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Briefing note

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Unseen and unrecorded: The impact of conflict and forced displacement on access to healthcare for women and children in Manipur

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Since May 2023, Manipur – a northeastern Indian state bordering Myanmar – has experienced a deepening humanitarian crisis prompted by ethnic conflict between its Meitei and Kuki-Zomi communities. The resultant violence has led to the displacement of over 67,000 individuals, many of whom now reside in internally displaced person (IDP) camps with severely limited access to healthcare.[1]

The ongoing conflict has triggered significant policy shifts, with far-reaching humanitarian impacts. The abrogation of the Free Movement Regime and sanctioning of border fencing along the entire Indo–Myanmar border – despite the conflict being localised to Manipur – have disrupted cross-border humanitarian access, particularly affecting Myanmar's Chin State and Sagaing region.[2]

Domestically, the conflict has severely restricted mobility between the Meitei-dominated valley and the Kuki-Zomi-inhabited hill districts, limiting the transportation of goods and movement of people.[3] Since July 2023, the Kuki-Zomi-dominated districts of Churachandpur, Kangpokpi, and Tengnoupal have experienced critical shortages of medicine and supplies.[4] More generally, domestic and cross-border humanitarian responses are being shaped by the militarisation of buffer zones and tightening of international borders. This context has urgent implications for health access and regional stability.

Despite extensive research on the multidimensional nature of the conflict in Manipur and its attendant peace processes,[5] there remains a gap in understanding concerning conflict as a determinant of

1 Internal Displacement Monitoring Centre (IDMC), '2024 Global Report on Displacement', 14 May 2024.

2 L. Vualzong. "Ethnic Tribes caught in the crossfire as free movement regime with Myanmar nears end", *The Wire*, 17 January 2025.

3 V. Singh, "One killed, several injured as government tries to impose free movement on highways in Manipur", *The Hindu,* 8 March 2025.

4 T. Barnagarwala, "HIV patients in Manipur hills at risk as medicine supplies disrupted", Scroll.in, 25 August 2025.

5 O. J. Singh, "Armed violence and human rights in Manipur", *World Affairs: The Journal of International Issues* 16/3 (2012). See also: T. Haokip, "Essays on the Kuki–Naga conflict: A review", *Strategic Analysis* 37/2 (2013).

health, especially in the hill districts.[6] The current crisis has disproportionately affected women and children, exposing them to heightened risks of malnutrition; mental health challenges; inadequate water, sanitation, and hygiene (WASH) infrastructure; and outbreaks of communicable diseases.[7]

Key health indicators reveal stark disparities between Manipur's valley and hill districts, most notably in the hill districts of Chandel, Churachandpur, and Ukhrul, on the border with Myanmar.[8] Historically, healthcare provision served as a fragile but vital source of social cohesion, with medical ethics enabling trust across ethnic divides even during unrest. The current conflict has disrupted these networks, denying communities access to specialist care – which is largely concentrated in the valley – and deepening health inequities.

Against the above backdrop, this policy brief examines the barriers to healthcare access faced by IDP populations in Manipur, with a particular focus on women and children. Building on this, it offers a set of policy recommendations aimed at strengthening healthcare infrastructure, improving service delivery, and supporting long-term recovery.

Methodology

Primary data collection for this research was conducted between May 2024 and March 2025 in IDP camps located in Churachandpur district. This district was at the epicentre of the initial outbreak of violence, with a significant portion of IDPs fleeing more rural areas for the main urban centre in the district, Churachandpur town.

The research team was composed of multidisciplinary women researchers (from such fields as public health, social work, education, and peace and conflict studies), supported by local volunteers and community workers. Localisation of the research methodology was informed by NEST-Lamka, the lead partner institution in Churachandpur, drawing on its decade-long, community-owned model for studying suicide.[9] This, along with prior studies in Bodoland (Assam), shaped the qualitative approach,[10] which was further refined through participatory workshops conducted on site.

