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Choosing not to weaponize healthcare: Politics and health service delivery during Nepal's civil war, 1996-2006

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Abstract

Healthcare has often been 'weaponized' during armed conflicts, with parties to the conflict interfering with or violently attacking health facilities and personnel for their own strategic ends - for example to deny access to services to supporters of their enemies. Such strategies have damaging consequences for the health system that continue long after the fighting has stopped. In this exploratory study of the civil war in Nepal (1996-2006), by contrast, we look at a case in which both sides (with a few limited exceptions) came to see it as in their interests to avoid targeting health facilities or deliberately disrupting healthcare delivery. As we seek to show, this does not seem to have been solely the result of a desire to comply with international humanitarian law, but rather the product of a strategic choice made by the parties for their own internal political reasons. Drawing on key informant interviews and documentary analysis, we identify four factors that appear to have contributed to the two sides making this choice: i) their interest in the continued functioning of the health systems (specifically, the need of the Maoists to access government-run facilities for treatment of their cadres, and the fact that Maoist healthcare provision ensured that at least some service delivery continued in areas under their control, contributing to the government's efforts to ensure national health indicators continued to improve); ii) the fact that healthcare did not become an important 'ideological battleground' in the conflict; iii) the roles played by humanitarian and development organisations in shaping the behaviour of both the warring sides; and iv) the part played by health professionals in navigating the pressures on them and quickly mobilising to resist more sustained attempts at interference with healthcare.

Keywords: conflict, health, weaponization, Maoism, Nepal, strategy.

Introduction

In many armed conflicts around the world, healthcare has become a target. The International Committee of the Red Cross's 'Healthcare in Danger' campaign (HCiD - http://healthcareindanger.org) has been one of the most high-profile attempts to draw international attention to this issue. The HCiD campaign highlights the fact that healthcare facilities and health workers are often subject to attack by warring parties and seeks to promote respect for International Humanitarian Law (IHL), which explicitly prohibits attacks on medical facilities. The motivation for such attacks seems to vary, including a desire to deny healthcare access to opposition fighters, attempting to disrupt service delivery to an opposition-supporting population, or spreading fear and social disruption. In other words, such services are often seen as having a strategic value in a conflict, and their destruction can be seen as serving a strategic purpose.[i]

The conflict in Syria has offered some particularly egregious examples of attacks on health services, with an inquiry by the Lancet-American University of Beirut Commission on Syria (Fouad et al 2017) finding that healthcare had been 'weaponized' in that conflict through the deliberate targeting of health facilities, health workers and ambulances. Importantly, Fouad et al (2017: 2516) pointed to the strategic nature of this weaponization in the Syria case, which they said "amounts to what has been called a 'war-crime strategy'". Attacks on health facilities were not, they suggested, instances of individual soldiers or units 'going rogue' or acting contrary to orders, but a deliberate strategy adopted higher up the chain of command. Syria is certainly not alone in this. In many other conflicts around the world, one side or the other (or both) have adopted similar strategies of weaponizing healthcare. Indeed, the Safeguarding Health in Conflict Coalition's 2018 report found a significant increase in attacks on healthcare in conflicts worldwide, documenting "at least 973 attacks on health workers, health

facilities and health transports in 23 countries in conflict around the world" (Safeguarding Health in Conflict Coalition 2018: 5).

Given the importance of finding ways to better protect healthcare during war, an important issue raised by cases of weaponization is understanding the reverse: when do warring parties take strategic decisions *not* to weaponize healthcare and, more importantly, *why*? Understanding the factors that lead to such 'non-decisions' is of course a methodological challenge. Yet answering these questions could have important benefits for policy and practice. In this small-scale exploratory study, we seek to make some initial inroads into this task by examining the conduct of both sides during the civil war in Nepal (1996-2006).

Nepal offered an interesting context for exploring this question for three reasons. First, previous literature had found that attacks on health facilities and personnel had been rare during the war, in contrast to many other conflicts. Second – even more unusually – national-level health indicators continued to improve through the war years, suggesting not only that health services had not been destroyed, but that in some ways they had been improved. Third, at the time the research was carried out, it was over a decade after Nepal's negotiated peace agreement and the former Maoist insurgents had transformed themselves into a legitimate political party, making it possible to access representatives of both sides and for those individuals to speak (relatively) freely about the conflict.

