2022 AMWHO REGIONAL CONFERENCE

HUMAN CONFLICT & GLOBAL HEALTH

THEME GUIDE

GILLINGS SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

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INTRODUCTION

In the words of Dr. Tedros, Director-General of the World Health Organization, ***"there cannot be health without peace, and there cannot be peace without health."*** Throughout history, human conflict has plagued several communities, resulting in infringement of people's health and human rights. Today, nearly 2 billion people are affected by conflict or violence, and by 2030, over half of these individuals are expected to experience poverty. With increased lengths of times of conflict, permeation of conflict into highly populated urban regions, heightened complexity of causes of war and conflict, and improved weapons with more significant impact, the concern for global health during these challenging times grows. 60% of food insecure individuals globally reside in conflict-affected regions.

Often times, conflict occurs in regions or countries where the healthcare system is already overwhelmed due to lack of resources and higher burden of disease, and this is exacerbated by the impacts of conflict as well. There are direct correlations between conflict and higher rates of infectious disease, mental illness, and chronic illness.[4] Conflict zones are often deprived of medical neutrality, which compromises the availability of healthcare resources and overall infrastructure to protect human health in a country or region.[1] The COVID-19 global pandemic has further highlighted the impact of conflict on addressing eminent health crises, as the WHO continues to brainstorm how to address the pandemic in war zones and regions of human rights violations.[1] The World Health Organization is committed to using health as a lever to mitigate conflict and advocate for peace. This includes the core value of ensuring that health is protected as a human right, even in conflict zones.[1]

This theme guide is designed to allow delegates to learn broadly about health as a human right for people living in regions of conflict. It is also focused on specific sub themes within this broad theme, including mental and emotional health; public health institutions and infrastructure; necessities for life; and the unique burden of conflict on children and families.

1 MENTAL AND EMOTIONAL WELL-BEING

The presence of violent conflict directly correlates to the degradation of mental health in a population. Violence, trauma, and stress are all outcomes of warfare and armed conflict and impact not only the physical wellbeing of society, but also the psychological state of the community facing the crisis. Victims of conflict are often innocent bystanders that feel helpless and hopeless in their current situation. According to the World Health Organization, about one of five people living in an area of conflict develop mild depression, anxiety, or psychosis. Additionally, one in ten people live with a moderate to severe mental disorder. In addition to victims of conflict, soldiers involved in violent conflict experience trauma and stress during deployment that can lead to the development of mental disorders. In the United States, the National Institute of Mental Health was established as a result of the disasters of World War I and World War II, which sheds light on how deeply warfare and violence disturbed the mental health of Americans. Based on a 2014 study, approximately one out of four active duty members in the U.S. developed mental illness including post traumatic stress disorder, depression, and traumatic brain injury. While these trends are seen in the United States, it is safe to assume that these trends are reflected worldwide.

Warfare and conflict as a whole remain large contributors to the development of mental illnesses. However, many times, access or willingness to receive mental health treatment remains sparse. Around the world, approximately 40-60% of military personnel suffering from mental health issues and those who could benefit from professional treatment, do not seek help due to cultural barriers such as stigma and economic barriers including cost of mental health treatment services. For other victims of war, access to professional personnel in conflict zones remains scarce and often is not catered to specific needs but is rather designed as a generic approach.

The global community has worked to help enhance access to mental health services for victims of conflict. The Inter-Agency Standing Committee (IASC) was created in 1991 to help strengthen humanitarian action globally. In 2007, IASC introduced the "Guidelines on Mental Health and Psychosocial Support in Emergency Settings" which intended to create a more structured response towards mental health in conflict zones.[8] The guidelines focus on identifying marginalized populations within conflict zones and determining their holistic needs while also addressing the mental health needs of the community as a whole. While the guidelines have been useful, they still remain only a framework. Funding and changes in practice and culture towards the treatment of mental illnesses and disorders still continue to be priorities while addressing the mental health of victims of conflict.

