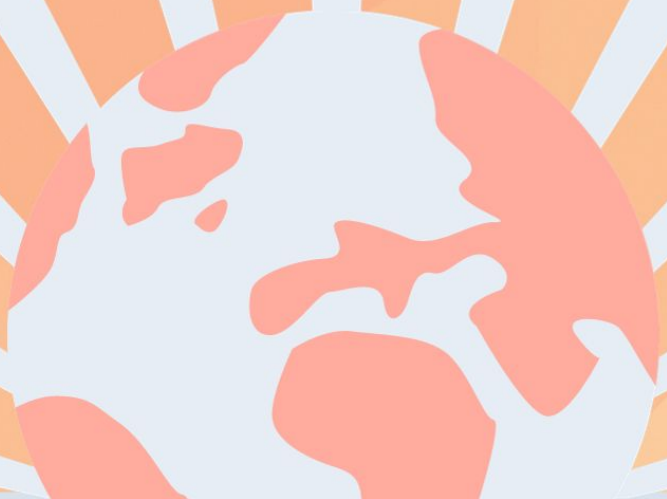
AMWHO

Rectifying Historical and Contemporary Prejudices and Oppressions Undermining Global Health

International Conference 2024 Theme Guide



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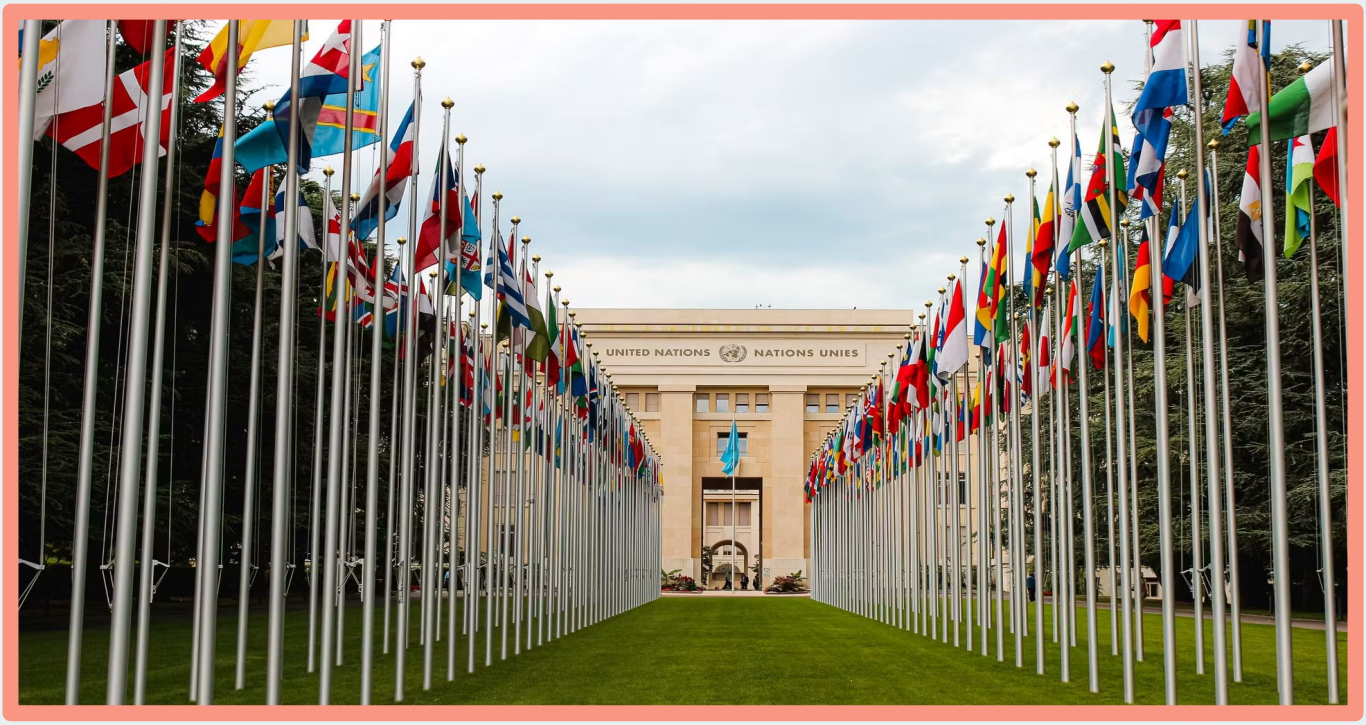
INTRODUCTION

