Conflict as a Social Determinant of Health: Deconstructing Health Service Impacts of the Ongoing Conflict in Manipur

Veda Yumnam[1]

Abstract

Manipur, nestled in north-eastern region of India, is a complex and pluralistic society representing multiple religious, ethnic and cultural identities. Amongst all the markers of community identity, 'ethnicity' has become a 'boundary –enforcement' apparatus in this society. The state has been marked by cycles of conflict and peace over decades since its merger with Independent India. Federal, state and local administrations have had mixed success in recognizing and addressing conflicts between different ethnic groups and armed entities. The ongoing violent conflict between two major ethnic groups-the Meiteis and Kuki-Zo communities, has taken multiple forms and are competing overtly on ethnic lines over the expropriable assets and resources.

The paper examines the health service situation in the backdrop of the current conflict, locating it in the large canvass of conflict as a social determinant of health. The present situation continues to affect access of health services and the capacity and performance of the health system to respond to the needs of people. Conflict is still under-recognized as a determinant of health services. The paper offers a nuanced understanding of this determinant in the specific context of the ongoing conflict. It has thus sought to establish the linkage of the social determinants of health from a geo-political and historical approach to understand the competing and contesting claims of the two conflicting communities.

Introduction

India's north-eastern states have a history of multiple ethnic conflicts dating back from the Independence of the country. Manipur, a state in the North-East Region of India, is currently experiencing unabated violent ethnic conflicts since 3rd May, 2023. The state is home to more than 39 ethnic communities and not new to conflict. Deep-rooted conflicts underlie ethnic tensions around issues of exclusive homeland, independent governance and integration of places into one unified administration division for a particular community. It is not merely a political contestation between ethnic

[1]Assistant Professor, Dept. of Social Work, University of Delhi. Email: vedayumnam@gmail.com

communities or the state and various non-state armed groups, but also between armed groups that are polarized along ethnic lines. The conflict can be traced to two different historical trajectories: the annexation of the state in independent India and the increased wave of growth of 'ethnic fraternity' amongst different ethnic groups that has grown in strengthen since the 1980s (Centre for Humanitarian Dialogue, 2011).

The Ongoing Ethnic Conflict

The current conflict started in early May, 2024 between two ethnic communities, the Meitei community and the Kuki-Zo community. Only 16 conflict-free days in nine months have been recorded so far (Radhakrishnan and Srinivasan, The Hindu 07 Feb 2024). Initially, the violence was restricted only in Kuki-Zo dominated Churachandpur district and Meitei dominated Imphal city. Subsequently, it has spread across multiple districts in the state viz. Bishnupur, Thoubal and Kakching districts which are dominantly populated by Meiteis and Jiribam, Tengnoupal and Kangpokpi districts dominantly populated by Kuki-Zo community.

Many long-standing tensions and unfulfilled demands of different ethnic communities have pervaded for decades without any political and diplomatic solutions. The current conflict was triggered in the aftermath of a solidarity march organized by the All Tribal Students Union of Manipur (ATSUM) protesting the Manipur High Court's directive to the state government to submit a recommendation to grant Scheduled Tribes status to the Meiteis. The clashes have renewed and reinforced a longstanding demand for a separate state/administration by the Kuki-Zo. The demand is either fiercely opposed or supported by armed groups and civil society organizations depending on their ethnic affiliations to defend their respective claims. The state and the federal governments have deployed extra security personnel to content the violence and restore peace in the state.

The violence and securitization of the issues is not only disrupts the harmonious existence of people threatened but halts overall developmental activities and socio-economic progress. The nature and origin of conflict in the state may have varied in the multiple-ethnic conflict witnessed in the state (Yumnam, 2017). What remains unchanged is the mode of praxis and herculean task to sustain levels of peace, security, and prosperity. In the ongoing violence, the state is challenged with fatalities and injuries, displacement, damage and burning down of houses and other crucial infrastructure like offices, temples, and churches. Provisioning of public services and supplies in the state has either become inadequate or disrupted or temporarily suspended. Prices of food and other household essential commodities have skyrocketed and supplies of medicine and food essential have been left stranded in the state.