Researchers documented broader shifts in healthcare access and supply chains through analysis of secondary sources, including journal articles, local media reports, and institutional publications. Fourteen key informant interviews were conducted with government and private healthcare providers, non-governmental organisation (NGO) representatives, frontline health workers, and traditional/spiritual healers. Insights were also collected from secondary sources, such as hospital admission records, displacement data, and survey data from humanitarian service providers. Forty-five in-depth, semi-structured qualitative interviews were conducted with women (primarily mothers and caregivers). Additionally, five focus group discussions (FGDs) involving a total of 70 participants were organised to explore IDP camp living conditions, livelihood challenges, and mobility patterns. Supplementary data was collected from small talks (four participants), group interviews (five participants), and extended field observations. Altogether, the study reviewed 13 camp settings.

Findings

Access to maternal health services

The escalation of violence in Manipur has led to widespread trauma, particularly among women and children. Displacement has occurred in unpredictable waves, with many people forced to flee without warning. Moreover, the timing of these waves has varied between regions.

The ongoing conflict has disrupted access to essential healthcare, forcing displaced populations to rely on alternative sources of support. Prior to the conflict, valley districts such as Imphal were key healthcare hubs, especially for emergency and maternal care. With access now cut off, displaced populations turned to alternative healthcare providers, including traditional healers and birth attendants. IDPs told researchers that traditional birth attendants (TBAs) played a significant role in limiting

6 V. Yumnam and R. Dasgupta, "Conceptual issues of conflict as a social determinant of health: Explorations from Manipur", in: D. Nambiar and A. Muralidharan (eds), *The Social Determinants of Health in India,* Singapore: Springer, 2017.

7 D. C. Sharma, "Ethnic conflict hampering health services in Manipur, India", *The Lancet* 402/10396 (2023).

8 National Family Health Survey (NFHS-5)- 2019-20. NFHS-5 District Factsheets. Dataset available at the National Family Health Survey.

9 NEST, "Lamka Suicide Survey 2014–2025", [unpublished].

10 S. Sinha and J. Liang, *Health Inequities in Conflict-affected Areas: Armed Violence, Survival and Post-Conflict Recovery in the Indo-Bhutan Borderlands*, Singapore: Springer Nature, 2021.

maternal mortality, especially prior to and during the initial days of the conflict, when thousands of people had to flee through densely forested tracts.[11] Having relocated to Churachandpur, however, women are opting for institutional deliveries at government hospitals, with TBA-attended home deliveries now considered impractical in the context of over-crowded relief camps.

Limited access to healthcare entitlements has deepened the vulnerability of displaced populations, particularly pregnant women. Bottlenecks in access to entitlements – such as the Chief Minister Hakselgi Tengbang (CMHT) scheme, which provides free treatment for disadvantaged families – have compounded these challenges.[12] Of the 91 births recorded in our archive, only four (4.3%) were covered by the central government's Janani Suraksha Yojana scheme, which provides cash assistance for institutional delivery.[13] Out-of-pocket costs for safe delivery and emergency C-sections were among the foremost concerns among the displaced pregnant women we met.

The normalisation of pregnancy loss among IDPs reflects the severity of the situation. Among interview respondents who were mothers, 28% had reportedly suffered at least one loss of pregnancy (whether a miscarriage, recurrent miscarriage, or stillbirth). The women affected often had not sought healthcare after pregnancy loss, as it was considered a common occurrence and not a significant concern. Other women reported carrying out intentional abortions, attributed specifically to relief camp conditions.

Water, Sanitation, and Hygiene (WASH) in IDP camps

The IDP (or 'relief') camps – set up in schools, government buildings, and community spaces – are overcrowded and lack basic infrastructure. Children are particularly affected due to the absence of safe, child-friendly areas for learning and play. Water scarcity is a major issue: camps in Churachandpur town rely on limited government supply, while camps on the outskirts depend on unsafe stream and rainwater. Many residents are forced to buy drinking water at high costs.

Sanitation is critically inadequate. Most camps use pit latrines, which deteriorate quickly due to overuse and rain. Most lack proper sanitation, or separate toilets for men and women, compromising privacy and hygiene. In the camps studied for this research, the toilet-to-population ratio was 33:1, far short of the Sphere Minimum Standard of 20:1.[14]

Access to humanitarian aid

The research showed that the delivery of aid could perpetuate existing inequalities. Research participants identified two distinct groups: families who lost everything due to looting or arson and are fully dependent on aid, and families with some remaining resources – such as savings or homes in unsafe zones – who rely less on external support. This uneven starting point has led to calls for equity rather than equality in aid distribution, as treating all IDPs the same risks reinforcing existing inequalities.

