

Post-conflict crisis in health and education: The case of women and children in the Bodoland Territorial Area Districts, Assam

Rajashree Borah, Guwahati

Abstract

While assessing the vulnerability of women and children in conflict and post-conflict situations the aspects of education and health deserve serious attention. In this analysis, an attempt has been made to examine these vulnerabilities in the Bodoland Territorial Area Districts (BTAD) in Assam, India which has been conflict prone over a long period of time resulting in internal displacement of diverse communities since 1990s. The study assesses whether the post-conflict situation holds greater risks to mothers and children. Are there higher health risks for children in the aftermath of conflict? Apart from gathering conflict related data from official sources, field data were collected from the affected villages. A cross-sectional survey was conducted to examine the vulnerabilities of women and children in post-conflict BTAD. The results reveal that prolonged exposure to difficult living conditions in the study area has had significantly detrimental effects on these population sub-groups.

Keywords: Conflict; post conflict, BTAD, internal displacement; vulnerability; health, education

Introduction

This study seeks to examine the vulnerability status of women and children in conflict zones and the ways in which persistent conflicts and their aftermath affect their lives with special reference to the attributes of their physical health and education. The consequences and ramifications of the conflict situations that confront women and children can hardly be gauged by numerical casualty data or statistics. Of diverse aspects of life that a conflict can adversely affect, health and educational attributes occupy a significant place. Studies undertaken by DeJong et al., Banerjee and Chaudhury on Kashmiri women, Von and Jacob on African conflict have shown long term effects of conflict on physical and mental health, which

can get aggravated when compared with pre-conflict situation. Often, the symptoms of post-traumatic stress disorder (PTSD) persist as much as twelve years after the conflict as was the case with survivors of the Rwandan conflict of 1994 (Munyandamutsa et al., 2012). Apart from the direct effects on physical and mental health, when lives get compromised by restricted healthcare facilities, the destruction of food sources in turn compromises their nutritional security. Further, economic instability or poverty arising from loss of livelihood sources due to conflict compounds fragile and vulnerable health conditions and aggravates the risks of malnutrition induced starvation. For women, the situation is all the more precarious since

they more often are responsible for provision of food and as caregivers in their families and households. An unhealthy mother also increases the vulnerability of her children suffering from adverse health conditions since they are at heightened risk of losing parental care (Das & Dutta, 2012).

Additionally, education is an area that can be severely affected by conflict situations. Frequent displacements and continued residence in relief camps increases the likelihood of a child being deprived of her education, either partially or fully. The conversion of schools into relief camps too disrupts normal schooling. Conflict affected children are constantly on the move, and are deprived of regular schooling for an extended duration. Moreover, disruption of social networks too adversely impacts the education of a child. Consequently, in both conflict and post-conflict situations, education is no longer considered a priority. Many parents under such situation get their daughters married off at an early age bringing an end to their education. In most conflict affected areas of Africa, school dropout of girls often preceded their marriages and this was considered a seemingly viable alternative to education for girls (Petroni et al., 2017). The net result is loss of education of the children and more so among girl children as a consequence of the conflicts. Women and children from marginalised and lower socio-economic strata of the society are understandably more vulnerable vis-à-vis other groups.

This paper explores the social concerns of women and children in the context of conflict for which a conflict prone region from Assam- the Bodoland Territorial Area Districts (BTAD) situated in the north western part of Assam (Fig 1) has been selected. The

