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Conflict, extremism, resilience and peace in South Asia; can covid-19 provide a bridge for peace and rapprochement?

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Hospital for Sick Children

South Asia, home to 1.97 billion people (25% of the world's population), is no stranger to conflict and confrontation. Longstanding border disputes (such as between India and China and the decades-old standoff between India and Pakistan), the forced displacement of Myanmar Muslims to Bangladesh, and the 2021 rise of the Taliban triggering a mass exodus of professionals and educated women from Afghanistan underscore the enormous volatility and unpredictability of the region. Climate change poses a further challenge, with the real risk of interstate "water wars."¹ Indeed, South Asia now faces a range of threats, with real risks of these spilling over into interstate conflict.

The links between longstanding conflict, insecurity, and poverty are well recognised.^{2,3} Abject poverty, especially when associated with disparities, underlies many of the known conflicts worldwide, unsurprisingly given the drain conflict places on social sector spending. And although lack of social inclusion and ethnic inequalities have been shown to lead to domestic terrorism,⁴ economic inequalities and grievances are stronger drivers of rebellion,⁵ and are particularly relevant in South Asia. Despite robust economic growth and progress on many technological fronts, South Asia still has the world's largest concentrations of poverty, illiteracy, malnutrition, and preventable maternal and child deaths outside sub-Saharan Africa.⁶ Widespread poverty is closely intertwined with social disparities, marginalisation on the basis of an egregious caste system, and vast inequities that perpetuate disillusionment, grassroots rebellion, and further conflict.

We have previously described the disruptive effects of conflict and insecurity on health systems, with

some long term consequences on maternal and child health outcomes.^{7,8} Conflict, insecurity, and uncertainty affect planning and stable investments in health systems, and the extreme distrust between India and Pakistan continues to jeopardise public health and social protection in South Asia. The two countries have fought three wars since independence in 1947, have hundreds of thousands of troops deployed on volatile borders, and dedicate 14-18% of their entire government budget to military spending,^{9,10} leaving little for human development and social safety nets. For example, the decades long face-off of troops at the Siachen glacier continues to cost India and Pakistan over \$600m annually,¹¹ about the cost of the entire primary care and public health programme in 34 provinces of Afghanistan for 2021-23.¹² These expenditures also pale in the face of the enormous cost of maintaining nuclear arsenals and delivery systems in India and Pakistan,¹³ a travesty given that 22-28% of children in both countries don't receive routine early immunisations.¹⁴

The history of conflict and vast inequities meant the region was a sitting duck for an infectious disease outbreak that took full advantage of social vulnerability. The covid-19 pandemic has clearly exposed the extreme fragility of health systems, the limitations of emergency response capacity, inadequate early disease warning capabilities, and miniscule social support systems in the region. Consequently, South Asia has fared badly, with massive social and economic disruptions and the emergence of the delta variant leading to tremendous excess mortality across many countries in the region, including Sri Lanka, which had been less affected in the early phases of the pandemic (fig 1).^{15,16} Education was interrupted for an estimated 434 million children, and numbers of teenage pregnancies rose by over 450 000 as young girls were married after dropping out of school.¹⁷