"History, despite its wrenching pain, cannot be unlived, but if faced with courage, need not be lived again." - Maya Angelou

"Prejudice is a burden that confuses the past, threatens the future, and renders the present inaccessible." – Maya Angelou

These are truths uttered from the mouth of a great poet, who could discern that the past and the present are not a dichotomy, but periods in a timeline that are interconnected. Contrastingly, there has been a failure within the global community to properly address entities in the past such as colonialism and imperialism as well as contemporary oppressions that impact global health. The Rohingya in Myanmar have been forcibly displaced and thus made more susceptible to communicable diseases such as cholera and typhoid; people of color continue to face systemic oppression within the U.S. healthcare system; shadows of colonialism and histories of medical experimentation have created an epidemic of medical mistrust; and femicide and oppression against gender and sexual minorities are rampant in many parts of the world and are a source of premature deaths. Both the past and the present propose painful realities, and it remains imperative that public health leaders recognize and rectify these realities that are at the very essence and core of global public health.



Make no mistake: **the past informs the present and the present informs the future.** To combat the inequities and inequalities present in global health, a lens of social justice must be fitted. In the words of Paul Farmer, the co-founder of Partners in Health (PIH) and a public health leader: "Medicine should be viewed as social justice work in a world that is so sick and so riven by inequities."

The word ***oppression*** refers to a combination of prejudice and institutional power that creates a system that regularly and severely discriminates against some groups and benefits other groups.[2] In the context of health, long-standing intersectional systems of oppression can put individuals at higher risk for contracting certain conditions, disrupt critical physiological processes essential to maintaining good health, and deprive individuals and communities of critical health protective resources.[1] In other words, these **systems of oppression have induced inequality on all levels of an individual's livelihood**. It would only be a continued disservice to ourselves as a global community to turn a blind eye to historical and contemporary oppressions because it leaves us vulnerable to these continued conditions of inequality. In what ways do the origins of tropical medicine and its links to colonialism impact global health? How does racism influence health outcomes and quality of care? How do systems such as patriarchy relate to mental and physical well-being? What bearing do previous wars and persecutions have on current health inequalities? These are the types of questions that we must ask ourselves as future global health leaders. We must have both the support and the courage to address these inquiries and their implications.

Delegates will examine existing inequities and inequalities in global health by looking at historical and contemporary injustices of humanity. The purpose of this guide is to establish the clear relations between prejudice/oppression and the state of health. In doing so, five sub-themes will be explored: **The Effects of Colonialism and Imperialism on Global Health; Racism in Health Care; Ethnic Persecution and Health; Gender, Sexual, and Queer Violence; and Migrant Health and Religious Persecution**. Each subtheme will contain two case studies that will help to better contextualize these patterns of inequity and inequality. During the coming 2024 AMWHO International conference, delegates will commune in their respective regions and discuss these issues at length, engaging in a respectful, courteous, and insightful manner for the purpose of curating fruitful solutions.

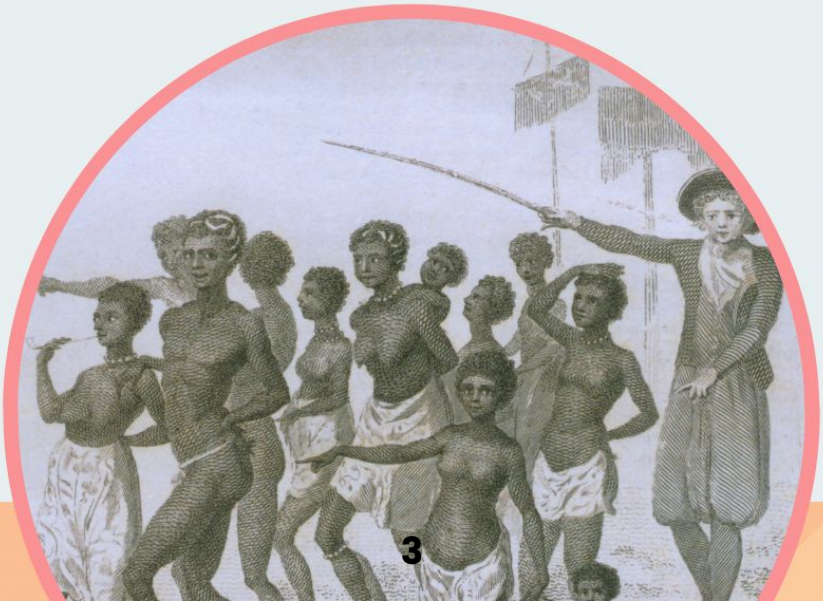
We encourage delegates to act with courage and utmost respect when reading and discussing the materials within this guide. The case studies are extremely sensitive works that contain painfully enlightening historical and contemporary realities that reference racial, ethnic, gender, religious, and sexual violence. Please treat yourselves, your fellow delegates, and the material with respect, courtesy, and empathy. These studies are not just written words, **they are the stories and lived histories and realities of our fellow human beings that we can learn from in order to shape better global health policy**. In the words of Audre Lorde: "All oppressions must be recognized and fought against simultaneously." Let us recognize and rectify for the sake of a healthier world.