BTAD came into existence as a consequence of the Bodoland Territorial Council (BTC) Accord in 2003 and the Bodoland Territorial Region (BTR) Accord in 2020. The BTAD consists of Kokrajhar, Chirang, Baksa and Udalguri districts of Assam with a total population of 3,151,047 and covering an area of about 25,000 km² (Statistical Handbook of Assam, 2011). BTAD (more popularly known as Bodoland) became a hotbed for militants of different armed groups over the period 1990-2020. Their main demand was a separate state of Bodoland. The area witnessed a series of violent and insurgent activities over a considerably long period of time. The demand for a separate state soon turned violent and took fratricidal to ethnic and communal character. Recurrent clashes and conflicts occurred time and again (1996, 2008, 2012, 2014, and 2016) and took a heavy toll on women and children in the conflict affected areas of the Bodoland. The area witnessed violent conflict along ethno-religious lines between the 'sons of the soil' Bodo tribesmen, the Adivasis (tribal communities in Assam brought by the British from outside the state to work in the tea gardens) largely associated with tea plantation works and the immigrant Muslims (Dutta, 2020) resulting in substantial displacement from the three distinct communities who were the traditional inhabitants of the area (Vandekerckhove & Suykens, 2008; Saikia et al., 2016). The district of Kokrajhar continued to be the epicentre of most of the conflicts that took place in the area. In terms of the number of casualties and displacement also it was one of the worst affected followed by the Chirang district. Although internal displacements have been a frequent phenomenon for the people of this region, it witnessed one of its worst kind in the year 2012 and 2014. The 2012 violence