Our findings suggest that this was indeed a case in which both sides came to see it as within their interests to avoid (with a few limited exceptions) interfering with or attacking healthcare services delivered by their opponents. This was in stark contrast to other sectors such as education, around which there was much more contestation and violence. Whilst the health sector was certainly not immune from interference during

the war, we found that such incidents were usually the result of ad hoc actions by individuals on the ground, and not part of a strategy coming down the chain of command. In the very few cases where there did appear to be a deliberate strategy of interference, these were quickly resisted and proved short-lived.

Given the contrast with other similar conflicts, we sought to understand the internal and external political factors that could help explain the decisions on both sides to avoid (in general) the weaponization of healthcare. We identify four factors that appear to have contributed to the two sides making this choice: i) their interest in the continued functioning of the health systems (specifically, the need of the Maoists to access government-run facilities for treatment of their cadres, and the fact that Maoist healthcare provision ensured that at least some service delivery continued in areas under their control, contributing to the government's efforts to ensure health indicators continued to improve); ii) the fact that the health system did not become an important 'ideological battleground' in the conflict; iii) the roles played by humanitarian and development organizations in shaping the behaviour of both sides; and iv) the part played by health professionals in navigating the pressures on them and quickly mobilizing to resist more sustained attempts at interference with healthcare.

The civil war in Nepal, 1996-2006

A brief history of the conflict

Nepal's civil war, fought between the Communist Party of Nepal-Maoist (CPN-M, "the Maoists") and the Nepalese government, lasted for a decade, from 1996-2006. The official government figure is that a total of 16,278 were killed (BBC 2009), making the civil war a high-intensity conflict under the common definition of 'more than 1,000 deaths per year' (Singh et al 2006). In addition, over 1,000 people 'disappeared', many

thousands more were injured during the fighting, and human rights abuses, perpetrated by both sides, were widespread (Amnesty International 2002; UNHCR 2012).

The longstanding failure of successive governments to effectively address economic and social inequalities was, by most accounts, the primary motivation for the launching of the Maoist insurgency. For the Maoists, the advent of multi-party democracy in 1991 failed to bring an end to the historical 'politics of exclusion' or to meaningfully challenge the distribution of power and wealth.

In the first few years of the war, violence was largely concentrated in the west of the country and was considered by the government primarily as a 'law and order' problem rather than a military conflict. Violence intensified significantly and spread across the country after the royal massacre in 2001 (Stevenson 2001), following which the new monarch, King Gyanendra, pursued a more militarised strategy, utilizing the Royal Nepal Army to fight the Maoists, who now came to be reframed by the government as 'terrorists'. By one count, 92.5% of the total war deaths occurred during this second half of the conflict (Kohrt et al 2012: 269), with the violence being so widespread that, according to Devkota and van Teijlingen (2010a: 2), it was impossible to distinguish between 'conflict' and 'non-conflict' areas.

Ceasefires and rounds of peace talks in 2001 and 2003 provided only temporary halts to the violence. But King Gyanendra's sacking of the Prime Minister and direct take-over as head of government in 2005 changed the political dynamic significantly (Thapa and Sharma 2009). At that point, the Maoists entered into talks with other parties in an attempt to create a unified opposition to the monarchy and to demand the restoration of democracy. This eventually came in April 2006 when, under pressure from mass protests as well as from the country's major political parties, Gyanendra announced that he would reconvene parliament. A peace agreement between the interim

government and the Maoists was signed in November 2006, bringing the conflict officially to an end.

Health and development during the war years

Nepal has long suffered from some of the world's worst health and development indicators. In 1996, at the outbreak of war, it was ranked 127th out of 137 countries on the Human Development Index and was placed amongst the category of 'Least Developed Countries' (UNDP 1996). The UNDP data showed that 94% of births were unattended by trained health personnel and 51% of under-fives were underweight (UNDP 1996). According to the World Bank's 1996 World Development Report (World Bank 1996: Statistical Annex Table 6) only 6% of the population had access to sanitation.

Perhaps surprisingly, Nepal continued to make progress against key health and development indicators throughout the war years. Poverty levels decreased and economic growth was steady (Macours 2011) – although inequality continued to increase. As Tsai (2009: 516) notes in relation to maternal mortality, "The improvement in maternal mortality despite the disruptions of the 10-year civil war has posed an interesting paradox to international health experts." This was evident in measurements of Nepal's progress against the Millennium Development Goals (MDGs). In their comparison of health indicators from 1996 (before the war started) and 2006 (immediately after it ended), Devkota and van Teijlingen (2010a) found that many key health indicators (including 16 out of 19 health-related MDG indicators) had indeed improved during the conflict, and that Nepal was on target to achieve a number of the MDG indicators despite the decade-long civil war. Nepal's final MDG status report (National Planning Commission 2015) indeed found that the country had achieved most

of the MDG targets, although a number were partially achieved and others unmet. Nevertheless, Nepal had performed much better on the MDGs than many non-conflict-affected countries.