Background Settings

Conflict situations are hindrances to governance and almost invariably pushed development and efforts to a standstill. A regular feature in the local newspaper in the ongoing conflict is the disruptions of the state health services in the state. This raises the

red flag on how conflict creates and cements inequities in providing basic services to the people essential services. The state has made substantial improvement nearly after three decades of health sector reforms including one-and-a-half decades of the National Rural Health Mission (NRHM)/ National Health Mission (NHM). This paper examines the genesis of the conflict to establish the linkage of the social determinants of health (SDH) from a geo-political and historical approach. These determinants affect the SDH that result in the unequal distribution of health damaging experience of the people during the prolonged conflict. Geopolitical and historical determinants are distinct from other SDH as it tries to understand health outcomes as products of national policies at the local and/or regional levels. Such focus help in recognizing that these policies are influenced by geographical, historical and political leadership (Persaud et al, 2022).

Methodology

Desk search of data and viewpoints available in the public domain including newspaper articles, NGOs/Civil society organization reports and other secondary sources are used to understand the impact of ethnic conflict on health services in the ongoing ethnic conflict. Incidence reports of newspapers were cross-checked and triangulated across multiple reporting channels /media as well as other open access websites such as social media platforms to maintain the authenticity of the data.

Additionally, another set of secondary data sources such as books, articles and grey literature were used to synthesize and bring forth the understanding of geopolitical and historical context of conflict in Manipur. This section was part of the author's doctoral work in understanding conflict as a SDH and its implication on the health of the people. It holds a strong relevance as health outcomes are a product of national policies. The focus on historical and geopolitical patterns shapes the experience of health of the people.

Findings

Unpacking the Historical Dimensions

Manipur has witnessed sustained conflict since the post-colonial era; the break down has been termed as '*extreme in the media and political circle*' (Hassan, 2006).The multi-ethnic make-up and the constant struggle over the available resources has led to protracted conflict. The deep-rooted can be traced back to the annexation of the state in independent India and the growth of 'ethnic fraternity' amongst different ethnic groups that has been growing since the 1980s (Centre for Humanitarian Dialogue, 2011).

Historically, Manipur was a princely state until its forceful annexation with the Indian federation in October 1949. The Meiteis were the revivalists who strived for the restoration of the pre-merger agreement and demanded a separate nation. They constitute about 60 per cent of the total population and reside mostly in the four valley districts, while the tribal population constitute 34 per cent and occupy 90 per cent of the total land area across the hill districts. Both the groups have sought two different constitutional arrangement in their respective areas, the tribal with their customary

laws and the Meiteis with the political arrangement followed during the princely administration [Fernandes, n.p; Baruah , n.d; Singh(K)]. These claims are elaborated in the writings from historians like Sanajaoba (1988) who traced the break-down of Manipur with the forceful merger with the Indian federation and subsequent emergence of a 'master-subject relationship' whereby the state's unique political, economic and cultural identity were made to fit into a mainstream Indian polity (Akoijam, 2001, Singh (M), 2010 and Shimray, 2001).

The second wave of conflicts restructured around the articulation of grievances and mobilization of the people on ethnic lines (Shimray, 2001). The construction of 'ethnic identity' plays major role as many groups - leading to upsurge of the Meitei-Naga-Kuki identity and further led to the rise of 'ethnic nationalism'. In a society like Manipur, as Baruah (n.d) puts it for the rest of the NER, '*a society characterised with primordial loyalties and non-liberal values*', it is only natural that ethnicity would be emerge as a powerful force.