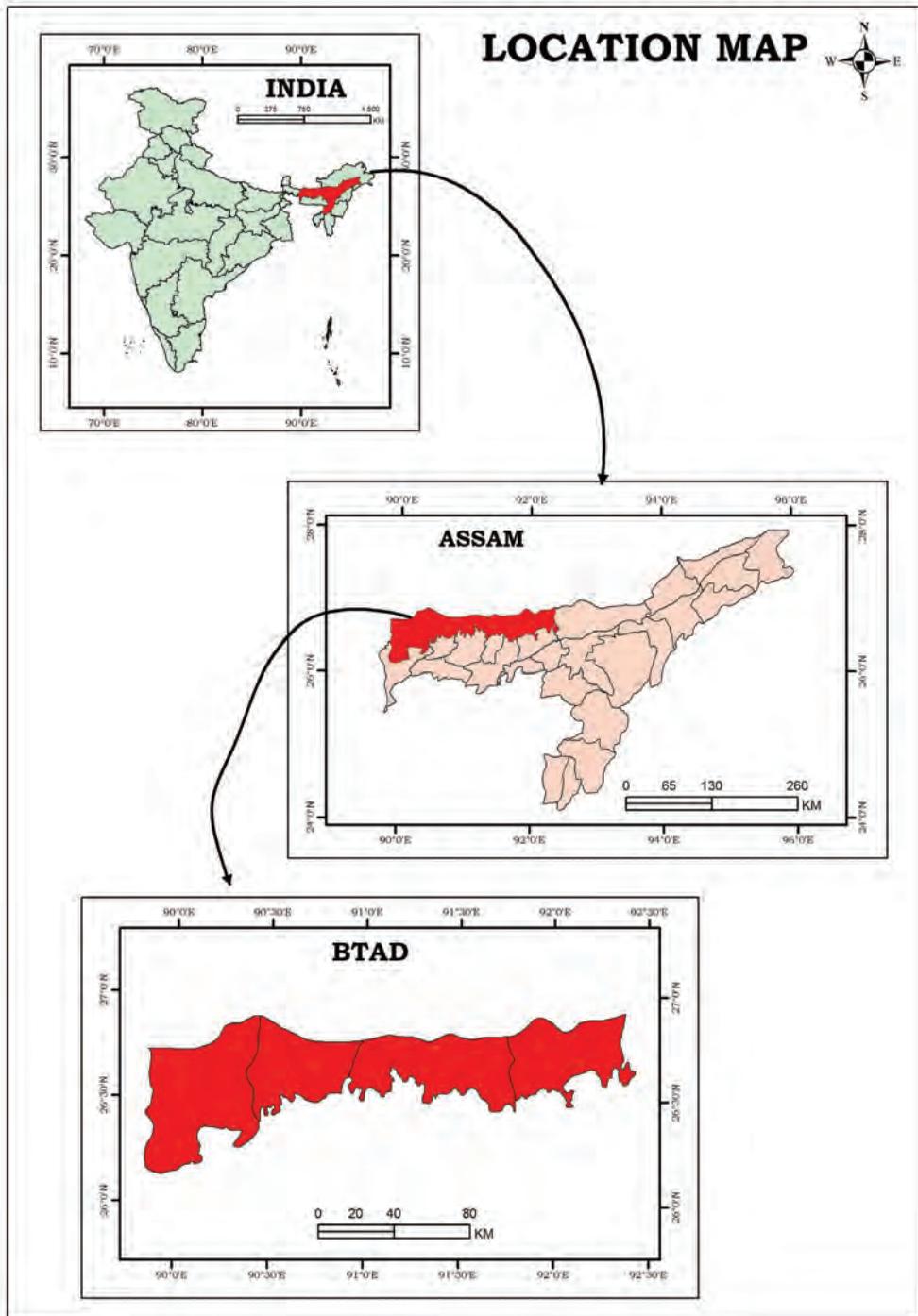


Fig. 1: Location of the Study Area

led to an estimated displacement of 2,16,382 persons from Kokrajhar district and 1,04,046 persons from Chirang District (Relief branch, DC office, Kokrajhar, Chirang, Baksa and Udalguri, 2014). The violence of 2014 led to a displacement of 2,35,385 persons from Kokrajhar District, 11,252 persons from Chirang, 498 and 468 persons from Baksa and Udalguri districts respectively (*Ibid*). A total of 15034 houses were completely burnt and 153 villages affected in Kokrajhar district alone during the year 2014 (*Ibid*).

The women and children affected by the conflict suffered major consequences. Many women had to suffer from frequent displacements with some up to four times in a short span of two decades and for long duration of nearly fifteen to twenty years. This study seeks to assess the vulnerability of the mother and the children in the post-conflict phase with a particular focus on their health and educational attributes.

Objectives

This research has the following specific objectives:

- a. Assessing the vulnerability status of mothers and children in the post-conflict BTAD
- b. To examine if there is higher probability of health risks among children in the post-conflict period
- c. Identifying the determinants influencing vulnerability of mothers in terms of education of children

Data base and methodology

For attaining the objectives, analysis and interpretation of both primary and secondary data has been undertaken. Secondary data regarding the figures of displacement, number

of households burnt has been collected from the offices of the district commissioners, relief branch, and office of the superintendent of police of the respective districts of BTAD. Field data has been collected from households during 2016-2018 with the help of pre-designed questionnaire keeping in mind the sensitivity of the topic and with most questions remaining open to their narratives. Women living in the previously identified conflict affected villages of BTAD and simultaneously who have been internally displaced due to the armed conflicts were specifically targeted for an in-depth interview. All married women, irrespective of their marital status, covering all communities and socio-economic background as well as age groups formed the core sample. This was done to ensure all groups had the equal probability of being represented in the sampling process. Relevant data pertaining to the children was collected from their mothers. The total number included in the study is 376. For estimation of this sample size the table of Krejcie and Morgan has been adopted in the current study. This table acts as an effective tool for any kind of empirical research as it enables to determine the sample size of a known population in a very simple way. Since long, this table has been used as a representative statistical sample in empirical research, and has been proved to be very reliable with minimum error for which the table was used as the base for determination of the sample size.

Impact on motherhood

Previous studies have revealed long term impacts of conflicts on maternal health. The impact on motherhood is seen with existence of psychological distress during pregnancy due to exposure to conflicts, besides suffering

Table 1: Number of Still Births and Infant Deaths in the BTAD

Years	Deaths
1991-1995	5
1996-2000	17
2001-2005	16
2006-2010	335
2011-2015	32

Source: Field Survey

from poor maternal health conditions (Khan, 2015). Exposure to conflict results in long term effects on the maternal emotional and psychological health (Khan, Chiumento, Rahman et al., 2015). This analysis seeks to assess the adverse outcomes for pregnant women while being exposed to armed conflict situations directly or being vulnerable to such unwanted circumstances. For this, some general indicators were used as parameters to support the research queries. The peak conflict incidents and displacements that occurred in 2008, 2012 and 2014 in the Bodoland were considered as the base years. For understanding the effect of conflict on pregnancy and infant deaths, the women were asked if they had experienced any cases of still birth, infant deaths in their lifetime and the year in which the incident happened.

