ARMED CONFLICT: CHANGING INSTRUMENTS AND HEALTH OUTCOMES: A STUDY OF URBAN HOUSEHOLDS IN KASHMIR"

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Abstract:

The present paper is an attempt to track the impact of armed conflict in Kashmir on health prospects at the urban household level. The paper delineates various instruments of armed operations and the associated health hazards inflicted upon the households.32.05% of the respondents reported physical violence against at least one member of the household in 2010-11. 58.46% have experienced verbal violence. The after effects of both physical and verbal violence have resulted into a myriad of psychological problems in the general population. 45.60% of the respondents complained of anxiety and 31.73% of depression for the reference period of 2010-11. These health hazards when co-related with the savings and borrowings of the households reveal 53.60% decrease in their savings 57.18% of the households reported to have had increased borrowings

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1. Introduction:

Health is a key component of human capital, which in turn is an important determinant of economic growth. Improved health can enhance workers' productivity by increasing both physical and mental capacities. Healthier workers are likely to be able to work longer, be generally more productive. Better health also has a positive effect on the learning abilities of children, and leads to better educational outcomes (school completion rates, higher mean years of schooling, etc) and increases the efficiency of human capital formation by individuals and households (Strauss and Thomas 1998; Schultz 1999). There exists a strong causal association running from health to aggregate economic performance. Health has a positive and statistically significant effect on the rate of growth of GDP per capita(Bloom, Canning and Sevilla; 2004). Thus from a purely *instrumental value* perspective sound health is in itself a very important asset. For health to deteriorate there exist both natural and man made reasons. Among the latter armed conflict and appropriation are prominent.

Conflict induced health hazards apart from inflicting aggregate welfare loses also result in physical injuries breeding such psychological disorders that not only make human life miserable but also turn an active member (productive asset) of a family into a liability and a source of mental agony, frustration and anxiety. It is in extension of this argument that the present study is carried out.In this paper we study the impact of armed conflict on household health in the urban District (Srinagar) of the State of Jammu and Kashmir that is sustaining with a two decade armed conflict.This perpetual armed conflict has claimed thousands of lives, rendered thousands disabled. Thousands of young men have gone missing and thousands of women have been living a life of "half widows". Children have been orphaned, displaced from the school. Women have been raped. All these developments over the last two decades are bound to inflict psychological harm and mental illness across the population. Anxiety, mental disorder, crime and suicide rates are bound to rise. People who witness abuses, torture, death and maltreatmentcan never be expected to be in the same socio-psychological state as those who do not.

2. Armed conflict and Health: Reflections from Literature

An estimated 191 million people died directly or indirectly as a result of conflict during the 20thcentury, more than half of them civilians (Rummel 1994). The exact figures are unknown because of generally poor record-keeping in many countries and its disruption in times of

conflict (Zwi, Ugalde and Richards 1999). Active armed conflicts – primarily civil wars – continue in many parts of the world: 21 major armed conflicts occurred in 19 different locations during 2002. During the post-Cold War period of 1990–2001 there were 57 major armed conflicts in 45 locations, all internal except those between Iraq and Kuwait, India and Pakistan, and Ethiopia and Eritrea, although in 15 of them other states contributed regular military troops. (WDR,2011). These civil wars exert a huge toll in human suffering. For example, at least three million civilians probably died in the civil war in the Democratic Republic of Congo (Roberts et al. 2001). Over 30 years of civil war in Ethiopia have led to the deaths of a million people, about half of them civilians (Kloos 1992). Civilians, particularly women and children, bear a disproportionate share of these casualties (Ahlstram 1991). Children are particularly vulnerable during and after wars. Many die as a result of malnutrition, disease or military attacks; many are physically or psychologically injured; some are forced to become soldiers or sexual slaves to military officers. Their health suffers in many other ways, as reflected by increased mortality and decreased immunization (Machel 1996). Rape on the other hand has been used as a weapon in many wars – in Algeria, Bangladesh, India, Indonesia, Korea, Liberia, Rwanda, Uganda, the former Yugoslavia and elsewhere. Soldiers rape the families of their enemies as acts of humiliation and revenge; during the war in Bosnia and Herzegovina military personnel raped at least 10,000 women (Ashford and Huet-Vaughn 1997).

Many people survive wars only to be physically scarred for life. Millions of survivors are chronically disabled from injuries sustained during wars or their immediate aftermath. Landmines are a particular threat. For example, one in 236 people in Cambodia is an amputee as a result of a landmine explosion (Stover et al. 1994). Around a third of the soldiers who survived the civil war in Ethiopia were injured or disabled and at least 40,000 people lost one or more limbs during the war. Millions more people are psychologically impaired from wars during which they were physically or sexually assaulted; were forced to serve as soldiers; witnessed the death of family members; or experienced the destruction of their communities or even nations. Psychological trauma may be demonstrated in disturbed and antisocial behavior such as aggression toward others, including family members. Many combatants suffer from post-traumatic stress disorder on return from military action (Kanter 2005).

