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# Conflict in South Asia and its impact on health

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# Conflict in South Asia and its impact on health

Improving access to healthcare, preventing gender based violence, and providing mental health services are essential to improve the health of people affected by conflict in South Asia, argue **Siddarth David and colleagues**

According to the Uppsala Conflict Data Program (UCDP), a conflict is a contested incompatibility that concerns government, territory, or both, in which the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle related deaths. Low intensity conflicts such as insurgencies, counter-insurgencies, civil strife, terrorism, and communal riots have taken the place of large conventional battles across the world. Such conflicts tend to continue at low levels for a long period of time with sporadic outbursts. Moreover, these protracted low intensity conflicts result in prolonged displacement, cross border migration, and trafficking. Most affected populations are unable to access existing healthcare services owing to lack of documentation, means of livelihood, and social capital.<sup>1</sup> Public health aspects such as nutrition, water, and sanitation are also severely affected. Healthcare services are often suspended, withdrawn, or rendered impossible, posing a huge health burden compounded by the health needs of displaced populations.<sup>2</sup>

Research has shown how protracted conflicts can affect specific health outcomes

## KEY MESSAGES

South Asia has a large population affected by different types of protracted conflict and can provide critical insights to understand health challenges in conflict zones

Health systems in conflict affected areas should prioritise domestic and gender based violence, along with reproductive and sexual health services

Mental health and psychosocial services for conflict affected populations in South Asia need to be strengthened, and these services should be integrated into existing primary care platforms

Building the capacity of the existing healthcare system and developing a trained local workforce can improve the access to and availability and acceptability of health services in conflict affected communities

Research capability must also be strengthened for mutual learning and regional collaborations to develop context specific solutions throughout South Asia

influenced by impediments to accessing healthcare services, pressures on health systems, burden of unmet health needs, and attacks on health facilities and service providers.<sup>2-10</sup> However, lessons have been also learnt, strategies devised, and innovations created to meet the challenges to health in conflict situations.<sup>11 12</sup>

South Asia, with its shared cultural and geopolitical history, is home to several protracted conflicts both within and between countries (box 1). The countries also share similar developmental, social, and health challenges and have been attempting to foster regional cooperation through associations such as the South Asian Association for Regional Cooperation (SAARC), albeit not in tackling conflict related problems. Home to a fifth of the world's population, the region has a history of protracted conflict and can offer critical insights into understanding the impact of conflicts on health. This, in turn, can help in identifying solutions, tracking innovations, and advocating changes to policy and practice that enable organisations and governments to respond better.<sup>23</sup> In this paper, we highlight some of the key health consequences and responses in conflict affected areas of South Asian countries and recommend key actions for the future.

## Impact on key aspects of health Mortality and morbidity

Given the different types, length, and intensity of conflicts in South Asia, estimating the overall number of casualties is difficult. Estimates from databases show 333 436 direct deaths due to conflict in the region since the 1980s,<sup>14</sup> although given the limited data collected on deaths due to conflicts, these figures could be underestimates.<sup>24</sup> Of these, more than a third of the deaths are of civilians.<sup>25</sup> Conflict in the region has also resulted in large numbers of indirect deaths, due to the collapsed health systems, which are difficult to record but represent a crucial mortality burden.<sup>26</sup> Data on injury are harder to determine, although evidence from Afghanistan and Pakistan indicates that the injured outnumber the dead.<sup>27</sup> Health facility based studies from the region indicate that with gunshots and bomb explosions contributing to most of the violent trauma, survivors need extensive

rehabilitation services, which are mostly unavailable and difficult to provide.<sup>28 29</sup>

## Women's and children's health

During armed conflicts, gender based crimes and violence become more frequent, with forced abduction or sexual violence.<sup>30 31</sup> Also, women experience unequal access to services such as healthcare when men control access to services and goods.<sup>30 32</sup> Studies from Afghanistan show that protracted conflicts also augment the risk of childhood morbidity and mortality owing to increased exposure to infectious diseases and unsanitary living conditions and destruction of health facilities.<sup>33</sup> The combination of displacement, poverty, infectious diseases, and lower food production may cause these children to experience food insecurity, malnutrition, physical (stunting and wasting) and diarrhoeal diseases, acute respiratory infections, and psychological problems (anxiety, depression, and post-traumatic stress disorder).<sup>30 33 34</sup>