The frequencies were calculated for a period of five decades beginning 1991 in five years interval (Table 1). The data clearly reveals much higher frequency of still births and infant deaths in years of peak conflicts, i.e. 2006 to 2010 and 2011 to 2015. This increase took place when, on the average, infant mortality rate (IMR) of Assam steeply declined by 28 percent during 1990 to 2012, at an annual rate of about 1.4 percent. In the year 2011-2012 and 2012-2013, the range of IMR was 74 per 1000 live births in Kokrajhar- one of the most affected districts of BTAD- which

was the highest among all the districts of Assam (Fig. 2). Assam's average IMR was 57 and 55 for the same years (SRS data, Human Development Report of Assam, 2016). Comparative statistics on infant mortality between countries with recent conflict and without recent conflict showed median under-5 mortality rate is 197/1000 live births and at 137/1000 live births respectively. Infant mortality was also found to be 10 percent higher during the Congolese wars of 1996-2003 compared to the pre-war period but it decreased in the post war period (2004-2010) which indicates a direct association of infant mortality with the intensity of wartime conflict (Lindskog, 2016).

Higher incidence of infant deaths indicates poor maternal health among displaced mothers. Of the 45 women who were pregnant during period of high intensity violence, 30 (66.6%) had complained of at least one health issue and 10 (22.2%) had reported 3 health issues. This specific group of women were also at a higher risk of health problem during the outbreak of chronic and contagious diseases like suffering from malaria (16.3%), diarrhoea (9.83%), typhoid (4.91%), stomach pain (14.7%), body swelling along with body pain (34.3%), jaundice (3.27%) and skin infections while living in the camps after suffering from displacement.

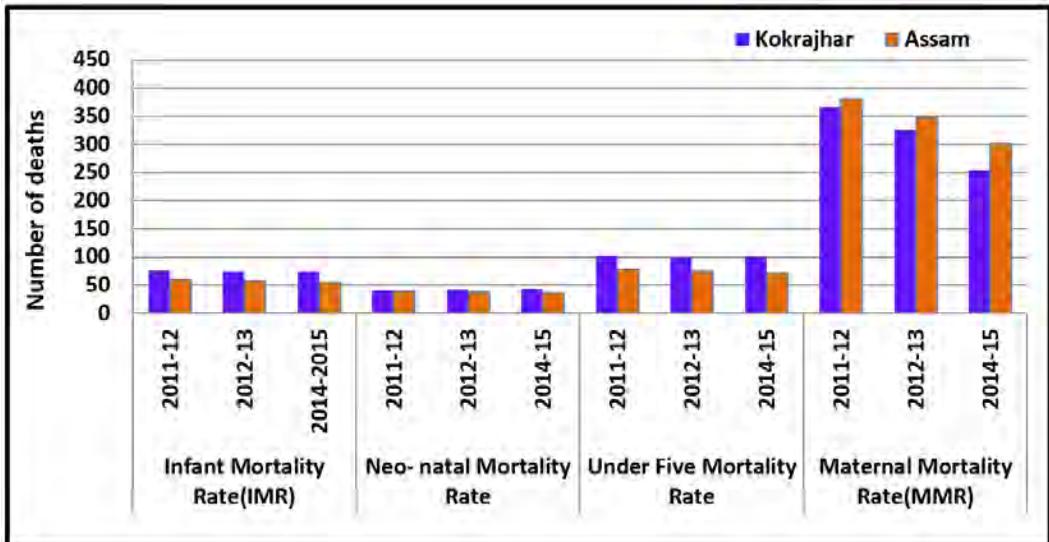


Fig. 2: Infant, neo-natal, under-five and maternal mortality rate in Kokrajhar District and Assam
 Source: Office of the Joint Director of Health Services, Kokrajhar District, 2014

Evidence of long-term effects on the physical and cognitive development of the child has also been linked with poor maternal mental health (Khan et al., 2015). Data relating to maternal mortality in the conflict affected Democratic Republic of Congo showed that the figures doubled during conflicts (Hare & Southall, 2007).