The health-supporting infrastructure, which in many countries is in poor condition before war begins, may be destroyed – including health-care facilities, electricity-generating plants, food-supply systems, water-treatment and sanitation facilities, and transport and communication systems. This deprives civilians of access to food, clean water and health services. For example, during Gulf War I in 1991 and the ensuing 12 years of economic sanctions against Iraq, an estimated 350,000 to 500,000 children died, mostly owing to inadequate nutrition, contaminated water and shortages of medicines, all related to destruction of the infrastructure. The 2003 attack on Iraq led by the US and UK devastated much of its infrastructure, leading again to numerous civilian deaths (summarized in Medact 2003 & 2004).

At the societal level war often creates a circle of violence, increasing domestic and community violence in countries engaged in war. It teaches people that violence is an acceptable method for settling conflicts, including children and adolescents. Men, sometimes former military servicemen who have been trained to use violence, commit more acts of violence against women. The return home of servicemen and women can damage health and well-being, through separations, divorces, dysfunctional family interactions and other forms of posttraumatic stress (Kanter 2005).

3. Rationale of the present study

Armed conflict impactsall aspects of national, societal and individual sustenancenegatively. Ranging from destruction of assets(see Rodrik, 1998; Binzel& Brück, 2006; Brück & Schindler, 2007),destruction of physical capital, reduction of investment (Knight et al., 1996; Imai and Weinstein, 2000). However at the individual level the health hazards (physical and psychological) are the most alarming. Individual effects of armed conflict are long lasting and have cascading effects on the ability of human race to live a life of dignity, self-esteem and entitlements. A proper understanding of the instruments of major health hazards in a low intensity conflict is still a missing link in the existing body of relevant literature. How these instruments translate into inflicting pain (physical and psychological) on the population and how it effects the household economic decision making is the subject matter of this paper.

4. Objectives of the study

Given the rationale of the present study this paper is an attempt to explore and understandthe instruments of violence presently prevalent in Kashmir. An attempt is made to explore the level of exposure of the general public to these instruments of violence. We also attempt an understanding of the immediate fall outs of these instruments of violence on the affected. The economic implications of armed conflicts on affected families are also studied.

4.1Hypotheses

To achieve the specified objectives of the study three hypotheses have been set up. Kashmir after 2000 A.D has witnessed downturn in combat activity and open violence. However life in general has not returned to normal. The forms of violence have changed. As such

H1: With a clear downturn in open violence in Kashmir there is an upsurge in non-lethal means of violence

Violence inflicts pain. However given the tolerance levels of societies forms of violence can have varied effects on the general population. A society that has witnessed prolonged phases of armed violence may be more accommodating to violence. A society which has as otherwise been peaceful can have huge health consequence with an upsurge/outbreak in violence. It is in line with this idea that

H2: There is a large incidence of psychological disorders faced by Kashmir households.

As health deteriorates the economic vulnerability of the households increases. With increased medical bills the crucial savings and borrowings ratios of the affected households change. As such

H3: Household savings and borrowings remain unaffected due to the vagaries of armed conflict.

4.2. Methodology

In order to realize the objectives of the present study primary data and information was collected through a baseline survey conducted in four administrative zones of the district viz, north, south, east and west suburbs of the Srinagar city.Reports from Non-governmental organizations(NGOs) particularly the*"Medicine sans frontier"*(MSF) have provided the theoretical benchmarks and data of secondary nature.

A simple random sample of total of 390 households has been studied. The sample was drawnafter dividing district Srinagar into five regions purely on the basis of geographical distinction. 75,95, 80, 90, and 50 households were selected fromNorth, South, East, Western and central parts of the district. The survey was completed in June 2012 and covered year 2011- 12. The data was then condensed studied and the results have been drawn.All the responses were recorded for experiences of the households during this year. The unit of analysis in the present study is the household defined as a group of people related to each other by birth and who share the kitchen and a roof. However the information collected, is in relation to atleast one of the actual members of the household excluding relatives of and visitors to the households.

5. Results

The dynamics of war determine its instrument. The present study was carried out on the observation that, with a down turn in conflict intensity the instruments of operation at the hands of the parties at war change. As such the study of instruments of violence was included in the questionnaire. The results for hypothesis H1 are summarized in table 1. Of the 390 households surveyed 125 (32.05%) reported physical violence against at least one member of the household in 2010-11. About the types of physical violence 77 households (61.60%)reported injuries. All types of killings accounted for the rest as reported by the households.