Participants also noted that the most vulnerable often remain silent due to low self-esteem and guilt. The elderly are especially vulnerable, as they face pressure to rebuild despite their age, losses, and lack of access to medicine and support. Thus, uniform aid distribution risks ineffective rehabilitation and exacerbating disparities.

Health vulnerabilities of IDP children

Medico-legal data offers a revealing lens into how conflict-related violence directly impacts maternal and child health outcomes. Data from 2022–2024 reveals a correlation between spikes in medico-legal cases (MLCs) – which often document injuries or deaths resulting from violence – and increases in neonatal emergencies and antenatal care (ANC) registrations (Figure 1, next page). It shows that periods of heightened violence – such as May 2023 – are followed by surges in maternal and child health needs, with neonatal and child mortality rates reflecting the compounded pressures of conflict, disrupted healthcare, and fragile infrastructure (see Figure 2, next page).

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11 Garces et al. point out that although TBAs, "generally have no formal training and are not recognized as medical practitioners, TBAs enjoy a high societal standing and many families seek them as health care providers". A. Garces et al., "Traditional birth attendants and birth outcomes in low-middle income countries: A review", *Seminars in Perinatology* 43/5 (2019).

12 See the Government of Manipur Chief Minster's Dashboard. The CMHT Health Insurance Scheme is supposed to provide cashless treatment at empanelled institutions (both public and private service providers) with cover up to INR 500,000 per eligible family.

13 Compiled from interview archives.

14 IOM, 'Standards of assistance and minimum requirements', https://migrantcentres.iom.int/en/toolkit/management-migrant-centres/standards-assistance-and-minimum-requirements, accessed 22 October 2025.