Research from Pakistan and Bangladesh shows that the culture of child marriage in the region is exacerbated in conflict areas, along with maternal malnourishment and sexually transmitted diseases, increasing the risk of maternal and child deaths.<sup>35</sup> Studies from Bangladesh indicate that women with lower levels of education, scant sources of income, limited mobility, and a smaller role in decision making are at the greatest risk of intimate partner violence.<sup>36-38</sup> All of these are common among displaced populations and against the backdrop of protracted conflicts and camp situations with breakdown of family and community safety structures. Prevailing insecurity means that enforcing any existing laws on protecting women from violence is a challenge.

## Mental health

The effect on mental health of protracted conflict and prolonged internal/external displacement in the region is extensive and compounded by large scale natural disasters such as the 2004 Indian Ocean tsunami, 2005 Pakistani earthquake, and 2015 earthquake in Nepal. The number of people in South Asia with mental illness was approximately 200 million in 2006,<sup>39</sup> and it is predicted to rise.<sup>40</sup> Although region-wide

**Box 1: Conflicts in selected countries of South Asia****Afghanistan**

Decades of conflict have had a devastating impact on health in Afghanistan.<sup>13</sup> A few years of partial stability and development followed the fall of the Taliban. However, violence has been increasing, leading to a rise in insecurity and consequent incapacitation of health services.<sup>14</sup>

**Bangladesh**

Two types of conflict related displaced populations are present in Bangladesh: Rohingyas (a stateless group from Myanmar) and Biharis (non-Bengali citizens living in refugees camps since the war of 1971). Both these groups are deprived of access to the national healthcare system and proper sanitation facilities and exposed to high risk sexual behaviour and hazardous health conditions.<sup>15</sup>

**India**

With diverse ethnic, linguistic, and religious groups, parts of India have low intensity and protracted conflict. Three major zones of conflict are the state of Jammu and Kashmir, insurgency in some of the states in the remote north east, and the Maoist insurgency (Naxalite) in parts of central India.<sup>16</sup> Violence by armed groups, counter-insurgency operations, and internal displacement have crippled the healthcare services through chronic disruptions.

**Nepal**

The Communist Party of Nepal (Maoist) led an armed insurgency against the Nepali state in 1996, resulting in a civil conflict that lasted for a decade and claimed more than 13 000 lives.<sup>17</sup> This conflict led to population displacements and destruction of healthcare facilities and affected the already weak health system.<sup>18</sup>

**Pakistan**

As a result of multiple large influxes since 1979, Pakistan has hosted a vast number of Afghan refugees, burdening the already resource constrained public health delivery systems.<sup>19 20</sup> Furthermore, in 2015, more than 1.1 million people became internally displaced because of repeated military operations and sectarian violence in the Federally Administered Tribal Areas.<sup>21</sup> These internal conflicts have caused substantial damage to health facilities and services in the area.<sup>22</sup>

**Sri Lanka**

Since independence, Sri Lanka has experienced violence from leftist insurgencies in the south and protracted conflict in the north and east that ended in 2009. Thousands have died or become injured, disabled, and displaced as a result. The health impact of conflict still cannot be fully measured, although health services have significantly improved in post-conflict regions.<sup>9</sup>

figures are not available, country specific evidence suggests high levels of mental disorders directly attributed to conflict across South Asia. Mental disorders most commonly attributed to conflict in the region are depression, anxiety, and post-traumatic stress disorder, with variations across countries (table 1).<sup>9 41 42</sup>

These variations may be influenced by factors such as the nature of the conflict (ethnic, religious, ideological), its duration (acute, protracted, recurrent), the region (urban, rural), and forced displacement. However, higher prevalence of mental disorder shows a host of similar sociodemographic associations across countries such as older age, female sex, displacement, being widowed/divorced, low income/education, and food insecurity. Despite the higher burden, the mental health treatment gap for conflict affected populations across South Asia is extensive, as a result of non-prioritisation of psychosocial health, stigma, lack of specialists, and lack of integration with primary care. The median allocation of health budget for mental health

was 0.44% in the World Health Organization SEARO region in 2016, compared with a world median of 2.82%.<sup>43</sup>