As far as the incidence of verbal violence is concerned, 58.46% of the sampled households reported to have experienced one or the other sort of verbal violence in the recent past. Verbal threats and insults have been widely reported by the respondent households.68% of the respondent households maintained that atleast one of the members of their household has felt insulted by the armed groups in the preceding year. Varying fromfrisking by security forces, round- up –raids to proving the identity at least once a day, numerous instances and instruments of inflicting insults were revealed by the respondents. As regards the reporting of (verbal) threats is concerned, 73 (i.e. 32.03%) households reported that at least one of their family members was threatened (at least once in the last year) on account of one reason or the other. 37 (i.e. 09.49%) of the households reported that none of their family members has reported experience of violence (physical or verbal) over the last one year.

From the above analysis of the data presented in table 1, it is clear that in Kashmir there is an alarming prevalence of non-lethal means of violence apart from the lethal or physical one. This result holds for an evenly distributed sample drawn randomly and is bound to be affected by such errors as do enter any sample study. However accounting for the sample errors it has been found that the results hold to allow the acceptance of H1.

Table 1: Frequency of and Exposure to various forms of Violence

Nature of Violence	**Frequency n= 390**	**As Percentage of n = 390**
(a) Physical (beating/lathichargeetc)	**125**	**32.05**
Types of physical violence and number of household respondents reporting the same		
Type of Physical Violence	No of reporting households	%age (n=125)
Injury (Bullet)	54	43.20
Injury (Blast)	23	18.40
Killing in Cross firing	19	15.20
Killing in Blast	17	13.60
Custodial Killing	12	09.60
(b) Verbal	**228**	**58.46**
Types of Verbal violence and number of household respondents reporting the same		
Physical Violence type	No of reporting households	%age **n = 228**
Threat	73	32.01
Insult	155	67.99
(c) Neither a nor b	**Frequency n= 37**	**09.49**

Source: field survey

Of the 390 households surveyed 228 (58.46%) had reported exposure to verbalviolenceand 125 (32.05%) tophysicalviolence (table 1). Thus, for an understanding of the psychological impacts of violence on the sampled households, the effected households (353 out of 390) were inquired about their health status and that, if any of their household members had visited a hospital during the last year. *Records of hospital visits were not to be found with most of the households as such the information gathered herein is purely based on what the respondents reported*. The questions that were posed to the respondents were drafted to highlight only those health problems that

would involve only the psychological aspects of human health.On enquiry of subjective well being respondents reported anxiety (45.60%) and depression (31.73%). Thus the prevalence of psychological disorders defined in terms of experiencing anxiety, depression and panic attacks are wide spread in the present Kashmir population. Hence the acceptance of H2 is warranted.

Table 02: The Psychological Health hazards of armed conflict instruments

The Psychological effects of physical and verbal violence for n = 353 (125 + 228)		**90.51% (n=390)**
Types of health hazards reported and number of respondents reporting the same		
Type of Physical Violence	No of reporting households	%age (n=353)
Anxiety	161	45.60
Depression	112	31.73
PTSD	59	16.72
Panic Attack	21	05.96

Source: Field

Health prospects of a household are closely linked to its economic well being. With deteriorating health apart from the depletion of earning capacity there is a considerable diversion of household resources to meet the treatment expenses. Expenditure on medicines and frequent visits to the hospitals has an opportunity cost. In this study we collected th information on savings and borrowings of the affected households and proxy them for costs of violence. Since deteriorated health outcomes because of armed conflict are believed to increase the borrowings and decrease the savings for the households. Information collected on savings and borrowings from the effected households is presented in table 03.The data as presented reveals that 23.59% of the households reported an increase in their savings during 2010 when compared to 2009. This although is a stark revelation of the household behavior but a deeper analysis reveals that under uncertainties and vagaries of shutdowns, lockouts and hartals savings are a very important component of household survival. 19.74% of the households reported constant savings with cyclical fluctuations therein but with overall savings remaining more or less unaffected. Explanation of the same is provided by the low level of sustenance of these household who exhibited abject poverty. Savings for them were always at some insignificantly low level and changes therein seemed (to them) to be insignificant. However confirming the already

established literary results a majority of population i.e. 53.60% reported a significant decrease in their savings over the last one year.

