insurgency in some instances[4] and in others underlay large scale despondency and suicides.[5 6]

Some may argue that nuclear capacities have prevented large scale war between India and Pakistan, but it has not deterred smouldering conflict. The *Siachen* conflict, a meaningless confrontation to contest an invisible boundary at an average height of 6000 m above sea level, is a case in point. This dispute alone has cost India and Pakistan almost 0.1% of their gross domestic product annually since 1984 with over 2000 lives lost because of inclement weather and avalanches.[7] The weaponry, missile delivery systems and warfare technology cost both countries over $60bn (£48bn; €55bn) annually[8]—money desperately needed to alleviate poverty and for healthcare and human development in both countries.

Even more alarming is the regression of grassroots movements for peace and resolution of conflict resolution over the past decade. Current generations are fed an incessant daily dose of jingoistic and nationalistic slogans and a highly selective, mutilated form of history. The growth of social media and communication technology may have increased contacts between people but it has also fuelled hysteria and war mongering.

Figure | **Map of South Asian countries**

It is in this context that revisiting the public health priorities of the region becomes even more imperative. South Asia comprises a diverse set of countries ranging from small nations with populations of less than a million, such as the Maldives and Bhutan, to one of the world's most populated nations: India with more than 1.3 billion people (figure). The South Asian Association for Regional Cooperation, set up as a platform for regional collaboration and economic development, is largely dysfunctional and symbolic. Human development indices have improved for some countries (Afghanistan, Sri Lanka, and the Maldives) over the past decade, yet for others the situation has hardly changed (table 1).

As this special collection of *The BMJ* underscores, gender disparities, undernutrition, and social inequities remain ubiquitous in South Asia, and over 300 million people in the region remain in abject poverty.[12] Authors from across the region draw attention to the health needs of people in South Asia and set out priority actions for governments and health systems in the region.

What can and should be done? Firstly, there has to be the political will and tangible action to bring peace, build confidence, and resolve our conflicts. This can be fostered by promotion of greater contact and dialogue between people in the region. Although this can be achieved through many avenues, including cultural and sporting activities, we believe that promoting health, especially public health priorities in the region, can serve as an important bridge to peace. There have been limited efforts to get public health professionals and research bodies to work together. Science collaborations remain nascent, and opportunities for scientists and student exchanges are few and far between and hampered by restrictive visa procedures. We propose that concerned authorities in all countries of the region as well as the donor community promote and facilitate platforms for joint public health projects, advocacy, training, and research. In addition to governments and public sector institutions, there are huge opportunities for collaboration towards defined public health goals to be explored within the private sector, professional associations, and civil society.

Secondly, South Asia needs to massively increase its investments in human development. The transition from the millennium development goals[13] to the sustainable development goals (SDGs) [14] offers the opportunity to tackle social determinants of health. SDG 16 sets targets for peace, justice, and strong institutions and SDG 17 calls for partnerships to achieve these goals. South Asia's medical and public health community can lead the way with concrete actions, joint planning, and mutual accountability. Setting up a regional task force to monitor progress and support action towards attainment of the SDGs is a starting point.

This collection of *The BMJ* is a step towards building those bridges for peace and development in South Asia. We call on the health community of South Asia to rise to the challenge and take several steps forward from jingoism, misplaced nationalism, and a potentially disastrous nuclear arms race. We owe this to our children and the generations that will follow.

Table 1 | Demographics and development indicators in South Asian countries[9-11]

Indicators	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Population :								
Total, 2015 (millions)	32.5	161	0.77	1311	0.36	28.5	189	20.9
Total, 2004 (millions)	23.5	14.1	63.4	1126	0.3	25.2	150	19.4
% change	38.4	14.3	22.2	16.4	31.1	13.2	25.7	9.0
Annual population growth, 2015 (%)	2.8	1.2	1.3	1.2	2.0	1.2	2.1	0.9
Urban population, 2015 (% of total)	26.7	34.3	38.6	32.7	45.5	18.6	38.8	18.4
Human development index:								
2014	0.465	0.570	0.605	0.609	0.706	0.548	0.538	0.757
2004	0.399 (2005 data)	0.530	0.538	0.611	0.739	0.527	0.539	0.755
% change	16.5	7.6	12.5	−0.3	−4.5	4.0	−0.2	0.3
GDP per capita, 2015 ($)	590.3	1211.7	2532.5	1581.6	7681.1	732.3	1429.0	3926.2
% of population living below national poverty line of $1.08/day (year of data)	35.8 (2011)	32.0 (2010)	31.5 (2012)	21.9 (2011)	15.7 (2009)	33.0 (2010)	22.5 (2013)	6.7 (2012)
No of physicians, nurses, and midwives per 10 000 population (year of data)	6.5 (2012)	5.74 (2011)	12.4 (2012)	24.54 (2011)	64.5 (2010)	6.69 (2004)	14.0 (2010)	23.21 (2010)
% with access to improved drinking water source:								
2015	55.3	86.9	100	94.1	98.6	91.6	91.4	95.6
2004	37.3	79.1	89.1	84.5	96.6	81.2	89.3	84.2
% change (%)	48.3	9.9	12.2	11.3	2.1	12.8	2.3	13.5
% with access to improved sanitation facilities:								
2015	31.9	60.6	50.4	39.6	97.9	45.8	63.5	95.1
2004	25.7	49.7	37.4	29.6	87.3	28.3	44.1	85.4
% change	24.2	22.0	34.9	33.8	12.1	62.1	44.0	11.4

Competing interests: We have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

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Cite this as: *BMJ* 2017;357:j1528
http://dx.doi.org/10.1136/bmj.j1528