One of the features of Nepal, however, is that national-level health and development indicators can paint a somewhat misleading picture. Levels of inequality were (and remain) extremely high – indeed those inequalities were a major factor in precipitating the civil war in the first place. Disparities between urban and rural populations in particular were huge. Singh (2004: 1500), for example, notes that the under-5 mortality rate in urban areas in 2004, towards the end of the war, was 93.6 per 1,000, but that it was more than double that at 201 per 1,000 in the mountainous regions (see also Singh et al 2006). When the war finished in 2006, Collins noted that "Life expectancy is 74 years in Kathmandu, but only 37 years in the mountainous district of Mugu in the mid-western region." (Collins 2006: 908).

Devkota and van Teijlingen (2010a) attributed the improvements in health indicators to the actions of a number of actors: (i) the Maoists (who, they argued, generally avoided disrupting the delivery of health services and put pressure on health care providers to ensure service provision continued); (ii) the government (which improved its coordination with other health sector actors; implemented new health improvement programmes; sought to “maintain a visible, sustained and adequate provision of health services at all levels”; increased the health sector budget; and improved national infrastructure); (iii) civil society; and (iv) the international community (not least contributions by UN agencies and international NGOs). In this paper, we seek to understand why the Maoists and the government decided, with some minor exceptions, to avoid interrupting health service delivery by their opponents (i.e. took strategic decisions not to weaponize healthcare).

Healthcare services during the war years

For the majority of the population, the state was the major provider of healthcare services through the war years. Nepal had – at least on paper – a well-structured health system directed centrally by the Ministry of Health and Population, with District Health Offices in each of the country's 75 Districts (there are now 77 districts after the implementation of the new constitution in 2015) directly organising the delivery of health services through District-level hospitals and village health posts in each 'Village Development Community' (VDC).[ii] In practice, the quality of healthcare varied dramatically across the country, with the system beset with persistent problems of under-resourcing, corruption, and health worker absenteeism.

Non-state actors, including both national and international NGOs and the private sector, also played important roles in delivering health services throughout the war. NGOs supported government services in many regions (or replaced them where they were absent). Private health facilities, meanwhile, were located primarily in urban areas and utilised for the most part by the relatively wealthier sections of society (with the exception of private pharmacies, which were common nationwide).

Finally, the Maoists provided basic services to populations in areas of the country under their control (sometimes referred to as their "base areas"). There is disagreement in the limited literature available on the extent of this. It is known – and was confirmed during our interviews (e.g. N001, N003, N004, N006) – that the Maoists initially developed medical capacities to provide treatment for their own cadres, but that later in the war they extended this to provide basic treatments to the general population in the areas in which they were based, with the aim of propagating their ideology through delivery of healthcare services. The information available in the

published literature remains fragmentary – although Devkota and van Teijlingen (2009, 2010b) have undertaken some important exploratory work.[iii] In this research, the authors attempted to examine, to the extent possible, what the Maoists had provided, and to whom. They found that the Maoists had trained around 2,000 individuals to be "people's doctors", and that in some areas they ran community hospitals and health centres (a 'People's Model Hospital' in Rolpa district and health centres in Kalikot and Udayapur Districts are cited (Devkota and van Teijlingen 2009: 381. See also Sahay et al 2016)). They also provide some details of the training system used– including the fact that the Maoists had developed curricula for training 'people's doctors' in four levels: Ordinary, Medium, Standard, and Advanced.

Methods

This paper is based on an exploratory study of 12 key informant interviews conducted with individuals who had worked in health policy and/or delivery in Nepal during the conflict: for the Government of Nepal, national and international NGOs, International Organizations, and the Maoists (see Table 1). Interviewees were purposively selected according to their professional/political role during the conflict, with care taken to ensure the representation of individuals from both the Maoist and government sides of the conflict, as well as those who worked for organisations (e.g. INGOs) that maintained a neutral stance. (Note that roles described in Table 1 do not necessarily indicate the allegiance of interviewees during the conflict). The interview with a former senior Maoist commander was made possible by the fact that, following the peace agreements, the Maoists had become legitimate political actors and he (and some of the

Maoist supporters) were able to speak relatively openly (albeit anonymously) about war-time strategy.