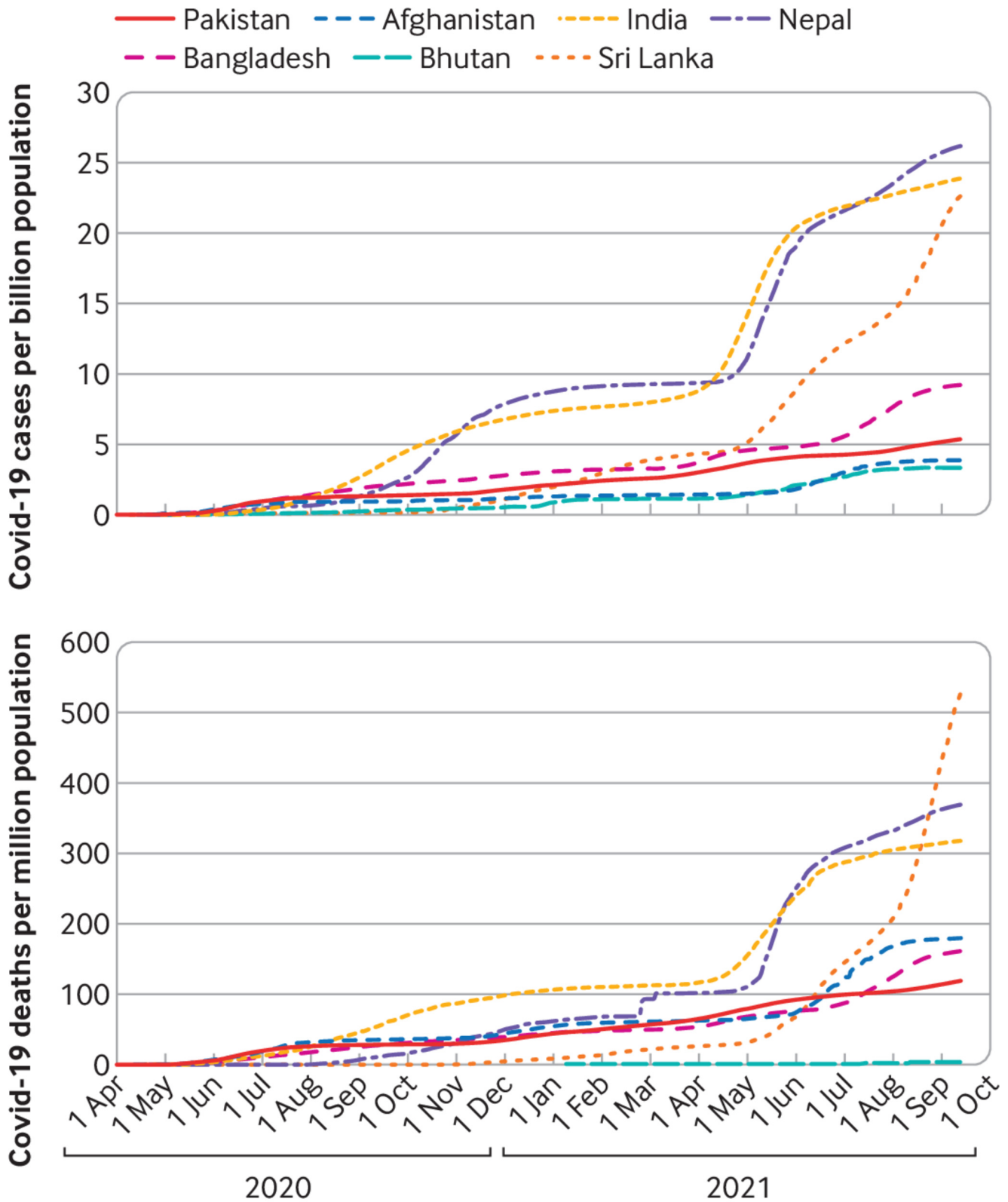


Fig 1 | Trends in covid-19 cases/million population (top) and deaths/million population (bottom) in South Asia. April 2020 to October 2021

Peace in the region and improved relationships between South Asian countries could have mitigated the toll of covid-19. The pandemic now offers an opportunity and a compelling reason to put conflict aside in the interest of public health.

Lack of common learning and exchanges

Despite past exhortations for a regional approach to emerging infectious diseases,¹⁸ the pandemic has been a reality check for

South Asia. There was negligible regional collaboration and information exchange, and no stable platform for joint action. An initial convening of the heads of states of countries in the South Asian Association for Regional Cooperation (SAARC) in March 2020 led to the creation of an extremely modest emergency covid-19 fund of around \$11.5m, mainly based on voluntary contributions.¹⁹ However, little of this money has been disbursed, and tangible collaboration in surveillance, information exchange, or early warning of emerging risks from variants of concern has been negligible. No large collaborative international projects have been launched by science bodies and research centres in South Asia.