CASE STUDY #1 | VIOLENCE AND MENTAL HEALTH IN CAPE TOWN, SOUTH AFRICA

Violence undoubtedly affects all aspects of health, however, it irrevocably affects a portion of well-being often overlooked upon first glance -- mental health. During adolescence particularly, the brain's pathways and mental health patterns are shaped with long-term impact, and being exposed to violent social or environmental factors have alarming effects. Being around violence in younger years has the potential to cause plentiful and serious mental health concerns. In a survey of seven government co-educational schools in Cape Town, South Africa, a vast majority of respondents (84.1%) had been exposed to violence so far in their lifetimes -- taken at an average age of just 14.2 years old.[3] This statistic in and of itself is alarming, but the compounding results on mental health draw more attention. Occurrences of depression were reported among 41.2% of respondents, with 21.5% exhibiting case level PTSD symptoms and 15.6% exhibiting case level anxiety symptoms. Amongst all respondents, 13.4% had attempted suicide.[9] The vast presence of life threatening mental health conditions in relation to violence demonstrates that adolescents' health conditions are being seriously worsened by violent surroundings and impacting their long-term well-being.

Furthermore, the amount of violent exposure plays an important part in the risk of mental diseases, as increasing violent exposure levels leads to increased risk of mental health problems in South Africa. In the aforementioned Cape Town survey, adolescents who saw the most violence experienced over a fivefold increased chance of depression and anxiety caseness than those adolescents who saw the lowest amount of violence.[9] In addition, respondents with the highest violence exposure had more than ten times the odds of exhibiting PTSD caseness.[9] This further highlights socio-economic inequalities in South Africa. Inner-city communities face deep structural inequalities, a lasting remnant of the Apartheid era, that causes these communities to be more prone to poverty and, subsequently, violence.[9]

Additionally, Black children had higher odds of facing depressive caseness and PTSD in comparison White and Indian pupils, further emphasizing the racial disparities, including in mental health treatment and services, that continue to exist throughout the country.

The direct relationship between violence and mental health issues, particularly for adolescents, is one that has been established in Cape Town through this research, and likely extends around the world. The mental health issues created by times of violence, while less apparent than the physical health concerns, have many consequences, and are exacerbated by environmental, social, and economic barriers to care and the absence of broad community interventions to address these issues.

2 PUBLIC HEALTH INSTITUTIONS AND INFRASTRUCTURE

As outlined by the Geneva Conventions, a collection of international treaties and protocols of international humanitarian standards, medical personnel or those aiding injured individuals are to be protected and unharmed. Over the years additional clauses have been added to protect the safety of aids, medics, and other public health and clinical support professionals.[10] These guidelines, though designed to be adhered to globally, are often forgotten during times of conflict. The frontline professionals managing human conflict extend beyond the armed forces, and include medical personnel, hospitals and the entities that make up the healthcare systems. In warfare, 90% of casualties are civilian deaths, including those medical personnel and victims of conflict. Warfare disrupts local communities and hospitals, putting both medical professionals and patients at risk and making healthcare inaccessible. Despite the efforts of organizations advocating for human rights and fighting injustice around the globe including Doctors Without Borders and Physicians for Human Rights (PHR), medical personnel are unable to care for wounded civilians and individuals when they themselves become casualties of warfare.

Warfare also diminishes supply chains and hurts the manufacturing process of healthcare supplies as well as healthcare technology. Oftentimes, factories and other infrastructure for manufacturing resources are used for purposes related to conflict, and are thus unable to prioritize developing medical technologies. Civil unrest plagues the countries as people ponder upon new government leaders and governmental structures, sometimes forgoing prioritizing public health and safety. Most countries redirect their health professionals to warzones, leaving very few healthcare providers for the general public, creating heightened chronic illness and lack of attention for emergent health issues. In Syria, nearly 190 medical professionals were killed during the war. Further into the conflict in 2015, 95% of medics, aids, and professionals had been injured, detained, or fled the city of Aleppo.[13]

The World Health Organization launched the Surveillance System for Attacks on Health Care (SSA) which records attacks on public health institutions and personnel globally. In 2019, there were a total of 1029 recorded attacks, 328 of which impacted public health facilities and led to 201 deaths and 634 injuries in 11 countries. These statistics show the clear threat that exists towards the public health and safety of these fundamentally important institutions and personnel in conflict zones.