[INSERT TABLE 1 AROUND HERE]

The interviews were in-depth semi-structured interviews, ranging from 30 to 65 minutes in duration. Interview guides were developed in advance and adapted as necessary for each interviewee with topics covering i) role during the conflict; ii) experiences of the impact of the conflict on healthcare; iii) knowledge of the healthcare-related activities of both sides in the conflict; iv) knowledge of political/military strategies as they related to healthcare; v) knowledge of the role of international actors (IOs/donors etc) during the conflict,

Interviews were conducted in a mixture of English and Nepali (depending on the preferences of the interviewee). In most cases, two interviewers (one Nepali; one from the UK) conducted the interviews, with BD translating into English for SR where necessary.

Where consent was given (n = 8), interviews were recorded and subsequently transcribed. Where consent for recording was not given (n = 4), detailed contemporaneous notes were taken.

Transcripts and notes were read multiple times and coded by one researcher, with subsequent checking by another. Given the limited number of transcripts/contemporaneous notes, hand coding was possible without the use of specialist software. The codes identified information pertinent to the (non)-weaponization of healthcare during the conflict. These findings were subsequently

triangulated with information found in the academic literature and in documentary sources.

Given the sensitive nature of the issues discussed, all interviewees are anonymised in this paper (in most cases both names and affiliations) and referred to by a numeric identifier.

This research was approved by the University of Sheffield Research Ethics Committee (Ref. 002342).

Results

While it is important to not underestimate the huge physical and mental health impacts of the war on the population, the improvement in national-level health indicators during the war offers an interesting puzzle – and stands in stark contrast to the experience of many other conflict-affected countries. As noted by Devkota & van Teijlingen (2010a), the tendency of both sides to seek to avoid the weaponization of healthcare was almost certainly at least a part of the reason for this improvement.

In line with the previous findings of Devkota and van Teijlingen, none of our interviewees (even those who were neutral between the parties) believed that either side in the conflict deliberately targeted health facilities. Although there were instances of damage to village health posts and, in one case, to a District hospital, these were seen by all interviewees who expressed an opinion on the issue as cases of 'collateral damage' rather than the result of deliberate attack. As we discuss further below, health workers did in some cases find themselves under pressure from one side or the other – or both. Some government and NGO health workers were pressured to provide treatment to injured Maoist fighters, inviting a risk of them being perceived by government forces to be collaborating with the insurgents. From the government side,

there were at some points attempts to pressure health workers to report cases in which they treated injured Maoists to the security services, undermining patient confidentiality. The government, at the height of the conflict, promulgated an act prohibiting health workers from treating wounded insurgents. In general, however – and certainly in comparison to the education sector, which became heavily politicised – there was limited political or military interference with healthcare and a general bilateral effort to avoid targeting healthcare facilities.

In this results section, we outline four factors that emerged from the interviews that were, from the perspective of interview participants, responsible for the parties to the conflict adopting this approach:

1. The needs of the Maoists for access to treatment meant they had a stake in the continued functioning of the government health system, and therefore a strategic motivation not to interrupt it;
2. Despite the Maoists' ideological commitment to improving services for the poor and marginalised, the health sector had a relatively low profile and did not become an important 'ideological battleground'. Unlike education, interrupting healthcare delivery was, therefore, seldom an attractive strategic choice for either side;
3. Humanitarian and development organisations managed to maintain neutrality and international organisations and donors played important roles in supporting healthcare by encouraging both sides to respect IHL. The role of the ICRC was important in orienting the combatants on the provisions of IHL. This helped reinforce the avoidance of attacks on healthcare as a political/military strategy

and enhanced respect for IHL in terms of people's right to health services or treatment;

4. Individual health professionals were often skilful in navigating paths between the competing demands of the government and Maoist sides. This helped diffuse tensions and avoid healthcare becoming a focus of conflict.

The Maoists' need for access to treatment

In many conflicts worldwide, insurgent groups have attacked government health facilities. During the civil war in Nepal, the Maoists had a stake in the continued functioning of health facilities, particularly in rural areas, because they regularly used them to obtain treatment for their own cadres - either those who were sick or those who had been injured in the fighting. According to a number of interviewees (e.g. N001, N002), this was the Maoists' primary interest in ensuring the continued working of health facilities – especially village-level health posts.