Although there were remarkable exemplars of resilience and stable national public health programmes such as the BRAC outreach workers²⁰—community health workers in Pakistan and India²¹—there were few common learning platforms specific to South Asia (despite the plethora of webinars with participants from the region) and no functional networks of public health institutions. Glaringly, unlike in other regions, there have been no data sharing exercises across South Asia related to covid-19 and vaccination coverage.

The capacity of the region to mount an emergency response to covid-19 partly depended on national and regional development of rapid diagnostic capacities; production of much needed personal protection equipment, oximeters, and ventilators; and a reliable oxygen production and supply chain across the region. Although India rapidly developed its own testing capacities, several South Asian countries spent a fortune importing expensive reagents and testing kits that could have been procured regionally at a fraction of the cost.²² The varying capacities within the region in vaccines and biological medicines could not have been starker; political differences and conflict pipped public health measures and international cooperation. India rapidly positioned itself to become the mainstay of the global supply chain for Covax vaccine distribution²³ and launched regional vaccine donations to South Asian neighbours, explicitly excluding Pakistan.²⁴ However, this vaccine diplomacy was also short lived as a rise in cases related to the delta variant led India to stop exports completely.

Collaboration, common learning, and shared experience could have improved other aspects of the pandemic response. For example, one of the serious harms of covid-19 mitigation strategies such as lockdowns has been their economic impact on people on low incomes, with social safety nets insufficient to meet the challenges. The first lockdown in India was associated with massive social upheaval and population displacement from cities to rural areas,²⁵ and although this was followed by a massive ramp up and expanded reach of food and other safety nets, the effects on food security remain.²⁶ Similar effects were noted in Bangladesh.²⁷ In contrast, Pakistan rapidly executed a programme of emergency cash transfers,²⁸ blunting much of the early economic shock and permitting the government to institute mitigation measures at scale. An early and free exchange of ideas and options across the region could have led to a much more coherent policy response and mutual learnings to the benefit of those on low incomes.

Potential role of health diplomacy

The ability of health related efforts to drive long term peace and stability has been questioned.²⁹ However, such efforts have

previously paused hostilities in Africa and Latin America to allow for humanitarian assistance and mass immunisations (such as for smallpox and polio).³⁰ Public health imperatives have previously surmounted conflict in South Asia, including the massive outpouring of support and sympathy from the region during the Pakistan earthquake in 2005³¹ and recent responses from civil society in Pakistan in the wake of the covid-19 disaster in India.³²

For their part, health professionals often already work in close collaboration with local, regional, and global civil society institutions and networks to promote peace, health, and wellbeing. Voices from the International Physicians for the Prevention of Nuclear War and International Campaign to Abolish Nuclear Weapons³³ and others³⁴ have been advocating for peace and de-escalation in the region for years. Public health and development professionals in the region must come together to strengthen learning and support regional peace and security as critical ingredients for South Asia's human, economic, and social development. Numerous examples exist of health experts from different countries mobilising to provide humanitarian assistance to neighbouring countries in times of crises, and they need to do the same in responding to covid-19. Improved technology now permits much easier intraregional interaction digitally.

Tackling poverty and inequity

Although the main goals of health diplomacy are to promote health by enhanced interaction and collaboration between states and civil society organisations and to improve health security and population health, an explicit focus on reducing poverty and inequities gives the exercise much greater legitimacy and appeal. Furthermore, progress towards peace and security cannot be made without tackling root causes of conflict such as poverty, corruption, and inequalities; ensuring application of the rule of law; respect for human rights; small arms control; and improved governance. Reducing inequities and social marginalisation could also help mitigate important root causes of obscurantism and militancy.