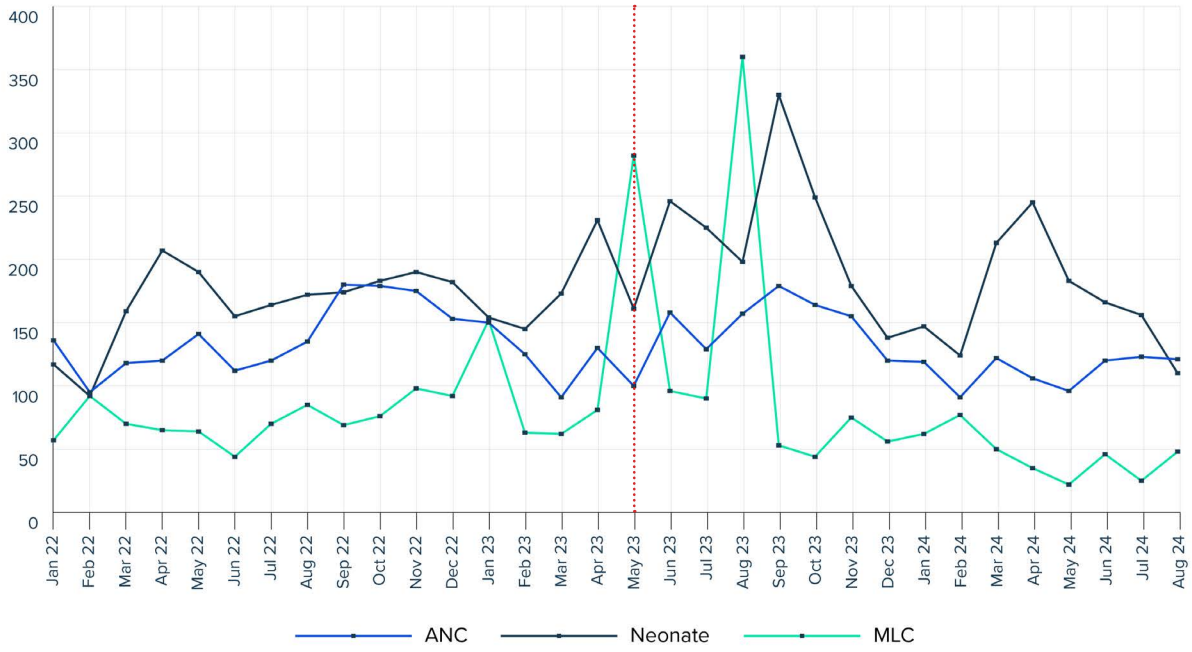

Figure 1. Comparison of neonatal emergencies, antenatal care (ANC) registrations and medico-legal cases (MLCs) in a health institution from 2022 to mid-2024, based on data collected by the research team. The dotted red line shows when conflict broke out.

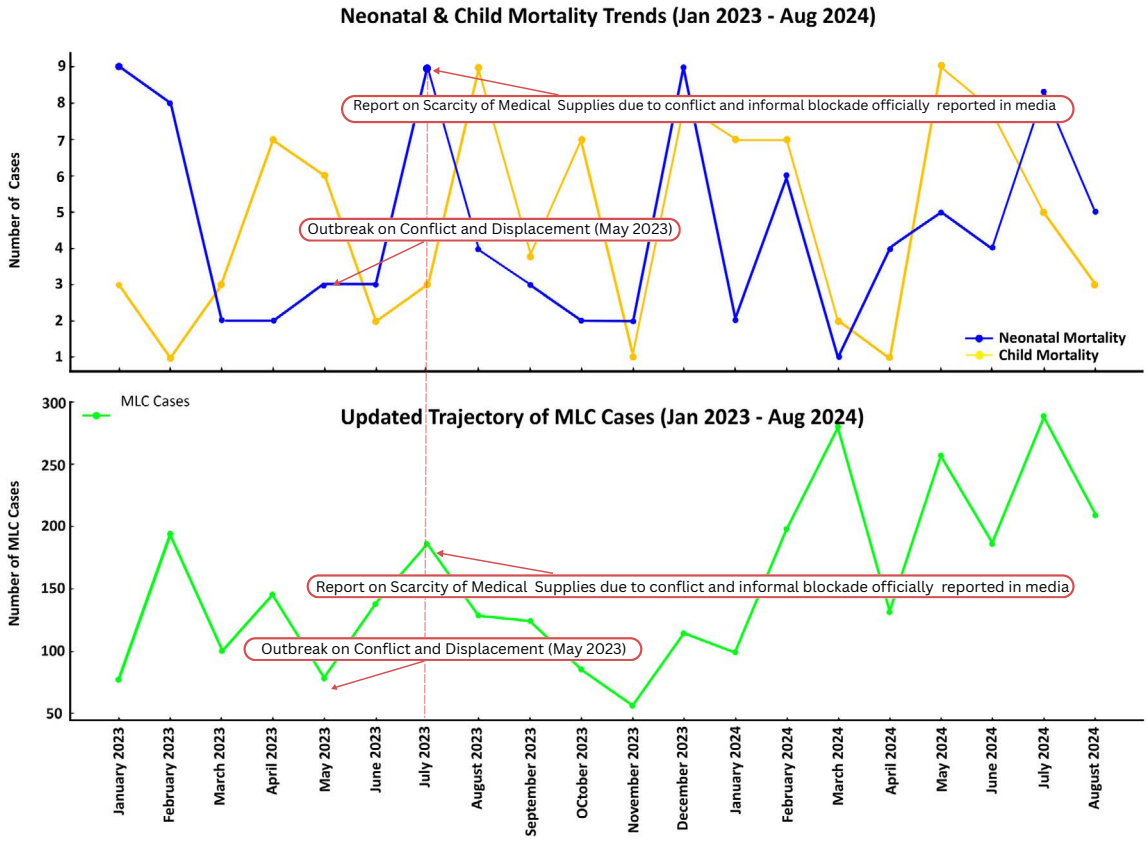

Figure 2. Comparison of number of cases of neonatal mortality and child mortality in Churachandpur since the outbreak of conflict in May 2023. The graph is the researchers' own, based on data collected by the research team.