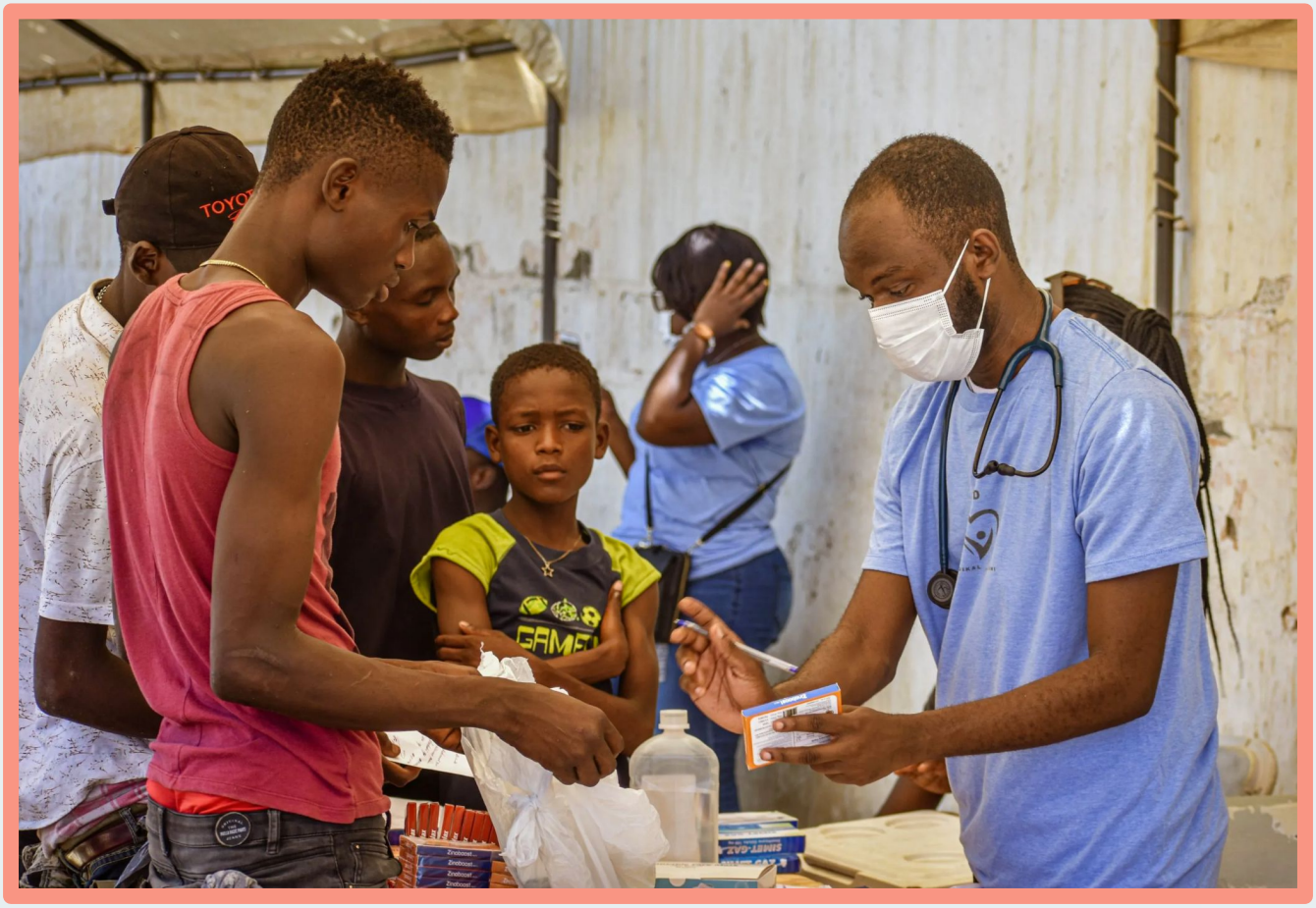
SUBTHEME #1

EFFECTS OF COLONIALISM AND IMPERIALISM ON HEALTH

Colonialism as an entity and practice was upheld through **enslavement, exploitation, devastation of culture and identity, and dehumanization**. It is the practice of domination and exploitation of one country over another. Colonialism was the spark that kindled globalization, but it is also the very thing that has carved a deep and painful scar over much of the world. The remnants of colonialism are alive and well, and they exist in almost every corner of humanity. These effects are most obvious when observing the crippling impact on health infrastructures in post-colonial countries. The current architecture of global health has been called several names throughout history: colonial medicine, tropical medicine, and international health, all of which harken back to colonialism.[1] From its use as a scientific rationale for assigning racial superiority and inferiority to its restrictions on the movement of indigenous people in the name of infection control, the injustices against people of color in the name of medical progress has long been woven into the history of global health.[1]

The highest mortality rates among Africans followed long periods of contact with colonizers.[2] Moreover, higher rates were associated with prolonged and hostile interactions.[3] Evidence shows that colonial health campaigns and blood transfusions, including using unsterile syringes and contaminated blood, contributed to Human Immunodeficiency Virus (HIV) transmission.[4,5] Thus, it is no surprise that **descendants of colonized populations often distrust modern medicine**. In helping to improve healthcare systems that have been weakened as a result of colonialism, Paul Farmer argues social medicine should be based in context, and involve "looking around (at what's going on outside the hospital) and looking back (in time)," such as at exploitation that made natives fearful.[3]





Increasingly, as modern medicine evolves, social medicine examines delivery and how to best deliver solutions to those with the highest need for them. With colonial rule defined by extractive goals, this question was rarely posed. The focus was largely on finding pathogens and developing treatments. Then, if discoveries were made, **treatment was limited to those viewed as deserving, which tended to exclude those most in need, such as rural areas that poor populations disproportionately resided in**.[3]