Manipur has around 30 armed group representing several ethnicities with multiple and competing demands that Singh (2001) frames as '*a rise of the culture of assertion or domination of group identity*'. The gradual transformation of the Meiteis, the Nagas and the Kukis as communities that struggled against feudal oppression and colonial subjugation to communities aspiring to assert their domination are an important phenomenon in the political landscape of the state. The failure of the successive union governments to resolve the differences has transformed these into conflicting communities (Fernandez, 1999; Hassan, 2006, Akoijam, 2001).

Anatomy of the Conflicts

Majority of the valley-based groups call for restoration of a pre-merger status and the hill-based groups demand an exclusive homeland and/or integrate specific geographical areas into the neighboring state of Nagaland, Assam and Mizoram. Political aspirations have been created along ethnic fault lines as in the case of Kuki-Naga (Bhagat, 2010, Singh (M), 2010 and Hassan, 2006).

Locating the strife across ethnicities, the formulation of Paul Brass (of three stages) is instructive. The first stage is the formation of identity itself but not symbolically recognized. The second state is the recognition of that identity and the initiation of that identity to further the interest of the group, and the third stage is the determination to uphold the identity and bring in to the stage of mark of domination. Michael E. Brown (1993: 5) frames the Manipur situation, as '*a dispute about important political, economic, cultural, or territorial issues between two or more ethnic communities*.'

Typology of Conflicts Shape the Dynamics on the Ground

The key conflicts that have emerged in Manipur in the past few decades are summarized as follows:

a. Kuki[2]-Naga[3] Conflict-1992 onwards: The conflict was mobilized and waged in line of what Oinam (2010) terms as 'fraternity feelings'. This was the first inter-community conflict in Manipur. Both the tribes have been struggling for exclusive homelands. Hence, the overlapping claims over land and territory led to the violent Kuki-Naga conflict which began in 1992 and continued till 1998.

b. Kuki-Paite (Zomi) Conflict: These clashes occurred in 1997 and 1998 and were an extension of the Kuki-Naga conflict. The root cause of the clashes was the non-acceptance of the nomenclature 'Kuki' by non-Thadou speaking groups like Zous, Simtes, Paites and Vaipheis. It was primarily confined in the Churachandpur district of Manipur. The territories claimed by both the Nagas and the Kuki-Chin-Mizo overlap over all the hill districts of Manipur, except Churachandpur.

c. Expansion of sub-nationalism seen in the context of 'Nagalim' leading to constant tussle between the Nagas-Meiteis: The Naga armed conflict which began in 1950s continues to have a tremendous impact on Manipur. The National Socialist Council of Nagaland-Isak Muivah (NSCN-IM), a prominent Naga armed group, has been pressing for the formation of 'Nagalim' comprising all Naga-inhabited areas of Arunachal Pradesh, Assam, Manipur and some areas of Myanmar to be the rightful homeland of the Nagas. The Nagas are in conflict with the Indian state and face opposition from the Meiteis of Manipur Valley who are opposed to the greater Naga Nation concept (Shimray, 2009 and Bhagat, 2010).

d. Secessionism from the Indian State as demanded by some Meitei armed groups: The circumstances leading to the merger of Manipur with the Indian Union remain an intensely contested issue among some groups. Many valley-based groups still seek to restore the pre-merger status and argue in favor of a separate homeland [Shimray, 2009, Bhagat, 2010 and Singh (M), 2010].

e. Meitei-the Meitei Pangals[4] conflict: A communal tension broke out between the Meitei and the Meitei-Muslims in 1993 in which several people belonging to both sides were killed. The exact cause of tension is still unknown [Singh (M), 2010]

The previous sections briefly outlined the historical and geopolitical factors of conflict in Manipur. This section aims to draw how conflicts modulate health determinants and act a social determinant of health with the backdrop of the ongoing ethnic conflict in Manipur.

Conflict as a SDH

The World Health Organization report (2008) highlighted two major determinants of health during conflict: (i) loss of human rights and (ii) breaches of medical neutrality.