Children's immunisation coverage and access to healthcare have been significantly disrupted, compounded by transportation challenges and socio-cultural barriers.[15] Among 104 children surveyed, 14 had discontinued immunisation during the crisis. Encouragingly, some displaced children are now regaining access to immunisation within camp settings, largely due to the efforts of Accredited Social Health Activists (community health workers), who have worked to maintain coverage despite periodic vaccine shortages. These shortages stem from various actors preventing medical supplies from reaching the camps, and surging demand due to displacement – factors not accounted for in existing procurement systems.[16] Additionally, the displacement of specialist doctors, particularly Meitei professionals from Churachandpur, have further weakened paediatric care.

Human resource strain in healthcare sector

The conflict in Manipur has strained health systems. Many doctors, nurses, and community health workers hailed from the Meitei community and have now left the region due to the violence. The resultant personnel shortages on both sides of the buffer zone have severely disrupted service delivery, especially in Churachandpur, where the absence of specialised doctors (e.g. cardiologists, paediatricians, neurologists, and oncologists) is keenly felt. Duty rosters have had to be extended in response, often requiring nurses to work up to 12-hour shifts, leading to burnout and frustration.[17] In one healthcare institution studied by the team, there were 28 nursing staff working; whereas there had been 38 before the conflict.

Informal health networks

A number of informal and alternative medical practices intersect with – and sometimes operate independently from – Manipur's formal healthcare systems. Here, our research identified three distinct strands of medical practice (private diagnostic services; spiritual healing; and traditional medicine) that form part of a broader, pluralistic health network.[18] These practices have often filled critical gaps in healthcare access, both before and after the onset of conflict.

Local humanitarian responses and long-term impacts on IDPs

For the most part, the humanitarian response in Manipur has been driven by a diverse set of local actors, encompassing the district administration, NGOs, student bodies, women's associations, churches, and community groups.[19] These actors have been at the forefront of addressing immediate needs, including constructing makeshift toilets for women and girls; facilitating self-sustenance through training programmes; and enabling market access.[20] The scale of need far exceeds available resources, however, leaving many gaps in service delivery.

IDP communities remain at risk of nutritional deficiencies, adverse educational outcomes, and psychosocial traumas. For instance, analysis of school enrolment trends in Imphal-East district for the academic years 2022-23 and 2023-24 reveals declining student numbers in certain schools,[21] while Churachandpur district saw a substantial 18% drop in enrolment.[22] A 2024 study conducted in IDP camps in Imphal-East district found that more than half (66%) the respondents suffered from post-traumatic stress disorder (PTSD). Moreover, a quarter of respondents were experiencing moderate anxiety, and 15% severe anxiety.[23] In the case of Churachandpur town, the NEST Suicide Survey estimated there had been a 20% rise in suicides between 2023 and

15 World Health Organization, "Reaching the unreached in Manipur", 24 May 2023.

16 Key informant interview.

17 Key informant interview, Churachandpur, 20 September 2024.

18 S. Cant, "Medical pluralism, mainstream marginality or subaltern therapeutics? Globalization and the integration of 'Asian' medicines and biomedicine in the UK", *Society and Culture in South Asia* 6/1 (2020).

19 Sphere India, "Situation Report -10 Manipur Violence", 11 August 2023.

20 M. Neihsial. "NGOs organise "Hope Market" in Manipur for Internally Displaced Persons to revive livelihood", The Borderlens, 28 December 2023.

21 The Frontier Manipur, 'EXCLUSIVE: Student enrollment sees unprecedented decline in Imphal East District for 2023-24 session', 28 July 2024.

22 Data provided by key informant interview.

23 B. Rajkumari et al., "Psychological effects of Manipur violence among the internally displaced persons residing in relief camps across Imphal valley of Manipur: A cross-sectional study", *Journal of Family Medicine and Primary Care* 13/10 (2024).

2024, with three of the individuals identified as IDPs affected by the ongoing conflict.[24]

Policy recommendations

The following recommendations aim to address the urgent humanitarian and development needs arising from the ongoing displacement crisis in Manipur. They focus on strengthening the delivery of essential services, improving access to government support for internally displaced persons (IDPs), and enhancing coordination across aid efforts. Together, these measures seek to promote equity, restore dignity, and lay the groundwork for long-term recovery and resilience.