Not only did this mean that the Maoists were less likely to target health facilities, in some cases interviewees reported that their presence in an area actually improved the functioning of government health posts. A number of interviewees (e.g. N008, N010, N011) noted that one of the positive side-effects of the conflict was that health worker absenteeism – a perennial problem prior to the conflict – reduced in many areas where the Maoists were present as health workers feared being away from their posts when the Maoists came looking for help. One interviewee directly linked this with the phenomenon of improving health statistics during the war, noting thus:

> One of the reasons [health indicators continued improving during the conflict] was that health workers were staying at post. Why were they staying at post? Because it

> was dangerous to leave. So they stayed in the villages rather than disappearing back to the cities and such. … Maoists would say "are your health workers at their post?" And to their credit, they contributed in that way. … They put pressure on. (N011)

There were, of course, unwelcome aspects of this pressure and, as discussed further below, government and NGO health workers sometimes found themselves placed in extremely difficult positions between Maoist demands for treatment on the one hand, and government suspicions of collaboration with the Maoists on the other. And whilst there were few instances of the wholesale looting of health facilities, a number of interviewees reported cases of Maoists coming to health posts and demanding medicines – either as a voluntary 'donation to the cause' or with an implied threat of physical violence. One interviewee, who was working for a national NGO during the conflict, recalled:

> On several occasions Maoists came and demanded supplies. That was difficult to deal with, because as an NGO you can't be seen to be supplying the Maoists with drugs. So we tried to have a policy that you only gave medication to patients you actually saw. But it could be very difficult for the health workers. … There were a few unpleasant situations. I remember two or three occasions where the Maoists brought injured people to the health post. As a medic you treat anyone, but if the army comes the next day – or if the army comes at the same time – you are always scared that you will end up in a "cross-fire". (N004)

As time went on, the Maoists increased their own internal capacity to treat their cadres – but they still also relied on government and/or NGO health workers to provide

assistance (either 'voluntarily' or otherwise). By the second half of the war, the Maoists had reasonably well-developed (if rudimentary) systems for treating injured fighters. Temporary field hospitals were put in place during major offensives. In a detailed examination of the Maoists' attack on the town of Beni in March 2004, for example, Ogura (2004: 93) describes the setting up of "treatment centres for the wounded in at least five places in Beni and some more in Mangalaghat", often in buildings commandeered from local residents. In these centres, first aid and basic surgery was delivered to wounded insurgents. Treatment was provided by what Ogura (2004: 103) describes as "'volunteers' who had been abducted by the Maoists from Chimkhola VDC [Village Development Committee]." It is apparent from this account that the equipment available in these field hospitals was extremely primitive. Although there is testimony relating to the use of painkilling drugs, confirming that the Maoists had at least some access to essential medicines, there is also an eyewitness account of one of those providing treatment using a kitchen spoon to remove a bullet (Ogura 2004: 106).

A senior commander in the Maoist People's Liberation Army (PLA) during the conflict (N003), recounted the development of the Maoist medical services that began with training troops in basic first aid, and subsequently developed through a number of phases, beginning with the establishment of a Health Committee within the party, followed by Medical Sections within Platoons, then an entire Medical Platoon, and finally a Medical Company. The interviewee also explained how the Maoists developed a network of contacts in the cities (especially in Kathmandu and Pokhara) who worked in establishments such as government hospitals and pharmacies and would source medicines and other supplies for the Maoists. Later, the interviewee recalled, the Maoists began purchasing items of medical equipment including x-rays and blood testing equipment, until they reached a stage where treatment could generally be

provided within the Maoist camps, reducing their need to rely on village health posts. A number of other interviewees reported knowledge of the fact that more serious Maoist casualties would be taken across the border to India for hospital treatment. Nevertheless, despite this internal medical capacity, Maoist cadres continued to rely to some extent on government health posts for the provision of treatment throughout the war, and therefore had a direct interest in the continued functioning and staffing of those facilities.

The relatively low profile of health as an ideological battleground

Improving the provision of health services (as well as other public services) was one of the main demands of the Maoists, who focussed particularly on the plight of rural populations and marginalized groups. The '40 point demands' made at the start of the war included, in Demand 35, that "All should be given free and scientific medical service and education."

However, our documentary analysis revealed that there is surprisingly little in the public statements of Maoist leaders during the war about the provision of health services or the health needs of the population. The collection of Maoist statements and documents collected by Karki and Seddon (2003: 183-290) contain almost nothing on health or healthcare. *The Worker*, the journal of the Maoists during the war years, was heavy on Maoist ideology but also paid little attention to healthcare, mentioning the subject only a handful of times in the first five years of the conflict. Only later in the war, as the Maoists developed their capacity and their base areas, did Maoist health service delivery begin to be mentioned. Even during this period, however, the coverage

of health service delivery was brief and infrequent.[iv] One article in *The Worker* (Vibhishikha 2006) was devoted to the Maoists' healthcare capacities, and this has as a result come to be one of the major sources relied upon by subsequent scholars of the Maoist 'health system' (e.g. Sahay et al. 2016: 30). That article focussed for the most part on the Maoist's military medical services, but also briefly mentioned the provision of health services to the general population in the 'autonomous areas'.

