
EDITORIAL**The long shadow of conflict: A public health perspective***G. Himashree**Editor-in-chief, Journal of Krishna Institute of Medical Sciences University,
Krishna Vishwa Vidyapeeth (Deemed to be University), Malkapur, Karad-415339 (Maharashtra) India*

War and conflict have far-reaching effects that extend well beyond the battlefield. After the guns fall silent, their population health consequences become increasingly visible. Active state-based armed conflicts have risen substantially since the Second World War, reaching a peak in 2022; more than 2,37,000 people died from organised violence that year. The WHO's 2026 global appeal, seeking nearly one billion US dollars for life-saving interventions across 36 emergencies, includes 14 Grade 3 crises in Afghanistan, the Democratic Republic of the Congo, Somalia, Sudan, Yemen, and Ukraine [1]. Conflict can no longer be treated as an occasional disruption to an otherwise stable health system. It is a determinant of health in its own right, with consequences that may persist for years.

Casualty count beyond the battlefield

The conventional accounting of war's toll focuses on combatants killed and civilians caught in crossfire. Yet this captures only part of the burden. Epidemiological reconstruction of conflict-related mortality consistently shows substantial indirect deaths resulting from health-system collapse, food scarcity, and interruption of routine care. In the WHO Eastern Mediterranean Region, one prolonged conflict between 2011 and 2020 was estimated to have caused around 874,000 direct and indirect deaths [2]. A child who dies months into a siege because the cold chain failed and a routine vaccine was not delivered may never appear in a casualty count, although the causal pathway back to

conflict is clear. The core public health case for treating conflict with the same seriousness we bring to epidemics or chronic disease is of paramount importance. The same surveillance, the same modelling, the same commitment to intervention. A gunshot wound is easy to trace epidemiologically. But a child who dies eighteen months into a siege because the cold chain broke down and a routine vaccine never reached them rarely shows up in the casualty count. Yet the line back to the conflict is just as direct.

The changing face of the conflict-affected patient

Twenty-first-century conflicts differ from the wars that shaped classical humanitarian medicine, particularly in the epidemiological profile of affected populations. Non-Communicable Diseases (NCDs) already accounted for more than 70% of deaths in Palestine before October 2023, while in Gaza adherence to chronic-disease follow-up fell from 96.7% before the war to 40.7% during it. More than 90% of primary-care facilities reported shortages of insulin, antihypertensives, and dialysis consumables [2]. Modelling from Gaza has also highlighted excess mortality from NCDs during wartime [3]. In eastern Ukraine, medication interruption among displaced patients with chronic disease reached 46–77%, compared with 9–14% among those who remained in place. These are patients with diabetes, hypertension, renal failure, or transplants whose survival depends on continuity

of treatment. The interval between disruption and serious morbidity or death may be measured in weeks rather than days. Humanitarian medicine therefore needs to move beyond a predominantly trauma-and-infection model to one that protects continuity of chronic care.

The collapse of systems, not just structures

Healthcare infrastructure is often damaged or destroyed during conflict, but the deeper injury is to the systems that make care possible: the health workforce, medicine and vaccine supply chains, laboratory networks, and health information systems. Vaccination coverage falls significantly after conflict begins, driven by displacement, damaged cold-chain infrastructure, and the departure of health workers [3]. The consequences can persist long after fighting stops, leaving cohorts with immunity gaps and increasing the risk of outbreaks. Health-system resilience therefore depends not only on buildings and equipment but also on trained personnel, resilient supply chains, and institutional capacity to restore services rapidly. Academic health-science institutions can contribute through curriculum design, operational research, and disaster-preparedness training. A conflict lasting only a few years can therefore leave population-level gaps in immunity. When outbreaks follow conflict, the roots may lie in vaccines that were not delivered during the period of disruption. A health system's ability to withstand shocks isn't just about how much has been invested in buildings and equipment. It comes down to whether there are enough trained people, whether supply chains have built-in slack, and whether the institutional knowledge exists to get services running again quickly once things stabilise. Building that kind of resilience through curriculum design, operational research, and disaster-preparedness training is work academic health science institutions are well placed to do.