Delivery of humanitarian services

These recommendations are primarily targeted at the district level and intended for government officials and NGOs delivering relief across those districts hosting IDPs.

- Prioritise timely, equitable access to medical care, particularly in remote and under-served camps, through the delivery of mobile medical teams, telemedicine platforms, and increased emergency transport capacity.
- Support reproductive health through regular specialist visits, access to safe contraceptives, and menstrual hygiene support, coupled with strengthened coordination among community health actors and strategic partnerships with national health institutions.
- Integrate mental health and psychosocial support across all interventions, fostering community resilience through a combination of external expertise and local capacities.
- Urgently scale up nutrition and WASH services, including expanded food baskets and improved sanitation infrastructure.w
- Provide children and youth with child-friendly spaces, bridge education programmes, and targeted scholarships.
- Give displaced youth access to vocational and technical training, empowering them to contribute to long-term recovery and self-reliance.

Access to government services and development of special schemes for IDPs

These recommendations focus on state-level government schemes and policies, outlining measures that require coordinated action across departments to ensure inclusive support for IDPs.

- Direct substantive emergency funding toward district health systems serving IDPs in order to support the procurement of essential medicines and vaccines, as well as the scaling of human resources, particularly nursing staff.
- Establish an institutionalised declaration system (e.g. a government-issued IDP card) to facilitate expedited, subsidised health treatment across public and select private hospitals nationwide.
- Adapt existing schemes (e.g. CMHT) to facilitate the inclusion of IDPs, including rectifying current implementation bottlenecks and extending inclusion to persons with disabilities through targeted welfare drives and expansion of disability programmes, such as the Unique Disability ID programme.
- Make monthly unconditional humanitarian cash transfers available to vulnerable groups, including mothers, pregnant women, girls, the elderly, and persons with disabilities.[25]
- Establish special compensation schemes for families who have lost loved ones due to a lack of access to treatment, and expand central assistance programmes (e.g. Project Assist) for victims of violence and orphaned children.[26]
- Promote community engagement and coordination when implementing development-linked initiatives such as the Civic Action Programme and Border Area Development Programme, thereby ensuring interventions are locally responsive and inclusive.[27]

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24 NEST, “Lamka Suicide Survey Report 2014–2025”, pp.3-4.

25 See Cash Learning Partnership (CALP) Network website. See also: S. Kurdi, “The nutritional benefits of cash transfers in humanitarian crises: Evidence from Yemen”, *World Development* 148 (2021).

26 Ministry of Home Affairs (MHA), “National Foundation for Communal Harmony (NFCH)”, undated.

27 N. Manoharan et al., “Secure through development: Evaluation Of India’s Border Area Development Programme”, *Strategic Analysis* 44/ 1 (2019). See also: Ministry of Home Affairs, “Civic Action Programme in the Northeastern States”, 2025.

Aid coordination

These recommendations focus on mainstreaming health into humanitarian response and peacebuilding efforts, recognising that sustainable recovery depends on addressing both immediate medical needs and long-term community resilience.

- Establish cooperative agreements and neutral mediation to facilitate the safe, periodic movement of essential medicines, vaccines, and food across buffer zones.
- Encourage community-based declarations that designate schools and health centres as zones of peace, with visible signage and enhanced security to deter attacks and preserve civilian infrastructure.[28]
- Ensure women's participation in dialogue processes, particularly around implementation of humanitarian corridors and peace zones, as their leadership can foster inclusive cooperation and ensure humanitarian arrangements reflect diverse community needs.
- Establish humanitarian corridors (e.g. those facilitating medical evacuation to/from Imphal, Dimapur, and Guwahati), supported by District-Level Emergency Health Clusters or Humanitarian Hubs that bring together state actors, private providers, and community interlocutors to coordinate logistics and monitor humanitarian data.
- Take concrete, incremental trust-building steps (e.g. allowing steady flows of vaccines, food, fuel, and medicines) that alleviate immediate suffering and demonstrate the viability of cooperation across geographic and community lines.

28 See Save the Children, "Case Study: Promoting Schools as Zones of Peace (SZOP Campaign) in Nepal", 2011.

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About XCEPT

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