If there is one lesson from covid-19 across the world, it is that systemic inequities and disparities led to much of the avoidable excess mortality. As we advocate for restoration of peace, confidence building, and strengthening public health services in South Asia, a clear focus must be on reducing health disparities and reaching the unreached. This requires investment in human resources and infrastructure for primary healthcare and education, both of which have been seriously hampered by the current pandemic. Redirecting public policy and funds towards unmet social needs and a renewed battle against poverty, hunger, disease, and illiteracy would surely be the most important triumph for a region that boasts 25% of the world's population and one of the largest clustering of economically disadvantaged people, including in urban areas.

Calls for strengthening of primary care and human development investments in South Asia are not new and were the centrepiece of the landmark Bhoré committee recommendations as far back as 1946.³⁵ The unprecedented crisis created by covid-19 offers an opportunity to make gains on the inequities it laid bare. However, building back fairer after covid-19 will need a substantial reduction in military build-up and expenditure and a corresponding increase in expenditures on health and education across the region, which are very low presently (table 1).³⁶⁻⁴⁰

Table 1 | Social sector investments and covid-19 deaths per million population in South Asia and other global regions

	Military expenditure ³⁰				Arms transfers ³⁰ (trend indicator values)				Health expenditure ^{31 32}				Education ^{32 33}		Covid-19 deaths/million population ¹			
	% of GDP		% of central government expenditure		Exports (\$m)		Imports (\$m)		Expenditure/capita (current international \$)		% of GDP		Expenditure per student, primary (% of GDP per capita)		Total expenditure (% of GDP)		2020	2021*
	2010	2020	2010	2020	2010	2020	2010	2020	2010	2018	2010	2018	2010	2018/2019	2010	2018/2019		
Afghanistan	1.9	1.4	9.4	4.5	—	—	377	277	45.0	49.8	8.6	9.4	12.0	—	3.5	—	54.9	127.1
Bangladesh	1.3	1.3	11.2	9.3	—	—	36	46	20.8	41.9	2.5	2.3	—	—	—	1.3	45.4	121.7
Bhutan	—	—	—	—	—	—	—	—	74.1	102.7	3.5	3.1	7.5	—	4.2	6.9	0	3.8
India	2.9	2.9	9.9	9.1	5	151	2911	2799	45.1	72.8	3.3	3.5	7.5	—	3.4	—	106.9	218.7
Maldives	—	—	—	—	—	—	5	3	600.6	973.5	8.5	9.4	15.2	—	4.1	—	88.3	353.2
Nepal	1.6	1.4	8.3	4.8	—	—	3	36	30.0	57.9	5.0	5.8	11.1	—	3.6	5.1	62.5	319.5
Pakistan	3.4	4.0	16.8	17.4	1	1	2205	759	25.3	42.9	2.6	3.2	—	—	2.3	—	45.2	80.8
Sri Lanka	2.7	1.9	13.5	10.3	—	—	4	59	108.3	157.5	3.9	3.8	5.1	7.9	1.7	2.1	9.5	622.0
World	2.5	2.4	6.7	6.1	—	—	25 718	22 400	914.2	1111.8	9.6	9.8	15.2	—	4.5	—	241.9	392.4
East Asia and Pacific	1.5	1.8	5.5	5.0	—	2287	6325	5848	478.3	721.9	6.3	6.7	12.4	—	3.6	—	19	110.8
Europe and Central Asia	1.8	1.9	3.9	3.8	14 334	10 353	4612	2998	2192.8	2346.6	9.2	9.3	22.2	—	5.2	—	624	875.1
Latin America and Caribbean	1.4	1.3	4.1	3.6	—	22	1600	951	654.9	666.9	7.3	8.0	13.9	—	4.7	—	853.54	1430.8
Middle East and North Africa	4.7	5.2	15.5	16.5	—	—	5279	6466	341.5	520.9	4.7	6.0	—	—	—	—	240.6	338.2
North America	4.6	3.6	11.2	2.5	8299	9572	1319	894	7644.7	10 050.3	15.8	16.4	22.1	—	5.4	—	990.7	1069.2
South Asia	2.8	2.8	10.6	9.8	5	151	5538	3834	41.4	67.2	3.23	3.5	9.3	—	3.4	—	91.1	197.8
Sub-Saharan Africa	1.3	1.1	5	4.7	—	—	1045	—	83.7	83.3	5.2	5.1	10.4	—	3.5	4.3	60.44	161.4

* Up to 23 October.