Global health in the colonial era was used for the sake of protecting the interests of those in power. This mindset continues to persist in the present day: it is sometimes masked behind select non-governmental organizations (NGOs) or health research efforts that are launched in the global south. While some efforts are helpful, these two institutions help to perpetuate dependency as well as exploitation. Much of the medical and public health research that is conducted, especially as it pertains to infectious diseases, is used to benefit Western countries in informing health practices, vaccine and pharmaceutical developments, etc. Secondly, many of the projects that are launched either in the research or clinical sector are led by Western individuals or institutions rather than native ones, which contributes to **a relationship of dependency**.

In order for the decolonization of the global health movement to succeed, **the world's political economy must be decolonized, which involves addressing socio-economic inequity that was exacerbated by colonization**.[6] Health, as a fundamental human right, cannot stand alone without a peaceful and prosperous society.

Case Study - Shadows of Colonialism in Haiti: Impacts of Treating Tuberculosis and HIV/AIDS

As Paul Farmer once said: **"Haiti's problems are not acute, they're chronic."**[7] This statement is not just referring to the after effects of the 2010 earthquake, rather, it encourages one to look deeply at the roots of Haiti's infrastructure failings, which germinated in colonial times. The epidemics of HIV, Acquired Immune Deficiency Syndrome (AIDS) and Tuberculosis (TB) are the leading causes of young adult death in Haiti. The emergence and persistence of these diseases are **intricately connected to European expansion in the New World and the slavery and racism embedded within the mindset of colonialism**.[7]

Many of Haiti's issues of abject poverty, crime, accidents, disease, and natural disasters are seen as being locally derived with little-to-no connection to underlying histories which further demonstrates the tactics of historical erasure being employed. This erasure gives rise to **structural violence**, a term that was coined by Johan Galtung, a Norwegian sociologist and mathematician, and is used to describe the **social and economic inequalities that are built into the fabrics of social, political, economic, and health systems that govern lives**. The coming paragraphs will describe the colonial history of Haiti and its influence on health infrastructure, contemporary health infrastructure failings within the country, and the decolonization of the global health movement.