Although the Maoists did provide basic healthcare services to local populations, overall the extent to which health services were used in an attempt to 'win hearts and minds' was seen by interviewees to have been limited. A former Maoist commander reported that the practice of providing health services to the population was part of the Maoists' policy:

> N003: When the PLA [Peoples' Liberation Army] came to the village all of the people would gather and they would ask for medicines.
>
> Interviewer: Was it party policy to provide those medicines?
>
> N003: Yes, it was party policy. It was part of the service.
>
> …
>
> N003: Many people were attracted to us [the Maoists] because of the services we provided. Later people began to choose to use Maoist doctors because the treatment was free, effective, and on the spot. People would shout "where is the Maoist doctor? I would like to meet".

Yet most non-politically aligned observers suggest that, at most, health service provision had been done in a small scale way. One (N006: a member of staff of an

International Organization who had been working in Nepal during the conflict) reported that the Maoists "always provided whatever they had to the general public, although their capacity was limited". Others (e.g. N001) thought that this did happen on occasions, but saw this as a secondary concern in comparison to providing for their own forces. We found a general perception that there had been limited use by either side of health service provision to win hearts and minds. This perception (whether true or not) helped avoid the situation where healthcare became a 'political football' and reduced the incentives for either side to disrupt services provided by the other,

The role of humanitarian and development actors

Humanitarian and development actors involved in the health sector (International Organizations, national and international NGOs and international donors) sometimes faced difficulties in navigating a neutral path between the two warring parties, and some interviewees reported incidents in which they were stopped and questioned at government and/or Maoist checkpoints and forced to explain their presence. In some cases interviewees reported being asked to make 'donations' before they were allowed to proceed. One (N002) recalled being challenged by a Maoist fighter on whether he was providing information to the authorities. All interviewees who reported such experiences, however, felt that the conflict's impact on their ability to operate had overall been relatively limited (N002, N003, N006, N008) and a number of interviewees stated that they had been able to successfully maintain positive working relationships with both sides (e.g. N006).

We found some indications of an exception to this general pattern in the case of United States-funded programmes (the United States routinely being identified in Maoist rhetoric as imperialist reactionaries).

> Some of our field workers suffered some interference so, for example, they had to justify who was funding a particular training. The Maoists didn't like things funded by the Americans, but things funded by Europeans were usually fine. (N010)

> Some international NGOs or development partners were in trouble because the Maoists felt that their governments were providing illegitimate assistance to the government of Nepal. (N005) [the US was not named, but was implied].

All international donors operating in Nepal during the war signed up to a series of *Basic Operating Guidelines* that, amongst other things, stated:

7. We do not accept our staff and development partners being subjected to violence, abduction, harassment or intimidation, or being threatened in any manner.
8. We do not work where staff are forced to compromise care values or principles.
9. We do not accept our assistance being used for any military, political or sectarian purposes.
10. We do not make contributions to political parties and do not make any forced contributions in cash or kind.
11. Our equipment, supplies and facilities are not used for purposes other than those stated in our program objectives. Our vehicles are not used to transport persons or goods that have no direct connection with the development program. Our vehicles do not carry armed or uniformed personnel.

12. We do not tolerate the theft, diversion or misuse of development and humanitarian supplies. Unhindered access of such is essential.
13. We urge all concerned to allow full access by development and humanitarian personnel to all people in need of assistance, and to make available, as far as possible, all necessary facilities for their operations, and to promote the safety, security and freedom of movement of such personnel.
14. We expect and encourage all parties concerned to comply strictly with their obligations under International Humanitarian Law and to respect Human Rights. (Reprinted in Kobek & Thapa 2004)

These principles were felt by some interviewees to have played a role in helping prevent health aid becoming politicized, and in encouraging both sides to allow development and humanitarian organizations to continue with their work, even in conflict-affected regions.

In addition, we found evidence (N003, N006) of some international actors – the ICRC and the government of Switzerland were specifically identified – being successful in maintaining close working relationships with both the government and Maoist sides, and in playing an active role in providing training on IHL to troops on both sides of the conflict. Such training included the need to respect the neutrality of health facilities, and may have played a role in further discouraging deliberate attacks.

The role of health professionals

Finally, it was frequently reported to us that individual health professionals played important roles in defusing tensions, resisting the weaponization of healthcare, and

ensuring the continued delivery of services regardless of political alignment – sometimes in extremely difficult circumstances.

