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Editorial

Structural Violence

Pak Armed Forces Med J 2019; 69 (6): 1162-63

EDITORIAL

STRUCTURAL VIOLENCE AND PAKISTAN'S ONGOING INFECTIOUS DISEASE SAGA

The concept that structural violence perpetuates disease is not new[1]. It is especially true for infectious diseases as evidenced by the overlapping footprint of poverty and diseases like tuberculosis, HIV/AIDS and malaria on the global map[2]. Structural violence describes social arrangements that expose people and nations to harm[1]. Poverty, lack of education, fragile health care, inequality, elitism, gender bias and political instability are just few of the problems that resource limited countries have faced. In the backdrop of these issues, the heavy burden of infectious disease in these countries should not come as a surprise.

In Pakistan, the situation echoes that in other developing countries. Infectious diseases remain a "clear and present danger"[3]. Whether it is the Dengue outbreak of 2019, rising burden of MDR Tb, increasing XDR typhoid cases, the polio debacle or the Ratodero incident, the dismal figures are constant reminders of a losing battle.

The Ratodero HIV crisis in April 2019 can serve as a cameo to examine the biosocial phenomenon underpinning infectious diseases in Pakistan. More than 800 people were found positive for HIV, 82% of these were below the age of 15 years[4]. Another concern was that incidents such as this one could herald the start of a generalized HIV epidemic in our country[5]. Consider the setting: Ratodero, an improvished area in Sindh, where the average per capita income is abysmal with nearly 55% of the households living below the poverty line. Over 61% of the adult population is illiterate, and has poor access to social and economic services including healthcare[6]. These parameters set the stage for the risk factors which were identified for the outbreak including lack of awareness, unsafe health practices, inappropriate injection usage, substandard infection control measures and hospital waste disposal[4]. These are the social determinants that made the population vulnerable and resulted in the incident.

Dengue outbreaks are a recurring theme in Pakistan's history and have been attributed to social, demographic changes, lack of effective vector control measures, poor hygiene and sanitation as well as tenuous access to health-care[7]. Again the social arrangements seem to be the insurmountable challenge.

Tuberculosis is inexorably linked to social inequality and poverty[8]. And so are a number of other infectious diseases which are widespread in Pakistan.

The social determinants lie beyond the control of the patients or at risk populations. Clinicians as well as public health practitioners are acutely aware of the vulnerability of certain sections of society to infectious disease. The solution lies in analysing the social arrangements using a biosocial approach[2], in order to develop viable interventions. These interventions need to incorporate both clinical and social facets as described by Farmer[1]. Distal Interventions which encompass clinical aspects and include diagnostic and therapeutic modalities as well asproximal ones which incorporate programs for improvements of social circumstance for prevention of disease are required. If the ongoing saga of infectious diseases in Pakistan is to be stemmed, multilevel holistic action is needed at all levels utilizing both distal and proximal interventions.

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