Impacts on children

Effect on the physical health of children in the post-conflict situation

It is important to determine the long-term effects of conflict on children living in areas exposed to violence. The intensity of the adverse effects on children exposed to conflict situations is far more on a child than his peers in the context of the level of parental care and emotional support to the child's needs.

For an assessment of the physical health conditions of children, all the children of the women who had been interviewed were taken into account.

In the study area, general weakness, fatigue, stunted growth and malnutrition was observed among the children. This can easily be attributed to the disruption in the livelihood status in most households including but not limited to growing household food insecurities in the aftermath of the conflict. This in turn has affected the nutritional levels in the children affecting their growth and general health.

Occurrence of diseases in the post-conflict period revealed that, as compared to the adults, the probability was higher among children who were more prone to illness than in the pre-conflict stage. About 46.01 percent (N=173) of the children were found to be suffering from at least one health problem. About 45 percent of the children that were born in the relief camps were seen to be suffering from disabilities.

Children in the age group of two to ten years were at a considerably higher risk of being infected with diseases in the aftermath



Fig. 3: Diseases across age groups in the post-conflict stage in the BTAD
 Source: Field survey, 2016-2018

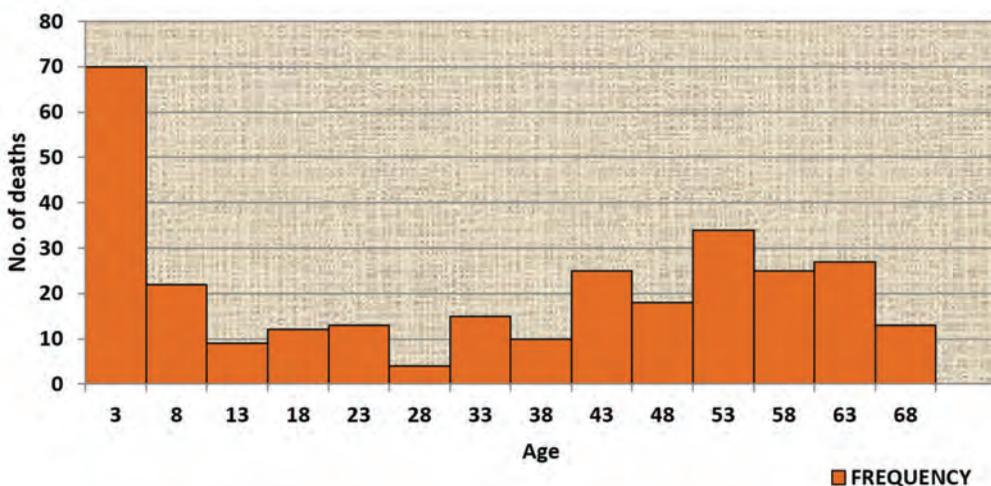


Fig. 4: Deaths across age groups in the BTAD
 Source: Field survey, 2016-2018

followed by the age group of eleven to fifteen years (Fig. 3). This implies that the children up to 13 years were more affected by the incidence of diseases. In post-conflict stage, even the most common form of symptom can get aggravated leading to complexities due to the absence of adequate healthcare

facilities or owing to unstable conditions and attention of their parents. Also, if we look at the nature of health problems amongst conflict affected children, it deviates from those that usually affects children generally under normal circumstances, which is usually communicable.

Table 2: Health symptoms in children in the BTAD

Health symptom	count	percent	Health symptom	count	percent
Weakness/anaemic	74	14.04	Headache	9	1.70
Stunted growth	42	7.96	Skin infection	15	2.84
Stomach ache	22	4.17	Body pain	13	2.46
Mental disorder/disability	16	3.03	Chest pain	7	1.32
Weak appetite	53	10.05	unknown illness	67	12.71

Source: Field survey, 2016-2018

Frequently cited health problems suffered by the affected children showed prevalence of health problems like body ache, stomach ache, loss of appetite, feeling of weakness, headache and mental issues (Table 2). Deterioration of child nutritional status and living conditions of households was seen affecting the nutritional standards of children wherein 14.04 percent children were found to be malnourished. While, stunted growth as compared to their age, were found in 7.9 percent children, suffering from an unknown illness. Children who were reportedly always sick and in bed with no medical treatment were found in 12.7 percent children. Injuries from conflict too often affected the health of the children in some cases causing disability for life. An estimated 3 percent were found to be critically injured during the period of escalated conflict causing permanent disability.