CASE STUDY #2 | ERITREAN INDEPENDENCE AND THE COLLAPSE OF PUBLIC HEALTH INFRASTRUCTURE

In 1970, Eritrea sought independence from Ethiopia, and communist leader, Mengistu Haile Mariam, took control. The Eritrean People's Liberation Front collaborated with the Tigray People's Liberation Front (TPLF) and other militia groups, and overthrew Mengistu Haile Mariam. Following the successful change in government, the TPLF seized power, and their leader, Meles Zenawi, became the first prime minister of Ethiopia. He did attempt to form a democratic government, but it ensured the TPLF would always remain in power. Conflict continued internally until Ethiopia's Prime Minister, Abiy Ahmed, won an election after an unfair election was conducted in favor of the TPLF. Ahmed ended the long civil war between Eritrea and Ethiopia. However, soon after, Ethiopia began attacking one of its own regions, Tigray. With their new ally, Eritrea, they began attacking Tigray, marking a civil war. This conflict has killed thousands and forced many to flee to nearby countries like Sudan.

The country's citizens have experienced famine, destruction, and trauma and the war, itself, has greatly impacted the healthcare system. Before the war, Tigray had one of the strongest health systems and public health infrastructure in Ethiopia. However as of January 2021, only 5 of 40 hospitals in Tigray were functioning, with Adrigat Hospital, one of Tigray's largest hospitals, functioning at very low capacity. Médecins Sans Frontières (MSF) found that over 70 % of Tigrayan health facilities have been rendered unusable as a result of conflict. This has reduced access and quality of care for those in the region who need it most.

Cases of sexual-gender based violence (SBGV) increased with the war, and due to lack of health institutions, survivors have not received adequate physical health support or counseling services.[18] Pregnant people have not been able to access antenatal care, postnatal care, or labor and delivery services, leading to a increase in deaths due to complications resulting from childbirth.[18] Furthermore, people impacted by chronic illness including heart disease and cancer have died because there is no healthcare infrastructure to prevent or treat their illness. Wartime conditions have also dramatically reduced access to food and clean water, exacerbating existing public health concerns regarding water sanitation and nutrition.

The collapse of health infrastructure due to wartime conditions will extend beyond times of conflict, and will require intentional approaches to rebuilding structures and improving them to be more prepared and able to manage future times of conflict.

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3 NECESSITIES FOR LIFE: WATER, FOOD AND SHELTER

The concept of 'necessities for life' is generally universally accepted. In fact, world leaders, government organizations, and civilians have long advocated for the delivery of said basic necessities to all people, which include but are not limited to stable and safe shelter, clean water, and nutritious food. There have been several disparities in the availability of these resources for several reasons throughout history and currently through several nations including socioeconomic barriers, political dispute, land degradation and climate change. The experience of violence takes a uniquely perilous toll on individuals', and populations', access to basic life necessities.

When an area experiences significant violence, vital resources decline as a nearly airtight effect. Research substantiates the relationship between violence and food and water insecurity. Countries which experience "significant violent conflict" have a high risk of famine.[1] This relationship is reversible and cyclical, as food insecurity causes violence on the grounds of scarcity, and violence leads to food insecurity due to resources being diminished. The Homeless World Cup Foundation describes the profound impact of violence on access to stable housing and shelter, with Ghana, Nigeria, the Ivory Coast all respectively saw 66,000, 541,000, and 3,900 people displaced by violence.

Access to basic necessities of life are profound social determinants of health, leading to cyclical damage to health and well-being as people experience a lack of access to these resources. When an individual lacks access to food, water, or shelter, there can be negative impacts on their mental health, safety, and relationships, as well. Designing solutions to protect access to basic life necessities during times of conflict are crucial to ensuring that global public health is protected, and is one step to improving quality of life for people living in conflict zones.