The colonization and relatively recent occupations of Haiti have carried over many health consequences and policies that influence current global health practices and organizations.[8] Haiti—formerly known as St. Domingue under French colonialism—was France's most important and lucrative colony. It is estimated that by the late 18th century, two-thirds of all of Europe's tropical produce and a great deal of French wealth was incurred from Haiti, and in the words of Bernier: "It was paid for in human flesh…".[7] According to Klien, approximately half of the enslaved Africans who crossed the Atlantic were bound to a single colony: St. Domingue. In any one year, over 600 vessels would visit the ports of the island to carry goods to European consumers.

Haiti declared its independence in 1804 after enslaved Africans and their descendants overthrew the French regime during the Haitian Revolution. France's refusal to lose such a "profitable" colony led to the deployment and expedition of the largest armada to ever cross the Atlantic.[7] In the years that followed independence, the U.S. and allied European powers helped France to orchestrate a "diplomatic" quarantine of Haiti. "The [U.S.] refused to recognize Haiti's independence until 1862…**This isolation was imposed on Haiti by a frightened white world, and Haiti became a test case, first for those arguing about emancipation and then, after the end of slavery, for those arguing about the capacity of [Black people] for self-government."**[7] Roughly a century after the revolution, the Caribbean nation was subjected to American occupation.

The American Rockefeller Foundation played a huge role in protecting American interests through packaging public health and medicine in the form of foreign policy, technical execution, and masked philanthropy.[8] During the U.S. occupation of 1915, U.S. Marines utilized the Rockefeller Foundation to finance a network of rural clinics and other health infrastructures in order to protect American soldiers from tropical diseases. Many hospitals and laboratories were built or converted and contributed to the study of sanitation in the context of tropical medicine in Haiti. This was based on the fear of European colonizers towards the ruthless endemic and epidemic diseases, such as tuberculosis, yellow fever, and dengue, within the climatic regions of the African, Asian, and American colonies. [8] In the words of Wake Forest University Professor Mary Agnes Palilonis: **"The scientific advancements coming from universities of Western countries were largely used as tools to protect colonists from tropical diseases and to control and civilize native populations."** That being said, the termination of U.S. occupation in 1934 was coupled with the American Rockefeller Foundation ceasing to finance Haiti's health infrastructure. The end of the U.S. occupation not only destabilized the country politically and economically, it also gutted the health programs and abandoned them to a fate of painfully slow development. In the words of Tacitus: "They created a desert and called it peace…

"In Haiti, the past is present." As Farmer so eloquently puts it: **slavery, racism, former colonization, and occupation are an ever-present shadow in Haitian society.** To quote Sidney Mintz, the late anthropologist: "If there ever were a society that ought to have ended up totally annihilated, materially and spiritually, by the trials of 'modernization' [slavery, racism, colonialism, occupation], it is Haiti." The development of Haitian health care systems continues to meet faults due to foreign political agendas, including trade and aid embargos.

This has been especially detrimental when looking at the prominent co-killers in Haiti: HIV/AIDS and TB. While HIV/AIDS weakens the immune system's ability to fight off infections, tuberculosis delivers the death blow, and the distribution of HIV/AIDS and tuberculosis aligns with patterns of slavery in previous times.[7] **HIV/AIDS and TB are exacerbated by brute poverty and have always disproportionately impacted the poor.** As the poorest country in the Latin American and Caribbean region, Haiti makes a perfect breeding ground for HIV/AIDS and TB. There are approximately 206 cases of TB per 100,000 Haitians.[9] Approximately 150,000 people in Haiti are HIV positive.[9] Among people living with HIV in Haiti, roughly two-thirds are aware of their status while only 58% are receiving treatment.[10] There lies a margin of error within these values due to underdeveloped national disease surveillance.