Many mothers reportedly did not visit the health centres due to poor medical outcomes and limited success accruing from medical interventions and treatment. Further, health centres were relatively few in number and were largely understaffed. As such, in most interior villages the occasionally conducted health camps were the only option of receiving reliable medical attention. This greatly compromised key public health functioning like vaccination, immunization

programmes etc.

For identifying the age group at a higher risk of deaths under varied circumstances an analysis was done based on the frequencies of death in different age groups by including the number of deaths in each family and age at the time of death (Fig. 4).

Considerably higher risks to deaths from diseases was found in the age group between one to 5 years (23.5%) followed by the age group of 6 to 11 years (7.4%) making them the most vulnerable group both during and in the aftermath of the conflicts. The state average of deaths by broad age groups however shows that the children between 1 to 4 years of age constituted only 1.1 percent out of total deaths, while children between 5-14 years accounted for 2.9 percent of the total deaths across broad age classes. (Census data, SRS report, 2017). While the state average death count across age groups shows an increasing trend, in higher age cohorts, the situation is somewhat reversed in conflict situation where deaths in the lower age cohort was more.

Vulnerability assessment

A child can be considered vulnerable if he or she is in a weak condition than his peers. A vulnerable child can face a high risk of falling into adverse situations particularly harmful for their well-being due to their exposure to

unfavourable environment (like conflicts). The factors that increase a child's exposure to risks constitute the vulnerability factors. Nevertheless, outcomes of the vulnerability can vary from child to child depending on the vulnerability of the parents.

An analysis was undertaken to determine the determinants of the vulnerabilities affecting a child's health conditions or born to such mothers. For this purpose, the vulnerable groups were categorised into two groups. Category I included children who have lost their fathers to a conflict or of a widowed mother and children who have lost a sibling. Such experiences are highly traumatic to say the least and can lead to complications in a child's life making them particularly sensitive. Data collected from the field revealed that 33 of the 39 children who have lost a sibling or father did develop chronic health issue. 173 children of widowed mothers were found to have at least one health issue. To assess the group of children with a higher death risks, the analysis was based on the marital status of the women. About a fourth of all the widowed mothers lost at least one girl child due to death and at least 5 percent such mothers lost two girl children. Lesser proportion (10.1%) of married women whose husbands were alive suffered death of one girl child, while 2.7 percent such mothers lost two girls to death. Likewise, widowed mothers (17.5%) also experienced higher deaths of their sons compared to their non-widowed counterparts (i.e. 11.6%). This fact clearly reveals greater vulnerability of the widowed mothers and their children as also those families which have experienced death of the male member of the family or kin.

Category II includes families based on the frequency of displacement of their

mothers during the child's lifetime. An analysis was done to find out if there are any association between displacement and health of the children including higher risk of death in the post-conflict period (Table 3).

Significantly, table 3 revealed that the frequency of displacement due to conflict was largely uncorrelated with deaths of children. Chi-square value on 376 participants was found to be 2.88 and 7.36 for sons and daughters respectively, with exact probability value of .841 and .207 for sons and daughters respectively. The Fishers exact p scores of .841 and .207 specify that the two categorical variables- number of deaths and displacement rate- are independent of each other. No significant association existed between the number of deaths of children (for both son and daughter) a mother had experienced, based on the number of times she had undergone displacement. In other words, children displaced frequently do not have higher risk of deaths under various circumstances when compared to the ones who have been displaced less frequently.

Access to education

An analysis has also been done to examine the vulnerability determinants affecting a child's access to education.