[2] Kukis: The Kuki is a generic term applied to the various sub-tribes, viz., Thadou, Paite, Hmar, Simte, Zou, Gangte, Vaiphei, Guite, Ralte, Sukte, etc. (Singh, K.G, n.d).

[3] Nagas: The name 'Naga' is a generic term applied to a number of sub-tribes, who were otherwise known by different names: Ao, Angami, Lotha, Sema, Tangkhul, Mao, Maram, Zeliangrong, etc. The origin of the term is shrouded in mystery. Whatever may be the origin of the name 'Naga', but it is widely accepted. There are 18 Naga sub-tribes in Manipur. They are: Aimol, Anal, Chiru, Chothe, Kharam, Koireng, Kom, Maring, Mayon, Monshang, Lamkang, Mao, Maram, Thangal, Poumai, Tangkhul, Tarao and Zeliangrong (Singh, K.G, n.d).

[4] Pangals are the Muslims community in Manipur.

The loss of human rights manifests as an inability to protect oneself, displacement, breaking down of social and family networks, loss of livelihood, and also lack of basic services including water, sanitation or health services. Additionally, medical neutrality is the neutral status acquired by the victims of war/conflict and their medical attendees so that they received unbiased treatment without any fear or favor during the time of conflict. It is a responsibility that needs to be upheld by all warring parties involved in the conflict so that the sick and wounded can be provided undeterred health services and are allowed freely to access health services. Medical neutrality is breached and remains pervasive across incidents of conflict.

The current conflict situation in the affected areas in the state had led to a breakdown of the social order and deepens health inequities. Deaths and injuries are the direct outcome on the state of health, and inaccessibility or reduced healthcare services to civilians. The indirect effects, on the other hand, are inconspicuous and may only come to light several months/years after the conflict ends

Conflict's Toll on Health Services and as Social Determinants of Health in Manipur

Most armed conflicts generate major public health consequences in terms of the health status of affected populations as well as the structure, policies, and financing of the health system (WHO, 2008 and Watts et al, 2007). Conflict not only has implications on the health status, but also has serious consequences on the broad social and economic determinants and conditions that affect people's health crisis settings (Watts et al, 2007).

The World Health Organization (WHO) Regional Office for the Eastern Mediterranean (2008) identifies

- Conflict as a SDH : Three social determinants have bearing on health in conflict settings: (i) loss of human rights, (ii) breaches in medical neutrality and (iii) progression from stress to distress and disease that results in constant exposure to life threatening circumstances.
- Conflict reinforces existing SDH: As in the conflict settings the social determinants of health get re-enforces and people who are marginalized and lower down in the socio-economic position and power structure suffer from the inequalities and the differentials in health status widen.

With the theoretical backdrop of the ethnic conflict "as" and 'reinforcing' social determinants of health, the impact of the health services in Manipur is examined.

Deaths and Injuries

Civilian casualties are high in conflict settings. Direct morbidities and morality caused by the conflict has been well documented (WHO, 2008). A serious implication of the post-war and post-conflicts are the disabilities and injuries as well as the psychological trauma of the survivors and the victims (WHO, 2008 and Watts et al, 2007). A high prevalence of symptoms of depression, anxiety and PTSD, even compared to other

population in a conflict setting was found in Afghanistan (Centers for Disease Control and UNICEF, 2002).

The violence have claimed over 200 lives as reported in media outlets as on February 2024 and injured more than 1,000. Unabated firings continue in the state. The death tolls are expected to increase. Armed-groups from the two warring communities, state forces and civilians including children and women are reported victims of clash in the state. The direct deaths amongst the civilians are preventable and avoidable.

A new emergent group, the 'village volunteers' have experienced high level of fatality in the current conflicts are the deaths amongst the 'village volunteers'. The 'village volunteers' are civilian youths who have armed themselves after the conflict started to guard their villages along the periphery area of affected valley districts and adjoining hills districts of the state to protect attacks from the rival community. These volunteers typically are young males between the age group of 18-35 years who have received hardly any combat or military training but have become an important stakeholder in the ongoing conflict.