CASE STUDY #3 | THE INDIA-PAKISTAN CONFLICT OVER THE INDUS WATERS

During the post-Partition period of the India and Pakistan divide, both countries held disagreements over the flow of the Indus River, which irrigates 65% of Pakistan's agricultural land. The Indus Waters Treaty (IWT) of 1960 led to a temporary agreement, with India claiming ownership of the Eastern waters and Pakistan claiming ownership of the Western waters in addition to getting financial compensation. However, the treaty has steadily eroded due to additional social and political concerns.[21] Currently, India's government has planned to build a dam within its borders, which may lead to an increase of water flow to India, in addition to the already heightened water flow as a result of India holding control over the upstream portion of the river.[21]

In 2019, Pulwama terrorist attacks that killed 40 Indian Central Reserve Police Force (CRPF) personnel, heightened tensions between the two countries. In response, Indian government officials in New Delhi stopped the flow of water by building a dam in the Ravi River. Narratives of Islamic-terrorism in Indian media and narratives of poor Indian water management in Pakistani media have been fuel for justification for avoiding diplomacy.[23] Pakistan is one of the most water-stressed countries in the world, and Indo-Pakistan conflicts place additional strain on their citizens who are seeking water access and Pakistani farmers whose sustenance depends on access to these water flows.[23] 90% of Pakistan's food comes from farming and the animal industry and 65% of Pakistan is employed in agriculture; lack of access to water could have broad impacts on financial security, food access, and the health of the population.[23]

There are several criticisms of the Indus Waters Treaty, including that it does not promote collaborative development of the Indus River Basin between India and Pakistan. Additionally, the treaty does not define a measure for water distribution, creating opportunity for exploitation of water resources.[23] Furthermore, it does not incorporate the impacts of climate change nor regional access to water in addition to national access.[23]

Scientific projections show that beginning in 2050, the river will be dry for specific seasons leading to energy and water shortages, and significant impacts on several industries.[22] Both countries would face significant impacts from these environmental conditions, in addition to the already present conflict, which may set precedent for handling future similar situations.

4 BURDEN OF CONFLICT ON CHILDREN AND FAMILIES

Children and family health is greatly threatened by the presence of armed conflict and violence. Over 10% of children worldwide, or 246 million children, live in regions that are affected by armed conflict, resulting in harm to both their physical and mental health.

Conflict affects children's physical health as they engage in or are surrounded by traditional and chemical warfare and sustain injuries. Young women are at heightened risk for sexual assault and gender-based violence, making them vulnerable to psychological trauma and sexually-transmitted infections. Schools, though formerly considered safe environments during times of conflict, have become a central location of armed conflict zones, as this is where child soldiers are often recruited, and they have been locations where militant entities center their forces.[24,25] Children have reported being harassed while pursuing daily activities, either as an activity of combatant forces or to be pressured to join these forces. The waning of the coronavirus global pandemic presents an opportunity for heightened conflict and warfare and the subsequent risk of increased recruitment of children in this manner, especially as schools reopen simultaneously.

In addition to direct harm, conflict also impacts social determinants of health, leaving families and children vulnerable to health threats. Due to wartime circumstances, primary sources of family income are compromised, causing children and families to lose stable access to food and housing and subsequently have adverse physical, behavioral, and psychological health outcomes.[19,20] Families have also been separated by times of conflict, with many children losing all of their guardians to wartime circumstances or death, and therefore losing access to necessities to sustain life. In 2017 alone, over 18,000 cases of family separation were being addressed by the International Committee of the Red Cross, and thousands of women and children were reported missing. These statistics do not include unreported cases of family separation and missing people, which is likely high due to the lack of access to reporting services in these environments.

Several studies have determined that the adverse impact of warfare on children requires psychosocial interventions for all children who live and/or grew up in a place of warfare, regardless of their involvement in the conflict. The American Psychological Association has also suggested that for families impacted by conflict, designing interventions for family members is as important as designing interventions for children themselves.

Impacts on the psychosocial and physical components of health due to conflict in such early childhood can bear longitudinal impacts that affect well-being throughout life. Damage to family structures can create additional barriers to well-being and quality of life. For these reasons and due to the disproportionate burden of conflict on women, children and families it is important to formulate targeted interventions to support these populations living in conflict.