The highest educational attainment reported was up to graduation level, with only 5.7 percent boys and 2.47 percent girls reaching that level (Table 4). Up to middle school, the rate of school goers was more among the girls but tapered significantly with higher level of schooling. The decline in educational attainment of girls at higher levels of schooling is often linked to parents getting their daughters married off to ensure their safety and security.

Table 3: Association between displacement of the mothers' and death of her children in the BTAD

	Deaths	Frequency of Displacement During Conflicts					Total
		No	Once	Twice	Thrice	> thrice	
Son	0	1(0.3%)	183(59.4%)	58(18.8%)	4(1.3%)	62(20.1%)	308(100%)
	1	0(0%)	40(59.7%)	16(23.9%)	0(0%)	11(16.4%)	67(100%)
	2	0(0%)	1(100%)	0(0%)	0(0%)	0(0%)	1(100%)
	Total	1(0.3%)	224(59.6%)	74(19.7%)	4(1.1%)	73(19.4%)	376(100%)
Chi Sq (8,376) = 2.88, $p = 0.942$, Exact $p = 0.841$							
Daughter	0	1(0.3%)	181(57.8%)	65(20.8%)	3(1%)	63(20.1%)	313(100%)
	1	0(0%)	42(71.2%)	7(11.9%)	1(1.7%)	9(15.3%)	59(100%)
	2	0(0%)	1(25%)	2(50%)	0(0%)	1(25%)	4(100%)
	Total	1(0.3%)	224(59.6%)	74(19.7%)	4(1.1%)	73(19.4%)	376(100%)
Chi Sq (8,376) = 7.36, $p = 0.499$, Exact $p = 0.207$							

Source: Field survey

Table 4: Educational status of the children in the BTAD

Educational Status	Boy		Girl	
	count	percent	count	percent
Primary	115	41.07%	138	48.7%
Middle school	61	21.78%	69	24.3%
High school	64	22.85%	52	18.37%
10th pass	14	5.0%	12	4.24%
12th pass	10	3.57%	5	1.76%
Graduate	16	5.70%	7	2.47%

Source: Field survey

The indirect effect that the conflict has produced can be estimated by higher proportion of children dropping out of school due to the conflicts and related displacements as a consequence of the conflict. An estimated 48.2 percent boys and 46.19 percent girls dropped out of school bringing the total average dropout rate of children to 47.2 percent. This is certainly much higher compared to the state average which is only 7.61 percent (average calculated from 2011 to 2018). The school dropouts were particularly significant during the transition

from primary to middle schooling stage. The extraordinarily high dropout recorded in conflict prone areas in the Bodoland can easily be linked to displacements, low level of parental education, poverty, under nutrition in children, poor mental and physical health.

In order to identify women who had a higher risk of putting their children in vulnerable conditions an analysis was done based on three characteristics of the mothers namely their marital status, educational status

and displacement pattern. School drop outs rates were considerably higher among the children of mothers who were displaced for a longer duration in the relief camps. Children of mothers displaced three to four times had a higher incidence of school dropout than those displaced fewer times. During conflicts, children in any case had no access to schools with the latter being converted to relief camps and hence remaining non-functional. While most schools reopened once the internally displaced persons (IDPs) returned, going to schools no longer remained the first priority and often became the least of the priority. The loss of livelihood sources forced many to leave school due to growing poverty and the compulsion to earn for the family. Financial hardship compelled the boys to seek work resulting in higher dropout rates among the boys compared to the girls.

Marital status was significantly associated with school dropout in boys, where chi-square value on 376 participants was 12.72 with probability value less than 0.001 for boys [$X^2(1,376) = 12.72, p < 0.001$]. The same was true in the case of girls, where chi-square value was 18.19 with probability value less than 0.001 [$X^2(1,376) = 18.19, p < 0.001$]. In other words, children of widowed mothers had a higher incidence of dropping out of school compared to the married ones (Table 5). Probability (Marital status=widow) is different across dropouts in boys as well as girls which signifies that the cases of children being out of school differ significantly among the widowed mothers compared to that of the married.

Fisher's exact test was used to determine if there was any association between maternal educational levels with those of children's education.