It has already been noted that there were cases in which government health workers came under pressure from both sides over the treatment of sick and wounded Maoist fighters. Most interviewees had knowledge (either first- or second-hand) of health workers successfully and skilfully navigating a path through these competing pressures. As might be expected in a conflict situation where being open about one's sympathies (to either side) can be dangerous, we found scepticism amongst interviewees about the extent to which health workers were really fearful of the Maoists. One interviewee felt that that some government health workers used the Maoist presence as "an excuse to leave their posts" (N001). The Maoist commander we spoke to, meanwhile, suggested that Maoists encouraged health workers to feign fear:

> Many government doctors sympathised with us and wanted to help us. But we told them: say "they pressed us to help them" – otherwise they would have been killed. (N003).

This may have sometimes been the case, but we also heard many stories of what sounded like genuine fear – as would be expected in a war zone. Set against this, however, most interviewees pointed out that it was relatively rare for health workers to encounter serious problems with either side, and although there may often have been difficult situations and moments of fear, for the most part they were able to resolve these tensions and continue their work relatively unimpeded.

Exceptions

It is important to also highlight the fact that healthcare did not entirely escape interference during the conflict. Low-level interference – roadblocks, small-scale extortion of money and medicines etc – was relatively common. We heard some reports (e.g. N001) of individual health workers suspected of being government spies being forcibly driven from their posts by the Maoists. For the most part, however, these were thought by interviewees to have been actions carried out independently by small groups of fighters on the ground, not the result of any higher-level policy decision. Indeed, some interviewees identified the Maoists' effective command structure as having played an important part in minimizing the prevalence of such incidents and in protecting health facilities.

There were two government initiatives that we came across during the research that appear to have represented more concerted attempts to draw health service delivery into the conflict, although in both cases they were short-lived.

The first was a brief attempt by the government to restrict transport of medicines to Maoist-controlled areas. However, the interviewee who raised this (N006) recalled that "after pressure from ICRC and others, they let them through."

The second, a more serious issue, was a government directive, introduced when the conflict intensified in 2001, requiring doctors to inform the authorities of individuals seeking treatment for conflict-related wounds, with any doctors who failed to so do being "considered supporters of terrorists according to the Terrorist and Disruptive Ordinance 2001 and liable to arrest and imprisonment" (Stevenson 2002: 1495. See also Mukhida 2006; Sharma et al 2002). This rule effectively made it impossible for doctors to treat such patients confidentially. However, this was a short-lived policy – and one strongly opposed by medical professionals within Nepal and internationally, until it was revoked.

Perhaps the most serious example raised in the interviews, however, was the destruction of a District hospital by Maoist fighters in Sindhupalckowk district. It happened during heavy shelling by both sides on a battlefield in close proximity to the hospital. All of our interviewees with knowledge of this incident, however, believed that the damage to the hospital had been accidental, and not the result of a deliberate attack.

Discussion

Whilst it is clearly not the case that healthcare remained an entirely apolitical and neutral space during the civil war in Nepal, our findings (in line with previous work by Devkota and van Teijlingen (2010a)) did suggest that violence around healthcare, and the strategic weaponization of healthcare was far less common in Nepal than during many other civil conflicts.

The efforts of international actors such as ICRC to promote compliance with IHL, no doubt, contributed to this. NGOs, International Organisations/donors and individual medical professionals also played important roles in resisting efforts by either side to draw the health sector into the conflict. One of the ways they did this was by signalling their own neutrality, and medical professionals were skilful in both navigating the pressures on them from both sides (often allowing for services to be delivered and conflict avoided) and also mobilising to oppose and reverse attempts to politicise the health sector. Some of these efforts (for example, the work of the ICRC in providing training to both sides on IHL) sought to bolster compliance with laws and norms around medical neutrality.

However, strategic self-interest on the part of both of the warring parties also seems to have played an important role. The incentives to attack health facilities were few, and were generally outweighed by the discinentives.

First, the Maoists had a direct interest in the continued functioning of the government health system (as well as services provided by NGOs and others). Although they did develop and enhance their internal medical capacities as time went on, cadres in rural areas continued to rely on village health posts in case of illness or injury. Although interference with the working of those facilities was not unheard of, the strategic self-interest of Maoist commanders for access to those services seems to have been protective of them.