Looking forward—fairly, sustainably, and peacefully

What practical steps can help the post-covid rebuilding process, rebuild confidence in collaboration, and promote peace? We propose several actions that are not resource intensive but could foster peace in the interest of public health and help in the recovery from the pandemic.

Empowering women to support public health measures and broker peace

South Asia must tackle widespread gender inequality in its largely patriarchal societies and support the role of women as peace makers. Women have often been central to conflict resolution and had key leadership roles in the response to covid-19 in South Asia, including as frontline health workers.⁴¹ In India, K K Shailaja, Kerala’s former minister for health and family welfare, was praised for her leadership in the covid-19 crisis, leading to calls for women leaders to have a greater role in national politics.⁴² In Nepal, Tika Dahal led a programme for the support of disabled people during the pandemic,⁴³ and Sania Nishtar spearheaded the highly praised safety net programme for women in Pakistan.⁴⁴

We call on many women leaders in public health, gender studies, and development in South Asia to take an active role in rebuilding

from the current crisis and perhaps to play a part in brokering peace. We also call on political leaders to acknowledge the substantial challenges that women leaders face and to remove the political, institutional, and societal barriers that exist.

Revitalise SAARC and create key partnerships

SAARC was founded in December 1985 to promote peace and prosperity through regional collaboration, working towards a common market and economic integration. It has remained ineffective in various areas, often because of disagreements between India and Pakistan. India has begun to preferentially engage with other regional groupings such as the Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation,⁴⁵ potentially undermining the relevance of SAARC. Shifting the focus of SAARC towards shared concerns for human development and health security, catalysing public health collaboration through a substantially enhanced SAARC Development Fund,⁴⁶ with an explicit focus on projects to rebuild health and education systems after covid-19, might revive its relevance and impact.

A critical prerequisite for this would be the restoration of confidence in the institution and a move towards promotion of peace through conflict resolution. The fact that the secretariat for both the Unicef

regional office for South Asia and SAARC are located in Kathmandu should make joint planning easier, and we challenge both agencies to work closely together for relevant health and education activities.

Create an independent commission for health, peace, and development in South Asia

We propose the creation of an independent commission of representatives from academia, research, and science bodies and civil society organisations to come together to deliberate on mechanisms for promoting health, peace, and development in South Asia. There is precedent in the form of independent civic society and citizen-led dialogues, the so called track 2 diplomacy efforts to break the logjam of inaction and advocate for increased collaboration and investments in social sectors.⁴⁷

The BMJ South Asia is one such initiative that has provided a platform for regional overviews and international scholarly outputs on issues related to health. It could be the host for an initiative focused on identifying regional priority actions for health and social determinants of health within a defined time frame, with clear deliverables and outcome measures. A common mission could also be promoting greater collaboration in development of vaccines and biological medicines in the region, an area where centralisation of capacity has been shown to have serious limitations.

Promote people to people contacts, cultural, sports, and educational activities

South Asian peoples are rooted in ancient civilisations and a deep and resilient culture. Despite diversity of faiths, ethnicities, and geographies, they have largely lived together peacefully. In recent decades, however, exchanges between different groups, especially the youth in the region, have been minimal. Shrill, jingoistic media and unwanted acrimony in cultural and sports events have further alienated civic society. As we emerge from the pandemic, we need to promote greater exchanges between peoples of the region. Removing arcane and divisive visa arrangements would help promote peace and many of the actions outlined above.

Mistrust and security challenges since independence from colonial rule have meant that too many South Asians live in fear, poverty, and ill health, with uncertain futures. Although the covid-19 pandemic has substantially set back economic progress and human development in the region, it also offers an opportunity to jumpstart change in building back a fair and secure future for our children. Now, more than ever, we need to join hands to support our shared humanity and shape a new future for generations to come.

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