The results were highly significant. Maternal educational level was found to be significantly associated with school dropout in boys, chi-square value for one df based on 376 participants was 31.21 with probability value less than .001 for boys [$X^2(1,376) = 31.21, p < 0.001$]. The same was true in case of the girls as well, where chi-square value was 38.44 with probability value less than 0.001 [$X^2(1,376) = 38.44, p < 0.001$]. This indicates higher probability of school dropout of children in case of children born to illiterate mothers as compared to educated ones (Table 6). Literate mothers often sought to ensure the continuity of their children's studies so as to secure their future. Such attempts were not institutional, rather limited to individual families. For societies under the transitional period from conflict to post conflict, the future towards building a safer society, highly dependent on the level of parental education as much as also is greatly affected by the children's educational status. Identification of the specific groups of vulnerable children, thereby, can help the authorities concerned to target them on a priority basis while implementing any rehabilitation measures.

In most cases however, fear played a determining role which inhibited parents from sending their children to the school.

Conclusion

Health status of children and risks of death in post-conflict BTAD increased significantly compared to adults. Frequency and range of health issues confronted children in the post-conflict period in BTAD. Children in the age group of two to ten experienced considerably higher risks of being afflicted with diseases in the aftermath of the conflict.

An assessment on the association between displacement of mothers and its effects with

Table 5: Marital Status of the Mother and School Dropout of Children in the BTAD

School Dropout	Marital Status		Total	Test of Significance
	Married	Widow		
Boys				
No	222(66.27%)	15(37.50%)	237	$\chi^2(1,376) = 12.72, p < 0.001$
Yes	113(33.73%)	25(62.50%)	138	
Total	335	40	375	
Girls				
No	231(68.96%)	14(35.00%)	245	$\chi^2(1,376) = 18.19, p < 0.001$
Yes	104(31.04%)	26(65.00%)	130	
Total	335	40	375	

Source: Field survey

Table 6: Association between maternal education level and school dropout in BTAD

Gender	Maternal Education Level		Total	Test of Significance
	Illiterate	Literate		
Boys				
School Dropout =No	107(50.95%)	131(78.92%)	238	$\chi^2(1,376) = 31.21, p < 0.001$
School Dropout =Yes	103(49.05%)	35(21.08%)	138	
Total	210	166	376	
Fisher's Exact Test 2-Tail <.0001, Prob (Education=Literate) is different across Dropout				
Girls				
School Dropout =No	109(51.90%)	137(82.53%)	246	$\chi^2(1,376) = 38.44, p < 0.001$
School Dropout =Yes	101(48.10%)	29(17.47%)	130	
Total	210	166	376	
2-Tail <.0001 Prob (Education=Literate) is different across Dropout				

Source: Field survey

health outcomes in children or to risks of death in post-conflict periods did not reveal statistically significant results. Thus, it would appear that under various circumstances, both frequently displaced groups of women and children were equally vulnerable to the risks of death or adverse health outcomes. Orphaned or children who had lost siblings were generally more vulnerable than those who had not been orphaned or those who lost their father or any siblings. Pregnant

or women who had given birth in conflict situations or immediately thereafter also experienced far greater adversities.

Among factors that affected a child's access to education; the duration, the mother's residence in relief camps and the frequency of displacements during the conflict/post-conflict situation were significant determinants. Mothers displaced for longer duration in relief camps tended

to increase the risk of children remaining out of school. Further, children of mothers displaced more than three times risked being school dropouts. Predictably, these risks were lower for children of mothers displaced fewer times. Further, children born to illiterate mothers tended to be more likely to be illiterate compared to children of educated mothers.

Post-conflict and post-displacement period tended to enhance vulnerability and uncertainty in the lives of mothers and children. Confronting conditions of uncertainty was detrimental to their overall well-being. It is imperative to address the problems faced by the women and children, particularly the widowed and women with young children who have spent years in the relief camps suffering the conflicts.

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Rajashree Borah

House no. 52, Shreenagar,
RGB Road, Bylane-03
Guwahati-781005, Assam

E-mail: rajashree.borah@gmail.com