As far as the household indebtedness is concerned 57.18% of the households reported to have had increased borrowings. With ensuing armed conflict, income generating opportunities become bleak. People dissave. To meet increasing medical bills in consequence of conflict related health hazards households start borrowing. This is in conformation with a number of studies that report the same phenomenon. (See Eswaran and Kotwal, 1989; Rosenzweig and Wolpin, 1993; Udry, 1994; Fafchamps, Udry and Czukas, 1998) 16.92% of the sampled households reported borrowings to have remained constant. 16.16% of the households reported that their borrowings actually decreased as a result of the conflict. This can be an indication of declining social cohesion among the conflict effected societies were lending declines because of uncertain market and social circumstances. How far this preposition is a valid one can be an interesting area of research. When read in light of the savings as reported by the sampled households, household borrowings do exhibit some degree of conformity with traditional economic prepositions. Data with respect to savings and borrowings reveal some interesting results. The households reported to have had reduced savings and increased borrowings consequent upon the deteriorating health of at least one of the family members.

Table 03 (Savings and Borrowings during Conflict)

Direction of change in savings/borrowings	Savings		Borrowings	
	Frequency (n = 390)	Percent	Frequency (n = 390)	Percent
Increased	92	23.59	223	57.18
Decreased	209	53.60	63	16.16
Constant	77	19.74	66	16.92
No information	12	03.07	38	09.74
Total	160	100.0	160	100.0

Source: Field Survey

6. Conclusion

In our survey, we worked to establish a causal relationship between the conflict and health and an attempt was made to study the savings and borrowings structure of the households..The novelty of unfolding these relationships lies in the approach taken. We looked into the various instruments resorted to in a mild conflict into which the Kashmir conflict has entered of late.

Whether verbal or physical, there is a considerable exposure of the public to both forms of violence. Conflict related deaths have been declining in the state of Jammu and Kashmir. (ChII page 6, MHA, 2011). The same has been substantiated by the present field survey. However given the fact that there was a mass uprising in 2010 in Kashmir valley which resulted in 120 killings, some of the households naturally came into the present sample and as such the number of conflict related deathsstood at 48 (12.30% for N=390)

Ranging from injuries and distress to amputation and mental rupture, the evils of conflict and the impacts thereof on psychological health go uncounted. As has been detailed in the above discussion the conflict affects health in a variety of ways. Physical and Verbal violence have huge effects upon the psychological health of the victim population. Almost all the sampled households reported one or the other form of health impairment as a result of ongoing conflict. It is evident that when insecurity through physical violence is experienced by the victim population it has a deeper impact on their minds which ultimately leads to mental health problems. No doubt the deterioration of health has taken place in all forms but psychological consequences of violence are of major concern.

7. Suggestions

Armed conflict in Kashmir is over two decades old now. There cannot be any single socio-economic or cultural unit that has remained unaffected from the vagaries of violence. At the household the impact has been more vivid. However the household health prospects over the years have deteriorated immensely. There is a high prevalence of mental health problems in Kashmir. Poor self-rated health and likelihood of poor socio-economic functioning were observed to be associated with high levels of psychological distress. Mental health problems in this context of chronic violence should receive full attention through the provision of appropriate community-based services that would improve access to care and reduce the burden on the health system. There is a dire need of awareness among the general population about mental health and the consequent hazards thereof. It was observed during the field survey that most of the respondents were not aware of the actual mental illness they suffered and its eventual fall out. Expert advices on mental issues at the community centre/ public health centre level can go a long way in the process of mental rehabilitation of the effected population.

8. Limitations of the study. The present study was carried in the urban district of Srinagar. It does not take into consideration the rural setting, as such the results drawn cannot be generalized for the state as a whole or far any inter-district comparison in relation with the selected variables. Another serious shortcoming of the study is the fact that it has been carried *ex-post* and as such variance of the conclusions drawn can be higher across time. The sample size is fairly good (n = 390) however results derived from a larger sample size can be better reliable. The variables under study may not be capturing the essence of the issues (entirely) discussed however given our understanding of the concept of health and the subjectivity related to psychological well being of individuals this was the nearest we could go.

9.* Scope *for future research. As noted elsewhere, this paper (to the best of our knowledge) is the first of attempts to study the consequences of a protracted armed conflict in Kashmir on the health prospects of an urban population with an attempt to link it to the variables like household savings and borrowings. Not much great has been accomplished herein except an opening made into the household dynamics and its interplay with exogenous factors like armed conflict and its linkage to such variables as savings and borrowings. The causal relationship between armed conflict $\rightarrow$ mental health$\rightarrow$ household welfare $\rightarrow$ armed conflict: in case of low intensity conflicts like Kashmir can be a very prosperous research area. Study of the various instruments of violence and the transition therein and the effects thereof can in itself be an independent research area. The relationship between armed conflict and psychological health of the general population and its impact(s) on the economic welfare of the households needs to be researched across time and space for generalization of the results. Higher percentage decrease in savings and a relatively lower percentage decrease in borrowings is an interesting phenomenon exhibited by the sampled households. The measurement of the determinants of the same can be an insightful research endeavor.

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