Disruption in the Health Services

Besides, the obvious mortality and morbidity it brings, one important aspect that have an important implication and determine the health of the people, is the implications it brings to the health services system (Guha-Sapir and van Panhuis , 2002).

In the ongoing ethnic conflict, the super-specialty medical hospitals and clinics concentrated in Imphal valley inaccessible for the Kuki-Zo and vice-versa for the peripheral facilities located at the hill districts. It has severely restricted the mobility of health staff as the staffs are not able to join work in their respective posting places which are dominated by other communities. Specialist doctors were reported to be called in from adjacent states such as AIIMS Guwahati. Patients were earlier referred to Imphal for treatment; however, they have to travel to adjacent states of Nagaland, Assam and Mizoram adding hugely to the financial burden and delay of treatment. With non-stop gun-fights and violence in the state the sick and wounded are either not availing or delaying seeking healthcare. Civilian areas are attacked indiscriminately by state and non-state forces. There is a constant threat to life of civilians and even the health care providers.

Issues of Health Providers

Health workers are crucial for a functioning health services system. Evidence points towards shortage of health workers in many countries, especially in conflict and difficult areas, and for various reasons health workers are reported not to deliver their duties efficiently. Furthermore, with growing opportunities available that encourages movement from conflict regions to search for better professional and secure environments point towards the disruption of services (Tulloch, Raven and Martineau, 2010, PHFI-NHSRC-SHRC, 2010 and Betsi, 2006).

Despite the existence of the normative framework enshrined in the Geneva Conventions of 1949 and its two protocols of 1977 and 2005, providers of healthcare are under constant threat impeding the health care delivery. Since, they comprise a smaller proportion of the overall number of violent events in conflict riddled regions the attacks on the health providers are less understood aspect of any conflict (Sinha , 2012).

Healthcare providers face extortions, rape, kidnapping, harassment, brutality, deaths and migrate to more peaceful areas due to undue extreme pressure they faced (Sheik, 2000 and Doull, 2008). The direct killings and attacks of the health workers are less in comparison to the deaths of the civilians by the warring parties; however, these had extreme repercussion in the operation and have made drastic implication on the availability of health care services of the people.

In the ongoing conflict in Manipur, resurgence of direct attacks on health workers, ambulances, and obstructions to emergency health service providers is recorded. Breach in medial neutrality is not new in Manipur. During the long-standing years of conflict, violent attacks on health facilities, ambulance and health personnel have been documented (Sinha et al, 2013). A particularly extreme case of a mother and child being burnt inside the ambulance is reported in the ongoing conflict. Doctors, medical students and paramedical staff had fled for safety during the early phase of the ongoing conflict in Manipur. Attack to medical personnel further has exacerbated the ability of the health system to cater to the health needs of disadvantaged population and people in large in the state.

Health Infrastructure

Health-care facilities like clinics, hospitals, medical stores and pharmacies are often destroyed with bombing, shelling and shooting in conflict and other situation of violence.The legal obligation as per the Geneva Convention, Article 12 of Protocol II have clearly set the protocol that, 'health infrastructure shall be respected and protected at all times and shall not be the object of attack'. Yet many of the health infrastructure needed to deliver services are often damaged or destroyed and supply of necessary medical supplies and equipment, and other essential services like water and electricity interrupted and faced shortage and delayed in supply (Waters, Garrett, and Burnham, 2007).

The ICRC in its report 'Health care in danger: making the care' (2011) clubbed the attacks on health facilities under four different categories. First, deliberate targeting of facilities to terrorize and get military edge on the opponents to access the health facilities. Second, targeting is carried out along political, ethnic and religious grounds as the health facility. Third, unintentional damage and destruction on account of actions by the militia and security forces. Fourth, looting of drugs and medical equipment, which is a common form of violence.