Second, perhaps surprisingly given the fact that rural service provision was a major motivating factor behind the emergence of the Maoists as an armed opposition force, healthcare had a low profile in statements during the conflict, and did not, for the most part, become an 'ideological battleground'. We found evidence that the Maoists did deliver at least some health services to the population in some areas. However, we found little evidence that either providing or denying healthcare access formed a major part of their political or military strategies. This is in stark contrast to the education sector, which became a major ideological battleground. Schools were targeted in many instances. According to the Asian Centre for Human Rights (2005: 24). between 1 February and 9 May 2005 (towards the end of the war) 23 schools were attacked by the Maoists, with over 100 teachers being killed and over 200 others fleeing to urban areas. The same report found that "In May 2004, the Maoists prevented approximately 7,000, out of the 14,500 newly appointed teachers, who had passed the licensing examinations conducted by the Teachers' Service Commission from joining duty." (Asian Centre for Human Rights 2005: 22). The Royal Nepal Army was also implicated in attacks on

schools carried out during Maoist cultural programmes (Asian Centre for Human Rights 2005: 23-4). Compared to education, then, the relatively low profile for healthcare seems to have been a factor in the relative non-politicization of the health sector during the war, meaning that (unlike education) it did not become a 'political football' between the warring parties.

Third, the government had a strong interest in continuing the country's improvements against key health indicators, partly as a result of international processes such as the MDGs, but also to bolster its own legitimacy. This created incentives for the government to increase investment in the health system throughout the war years. It also meant that, in parts of the country under Maoist control, the incentives for disrupting Maoist healthcare provision (which ensure that at least some basic services were available) did not outweigh the disincentives.

Limitations

This study was based on a relatively small number of interviews, although we found that the majority of interviewees were in agreement on most issues – despite their very different roles and positions during the war years. This study did not involve interviewing former Maoists health workers themselves for their perspectives, although that work is underway as part of a follow-on study.

Interviewees were being asked about their perceptions of events from over a decade previously, and their recall may have been imperfect, or may have been coloured by the passage of time and subsequent political developments. In addition, as in all research in conflict-related settings, few if any observers can be considered truly 'impartial': most will have either conscious or unconscious bias against one side or the other.

Despite the passage of time, it is possible that some interviewees would still have found it difficult to talk honestly and openly about their experiences during the war. However, this danger was mitigated in a number of ways: i) all interviewees were promised anonymity; ii) participating in the research was voluntary, and this was reiterated to participants both before and at the end of their interviews; iii) by the time of the interviews, the Maoists had become a legitimate political party, reducing the danger of any exposure of interviewees' affiliations or sympathies opening them up to adverse consequences.

It is conceivable that the presence of a non-Nepali researcher could have affected the responses of some interviewees. Equally, some interviewees may have found it easier to discuss the history of the conflict with a non-Nepali interviewer.

Conclusion

The problem of violent attacks on healthcare facilities and health workers has rightly been highlighted in a wide range of conflicts. Bodies such as the ICRC and medical professional organizations have frequently called for the principles of medical neutrality to be respected by all sides to a conflict, and have often condemned breaches of this principle. The lack of respect for the principle of medical neutrality is rightly seen as being one of the most important problems plaguing healthcare delivery in war zones, given its direct and indirect consequences on populations and health systems.

Our findings here suggest that, in addition to laws and norms of war, the strategic self-interest of warring parties can in certain circumstances also be protective of healthcare. Whilst all conflicts vary in their contexts and specificities, the Nepal case suggests that parties in some cases see it as being within their strategic/political interests not to weaponize healthcare (indeed to some extent even to improve it). Further and

larger-scale research is required to identify other cases in which similar dynamics have occurred, which could even provide further insights into how such a conception of interests can be encouraged in other conflicts.

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Table 1: Profile of interviewees (n = 12)

Role/sector	No. interviewees by role/sector during conflict	No. interviewees by role/sector at time of interview
Government	3	1
Maoist guerilla/party	2	1
NGO	2	2
International Organization	2	4
International Donor	2	3
Academic	1	1

[i] Even when medical facilities are not subject to deliberate attack, health services can still be severely undermined by armed conflict through a variety of mechanisms: accidental damage to facilities can occur; supply-lines for medicines and other vital resources can be disrupted; health workers can be forced to flee; it can become difficult for patients to travel to their nearest health facilities – and so on (Levy & Sidel 2007).

[ii] Note that this structure has changed dramatically since the adoption of the new Federal Constitution in 2015

[iv] The provision of health services did appear on occasion in statements of the Maoist's plans for their government programme after the hoped-for victory. For example, Prachanda (the *nom de guerre* of the Maoist leader)'s 'Brief Introduction to the Policies of the CPN (Maoist) (Prachanda 2004) promised a " universal health service".