**Health costs**

The costs of conflict in South Asia have had an impact on individuals, countries, and health systems in multiple ways. Firstly, the number of people affected by conflict is increasing, leading to increased mortality and morbidity and increased pressure on existing health systems to respond. This is compounded by diversion of public health finances for military requirements and weakening of existing health systems due to lack of funding and conflict related violence. Secondly, the cost of obtaining healthcare for people affected by conflict, especially refugees and internally displaced people, is increasing as a result of breakdown of primary healthcare systems and a lack of human resources, medical supplies, and access. Thirdly, the region's historical under-investment in healthcare has resulted in weak health systems that require significant costs for maintenance and upgrading,

especially during times of conflict. Sri Lanka may be the only exception in the region, although recent evidence suggests that the cost of protracted conflict in the country has taken a heavy toll on its public health system.<sup>44</sup>

**Health impact over time**

The effects of conflict over time on the health of affected South Asian populations are manifold. Evidence from Sri Lanka shows an increased risk of infectious diseases such as tuberculosis, polio, malaria, and diarrhoeal diseases; increased war related physical injuries and disability; child health problems such as malnutrition, developmental disorders, and infections; reproductive health disorders and gender based/interpersonal violence; and increased numbers of children and adults with war related mental health problems.<sup>9</sup> Some South Asian countries such as Pakistan and Afghanistan continue to experience chronic conflict, and others such as Nepal and Sri Lanka are yet to recover fully from the lingering effects of protracted conflict on the health of their populations.

**Terrorism**

In the past decade, South Asia has seen a distinct rise in the number of terrorist activities, violence, and deaths. Although the number of lives claimed by terrorists is relatively small, the consequent fear in

**Table 1 | Prevalence (%) of mental health disorder attributed to conflict in select countries in South Asia<sup>9 41 42</sup>**

Country	Depression	Anxiety	Post-traumatic stress disorder
Afghanistan	38-68	52-72	20-42
Nepal	27	23	10
Sri Lanka	5-30	2-40	2-27

populations after they witness reports in the media of deliberate and destructive acts is disproportionately large. The most densely populated cities in the world are in this region and are the usual targets for terrorist activities and the threat of use of chemical and biological materials. The other damaging effect is on a city's trade and financial markets. Explosives and small arms remain the most common weaponry and more recently are combined with arson and hostage taking.<sup>45</sup> The growing nuclear capability in the region makes the use of nuclear weapons an important concern, despite governments claiming a no first use policy. The aetiology of terrorism leading to this fragile security situation is complex, with non-resolution of core disputes, uneven development, social injustice, calls for revenge, poverty, and exploitation in the region. Political solutions are more likely to be successful than military ones in conflict resolution.

#### Access barriers

Multiple barriers to access to healthcare for conflict affected populations are common across the region. Some of these barriers are similar to those in other global regions such as the Middle East, Africa, or South America, whereas others are unique to South Asia. For example, weak health systems, rural populations, and lack of adequate human resources, financial resources, and political will are barriers commonly found across South Asia and other parts of the world. Displaced populations have no formal linkages to existing health facilities and are often at risk of being discriminated against and abused, compelling them to obtain services from informal providers who may be unqualified and offer services that are of substandard quality.<sup>46,47</sup> Problems with access due to geographical limitations, weak transportation links/systems, rapid urbanisation, growing economic inequalities, and historical cultural/language/religious mistrust are some of the more specific factors that hinder adequate access to healthcare for conflict affected populations in South Asia.<sup>46-49</sup> These factors combine to create significant disparity in how services are accessed by different population groups.