Delays in supply of basic medical care and equipment, and looting them have also been reported in war torn countries. In the testimonies released by MSF staff in Syria,

healthcare delivery has been disrupted due to delayed in supply of medicine and equipment. Similarly, in Bosnia, gaps have developed in the supply of specific medicine and other equipment needed to deliver health care (Mann et al, 1994). In Nepal, looting of drugs from health facilities has been documented. The health providers have to apply different tactics like naming of drugs for free and for sale to avoid confrontation with the insurgents as they insisted on supplying all the medicine free of cost as it was supplied by the government (Devkota, 2005). Similar evidence was documented in Liberia during the civil war where drugs and equipment were repeatedly looted in 1994 and 2002.

Service Delivery and Barriers in Access

WHO (2007) defined 'good health services delivery as those which deliver effective, safe , good quality , personal and non-personal care to those that need it, when needed, with minimum waste. Services could be deliver at home, community, workplace or the health facilities'. A good health service delivery with equitable access is crucial for the healthcare needs of the people, however, in conflict settings service delivery gets sub-standard, disrupted and are inequitable (WHO, 2008)

In conflict settings due to the frequent disruption caused by violent activities, bandhs, road blockades, restriction in mobility and the threats faced both by the providers and the users while accessing and delivering the services, the delivery of healthcare is either compromised, denied or inequitable (WHO, 2008). Moreover, in large-scale and prolonged events, access to preventive health care amongst the population becomes more limited and conditional due to the insecurity exacerbated by the crises. Disruption and hindrance in the implementation of preventive services like routine immunization, and other health related programs like tuberculosis control program carried out by the government and other international organizations have implications not only on the long-term health impacts of the population but also increases the inequities of health.

Sub-optimal standard of care provided in public sector lead to the gradual shift to private services, however, since most of the people who are afflicted by protracted conflict, are poor and unemployed, public services remained the important source of care. Concordance in terms of ethnicity and race has proven to have strong correlation with patient satisfaction and higher self-rated quality of health care. It is more visible in protracted conflict where the mobilization of the people are carried out in terms of ethnic and racial lines. Given the situation that the providers understand the social and cultural context of the population they served, the racial /ethnic compositions of the workforce contribute in the availability and accessibility of healthcare (Betancourt et al 2003).

Healthcare facilities are specifically targeted in conflict situations so that those who are wounded in fights or otherwise are unable to access care they need. In Manipur, to further compound the problem there are frequent transportation blockades and seizure of medicines and medical supplies. The blockade called by armed groups and other civil society organizations lead to shortage life-saving drugs and medical supplies in conflict affected areas. Incidents of non-availability of lifesaving drugs, medical

equipment and devices are frequently reported. At the community level essential medical supplies including drug supplies for chorinic conditions such as HIV, diabetes and cancer are disrupted. Multiple barricades created by state forces and civil society's organizations representing both on Kuki-Zo and Meitei communities lead to disruption of transportation of medical supplies and vaccines. It is in those backdrop that the state government is making efforts to deliver medical supplies to the districts and frontlines, with multiple units being transported by the Health Department, Border Security Force (BSF), Assam Rifles, and Manipur Police

Conclusion

The WHO recognizes the highest attainable standard of health as fundamental rights of an individual guaranteed by international human rights laws and treaties. Such laws are enforced through regional and international treaties. The State acts as a guarantor to provide these rights amongst those living under its jurisdiction. Health facilities and personnel involved in delivery services are attacked. Such incidents not only violate the rights of the people but are an affront to international humanitarian law. Ensuring right to health not only encompasses impartial services and treatment but the obligations for the state and non-state forces not to impede service delivery and access, and passage to medical vehicles. A preliminary understanding of the nature and types of attacks on, and interferences with the healthcare services revealed physical and mental violence to health personnel, health facilities and communities. There is a pervasive insecurity amongst the provider which creates a big challenge in the delivery of healthcare.

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