CASE STUDY #4 | CHILD SOLDIERS IN UGANDA

In many countries, child soldiers are a fundamental and crucial aspect of the military force and activities, particularly during times of conflict. These children are forced to participate in armed conflict or other wartime support functions, including cooking, spying, manual labor, and sex slavery. Due to the nature of armed conflict and warzones, there are several lasting impacts on a child soldier's physical, mental and behavioral health. Child soldiers on the front lines of combat have a significantly higher mortality rate than adult soldiers.[24] The health impacts that child soldiers face extend through society and communities for generations, impacting the economic security and general well-being of many countries. Many former soldiers lose the ability to achieve their full potential, as they deal with the health implications of being child soldiers and attempt to compensate for academic time lost. When large proportions of a country's child population in a given generation dedicate their time to serving as child soldiers, there is a reduction in productivity in the future.[29]

In Uganda, the government opposition group, Lord's Resistance Army, has one of the highest child soldier recruitments in the world. Child soldiers in Uganda have faced high rates of posttraumatic stress reactions. In one study, 97% of child soldiers interviewed reported symptoms of posttraumatic stress. Additionally, though PTSD is present in all children in warzones, child soldiers who fought in the Ugandan warzone have a 14% higher rate of PTSD than other children. Many children refer to their time in the warzone as "better" than their time after coming out of it, because of the challenges of becoming accustomed to normal life again. Child soldiers also faced deep isolation, leading to compromised social and emotional skills and ability to connect with others. [,31]

Many children were forced to forego key aspects of their identity such as their home, parental and familial background, and cultural values to be in the Lord's Resistance Army, which created long term adverse social impacts as well. Children were also asked to partake in killings of their own family members, or suicide bombings. A disproportionate number of girls were part of the suicide bombers, making up 75% of them, but only 40% of the armed force. Girls also demonstrated a higher rate of anxiety and depression afterwards, and a more hostile relationship with boys and men in their lives.

To address these long-lasting impacts, the United Nations Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict stated that all children involved in armed conflict must immediately be demobilized and provided comprehensive psychological, physical, and social reintegration services. Furthermore, additional research about Ugandan child soldiers highlighted that access to high-quality psychological care to guide reintegration into society would be more beneficial to these individuals than academic support for lost school years. While these actions facilitate support for child soldiers, states must strive to prevent the need for services, by protecting the emotional and physical well-being of child soldiers and through policy and community-based interventions.

The forced labor of children as soldiers during times of conflict further highlights the heightened vulnerability and marginalization of children and family structures and demonstrates that these populations require additional interventions for the protection of their health and safety.

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CONCLUSION

The WHO Constitution of 1948 declared that all people have the right to "enjoy the highest attainable state of physical and emotional health." People in conflict zones or violent environments are often deprived of this due to the conditions in which they must survive, the lack of structured support in their environment, and the constant uncertainty of their situation.

This regional conference provides a platform for delegates to consider the magnitude of impact that conflict has on health as a human right, and avenues of mitigating this impact. Delegates must consider the unique landscape of conflict in their country, including the impacts of intrastate and interstate conflict on their country, and design solutions to protect health as a human right in the context of this landscape. The primary goal of this conference is for delegates to craft policies that advance the overall well-being of the world. While this goal is central to the World Health Organization, delegates should also center the core values of their country or organization in their advocacy regarding different policy solutions.

Delegates will look at the issue of conflict and its impact on health as a human right through the lenses of four different sub themes which include mental health, public health infrastructure, protection of basic necessities, and children and families. The mental health subtheme will examine the unique short and long term mental health impacts of conflict on people within and adjacent to conflict zones. Delegates will collaborate to design solutions that address mental health as a part of whole-person well-being, and affirm the necessity for mental health services as a human right. Several countries experience damage to their public health infrastructure as a result of conflict, particularly due to a weakened government and diminished resources to distribute for public services. The public health infrastructure subtheme will focus on how to prepare, reinforce, and rebuild public health infrastructure that is compromised as a result of conflict. Conflict, especially in impoverished areas, results in damage to access to life-sustaining resources such as food and water. The basic necessities subtheme will identify the different life-sustaining resources that are disrupted by conflict (i.e. food, water, housing) and determine how to maintain a reliable supply of these resources globally. The children and families subtheme will explore the specific health and safety concerns for women, children, and their families during times of conflict, and how to mitigate these concerns through solutions oriented and designed for this population. At the end of the conference, subtheme committees will come together to amend proposed policy solutions and synthesize their proposals into a single working document about addressing health as a human right during times of conflict.

We hope that delegates will collaborate and synthesize their perspectives to institute solutions that protect health as a human right and utilize the advancement of public health as a lever of peace during times of conflict.

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