For example, Sri Lanka, despite having developed a robust public health system, still has a significant gap in mental healthcare provision to post-conflict populations owing to the lack of integration of mental health into the primary care system.<sup>9</sup> In 2002, after three decades of conflict that devastated the public health system, Afghanistan's maternal mortality ratio, under-5 mortality, and infant mortality

rates were 1600/100 000 live births, 257/1000 live births, and 167/1000 live births, respectively. However, after the introduction of a basic package of health services and an essential package of hospital services by the Ministry of Public Health of Afghanistan, with support from the international community, access to health services and health indicators in the country have improved significantly, reflected in the results of the recent Afghanistan mortality survey.<sup>50</sup>

#### Innovations and initiatives

With such a wide array of health challenges, resource limitations, and a range of stakeholders, any attempt to tackle these health problems would require contextual strategies, combined efforts of multiple partners, and different approaches. It is important, therefore, to explore such endeavours in the region, however few or small they may be, as they could offer insights and lessons relating to the health problems raised above in different conflict affected areas in the regions, as well as ways to improve existing capacities.

#### Role of government and international humanitarian organisations

Governments and international organisations have played a significant role in improving the health of conflict affected people in the region. For example, the Sri Lankan government has, with the support of international agencies, invested significant financial resources in the health infrastructure of post-conflict areas.<sup>9</sup> In Nepal, non-governmental organisations including international humanitarian organisations have significantly contributed to improve psychosocial services for post-conflict populations.<sup>51</sup> Health service delivery in some provinces of Afghanistan has been contracted out to national and international organisations and is seen as an effective way to expand services to remote and insecure areas.<sup>11</sup> International medical organisations such as Médecins Sans Frontières have joined the government to offer emergency medical care including mental health services in conflict affected regions of Pakistan.<sup>52</sup>

However, a lack of public-private partnerships is common across the region, and a lot of work by non-governmental organisations and international humanitarian organisations is conducted in isolation. Despite the common problems and experiences with conflicts, displaced populations, and provision of healthcare, regional initiatives attempting to find common solutions are scarce. Governments of South Asian countries need to lead sustained

attempts to learn from the experiences and expertise of neighbouring countries to manage conflict related health problems of their populations. Regional intergovernmental bodies such as SAARC should lead the mobilisation of health professionals, academics, and researchers to find regional health solutions for conflict affected populations in South Asia.

#### Capacity building of healthcare providers to serve in areas of conflict

Enhancing the capacity of healthcare providers, particularly through reconstructing and strengthening health infrastructure in conflict affected areas, is a priority.<sup>53,54</sup> Strategic placement of effective leaders in health institutions is needed to ensure effective service delivery and an accelerated development of health infrastructure.<sup>53</sup> Furthermore, provision of targeted training sessions combined with performance linked incentives is needed to entice motivated staff to conflict areas.

The initiative in Afghanistan, involving training community midwives and nurses from local communities through a two year programme, with a bond to work in facilities located in their villages, played a major role in ensuring availability of skilled female health workers in remote and insecure areas.<sup>55</sup> This is underscored by the fact that there were only 467 midwives in Afghanistan in 2002 and there were more than 4500 working midwives in 2014.<sup>56</sup> These trained midwives and nurses are locally accepted and have played an important role in improving maternal and child health indicators.<sup>55</sup>

#### Research capability

Although there are country specific initiatives to tackle health outcomes related to conflict in the region, huge scope exists for more research, to understand the needs of conflict affected population and identify possible solutions to them. Additionally, any health research conducted in conflict zones should adhere strictly to ethical guidelines, especially posing minimal harm and preventing re-traumatisation. Creating consortiums of public health researchers, experts, and administrators from the region to collaborate in building evidence of challenges, lessons learnt, strategies, and innovations would be an important step to tackle some of these problems. The outputs of such platforms can shape better policies and practices to improve and expand health interventions in conflict areas.

#### Conclusion

This paper has attempted to map the broader cross cutting problems related to



protracted conflict and health in the South Asia region by exploring a range of matters such as mortality, sexual health, mental health, costs, access, and innovations in the regional context. There is a need to focus on reproductive and child health, including gender based violence, mental health services, local innovations, and trained workforces in conflict affected areas to improve health outcomes. A huge opportunity also exists for mutual learning, regional collaborations, and enhancing research capabilities to improve access to healthcare and the capacity of existing healthcare systems to meet the health needs of conflict affected areas. This will enable development of context specific solutions that can tackle health concerns related to conflict zones in South Asia and may offer lessons for the rest of the world.

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