It's a role that goes far beyond what we'd normally think of as clinical education.

The invisible epidemic: Mental health

The psychological toll of conflict is pervasive and can persist long after hostilities cease. A WHO-linked systematic review of 129 studies across 39 countries estimated that about 22% of people exposed to conflict within the preceding decade had a mental disorder, compared with about 7% in the general population [4]. WHO estimates also indicate that close to one in ten people in conflict-affected settings live with a moderate-to-severe mental health condition [5]. Depression and anxiety are particularly important components of this burden. Mental-health services therefore need to be integrated into humanitarian response and post-conflict recovery rather than treated as an afterthought. The consequences extend beyond psychological distress. Untreated mental disorders can contribute to physical morbidity, substance use, and impaired participation in family, social, and economic recovery. Investment in mental-health infrastructure must therefore form part of health-system reconstruction.

Maternal, child, and intergenerational health

Maternal and child health provide visible indicators of health-system disruption, but the intergenerational consequences may be less immediately apparent. In-utero and early-childhood malnutrition can produce lifelong effects on cognitive development, immunity, and chronic-disease risk, creating a health burden that persists well beyond the conflict itself.

Five converging frontiers

Five clear frontiers need to converge to reduce the long-term effects of conflict on population health.

Artificial Intelligence (AI): AI may support triage, perioperative decision-making, surveillance, and resource allocation in resource-constrained conflict settings. Such applications require appropriate ethical, legal, and governance frameworks, as well as offline-capable tools that can function when infrastructure fails [6].

Health diplomacy: Negotiated humanitarian pauses, or “days of tranquillity,” have enabled vaccination campaigns during active conflicts since 1985. These should be recognised as a public-health instrument rather than treated as a diplomatic footnote. The September 2024 polio campaign in Gaza illustrates the continuing value of such negotiated access [7].

Migration and mass displacement: An estimated 117.8 million people were forcibly displaced by the end of 2025. Health systems and public-health policies must be designed to provide both routine and emergency care to populations on this scale [8].

Food security: Conflict and displacement are closely linked to food insecurity. The 2026 Global Report on Food Crises highlights the scale of acute food crises among forcibly displaced populations and the continuing burden of child malnutrition [9]. Health systems and governance therefore need to incorporate food security into conflict preparedness and response.

One Health (human–animal–environmental health): Conflict can alter ecological conditions, animal-human contact, disease surveillance, and antimicrobial use. Evidence of increased infectious and zoonotic disease risks in conflict settings supports a One Health approach to preparedness, response, and recovery [10].

Public health's permanent agenda: Conflict

In a world where conflicts in all dimensions and magnitude are possible, the following is the way forward:

Analysing to predict and prepare: Conflict-health data should not be an emergency-only exercise. Reliable estimates of conflict-related death and illness remain difficult to obtain and are measured inconsistently across settings, weakening both humanitarian response and post-conflict reconstruction [2]. Institutions with research capacity should help develop and validate methods before crises occur.

Mental health: Mental health cannot remain an afterthought in humanitarian response. The burden documented across conflict-affected population's warrants sustained attention in public-health policy, governance, service delivery, and academic training [5].

Responsibility of academia and research: Higher-education and research institutions should undertake tailored research to address the long-term health consequences of conflict. Academic medicine and public health need to anticipate these needs rather than respond only after crises emerge.

Humanitarian financing: Adequate financing, directed to the right priorities and delivered where it is needed, remains fundamental. Global humanitarian financing fell sharply in 2025 [1], with consequences for vaccination, mental-health care, maternal health, and essential services. For academic institutions working in health sciences, conflict is not someone else's health problem: it belongs in research agendas, curricula, preparedness planning, and institutional priorities.

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*Author for Correspondence:

Dr. (Brig) G. Himashree, Editor-in-chief, Journal of Krishna Institute of Medical Sciences, Krishna Vishwa Vidyapeeth (Deemed to be University), Karad-415339, Maharashtra, India Email: editorinchief@jkimsu.com Cell: 9465184159

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