In order to address the harmful synergy between the past and present that manifests itself within Haitian development and health systems, the international community must take steps to decolonize global health. **The decolonization of global health refers to the "reversal of colonial legacies in health equity work."**[11] Similar to how tropical medicine was employed for the sake of protecting colonizers, current global health research remains a form of plunder in strengthening those who are already powerful (high-income countries) while decimating low-income countries.[11] Almost all current campaigns in global health and related fields, such as climate change, universal health coverage, and previous campaigns on HIV/AIDs, TB, and malaria are all initiated and led by people born and raised in HICs.[12] **Limited projects are being led by individuals and institutions in low-to-middle-income countries**.[11] This same pattern can be seen in the fragmented efforts of foreign health interventions: Haiti has been nicknamed the "Republic of NGOs" because it has the largest number of nongovernmental organizations per capita. Nearly 80% of Haiti's basic health services are provided by the private sector, with approximately 10,000 NGOs nationally, a number that has increased since the 2021 earthquake.[11]

On the surface, the large number of foreign aid within the country seems promising. However, it fits an old mold, as **practitioners are delivering healthcare in a way that further cripples the local healthcare system and deepens dependency on external help.**[12] The colonial legacies that remain in global health include anything that perpetuates the inferior status of the people and system on the receiving ends of global health services.[12]

Case Study - Ebola Tied to Colonialism in West Africa

Early detection of Ebola, a viral hemorrhagic fever, is key to controlling the virus. However, by the time health officials determined Ebola was the causative agent of escalating deaths in Guinea on March 23, 2014, it had been spreading for nearly three months.[13] **Sierra Leone, Liberia, and Guinea were three West African countries affected disproportionately by the Ebola epidemic** and are among the poorest nations globally, with per capita gross incomes around $500, fewer than 200 doctors (amounting to a ratio of one or two doctors to a population of 100,000), and scarce expertise in infectious disease.[14,15] The epidemic further reduced this ratio, with 700 medical professionals infected, half of whom died, within a single year.[13] According to Paul Farmer, such weak health systems lack the "staff, stuff, space, and systems" required to stop Ebola.[16]

A century and a half of colonial disregard for the health and welfare of West Africans, while exploiting their labor and land to extract abundant natural resources, left a dearth in healthcare.[17] Despite high economic growth and significant wealth produced by sales of diamonds, minerals, rubber, timber, and other resources, negligible revenue was allocated to colonial health systems and local directives. Subjugated populations were expected to generate their own wealth in the midst of exploitation. Thus, there was rarely sufficient money to develop health services that matched needs.[18] Extractive and forced labor increased illness and injury, consequences of structural violence.[19,20] **Besides physical ailments, the trauma of slavery, capture, recapture, and release, as well as cultural disruptions of being forcibly resettled, caused mental health problems among Africans** to surge, leading the British to establish the Kissy Lunatic Asylum, the first West African psychiatric institution in 1817.[21]

Farmer describes the colonialist public health approach as a "control-over-care paradigm" that induced fear rather than comfort and ultimately influenced poor responses to Ebola.[21] In Guinea, French colonists' response to epidemics included destroying houses, restricting and segregating building codes, quarantine, isolation, fines, and other consequences for minor offenses, all of which had negligible impact. This strict disease control was applied discriminatorily to natives, sparing Europeans and their businesses. **Medical care for natives was frequently second rate to whites.** Colonial health officials often denied offers of therapies and treatments for natives while seizing them for themselves, and they largely viewed epidemics in West Africa as hopeless; once Africans were ill, colonists neglected clinical care and did little beyond sanitarian campaigns that emphasized containment. Few to no natives were permitted to serve in colonial healthcare positions.[21]

Post-independence, health ministries continued to receive little investment, which worsened when governments adopted structural adjustment plans. The meager amount of investment was largely siphoned towards urban areas.

Additionally, internationally forced austerity measures compelled governments to continue to take an approach of discipline in healthcare delivery rather than engage in care.[21] With a failure to include Africans in governing their own country or healthcare roles, it is no surprise that following independence, **former colonies frequently had inadequate healthcare systems and devolved into instability or civil war. Political unrest that led to civil war exacerbated the situation, with hospitals destroyed, ransacked, abandoned, and reappropriated as bases for rebel groups.**[17] Exemplifying this, the epicenters of Ebola outbreaks were often these locations of high conflict during civil wars from 1991-2002 in Sierra Leone and 1989-1996 in Liberia.[9] Already deficient medical training and other tertiary education was discontinued, and many knowledgeable medical professionals fled, contributing to the phenomenon of "brain drain" when healthcare professionals migrate from home nations with crippled healthcare systems in favor of better conditions in more developed nations.[22]

Contrary to the insistence of some that Ebola was entirely new to West Africa, serological evidence has shown that Ebola existed in the region.[23] During the discovery of Ebola in the 1976 outbreak in the DRC, there were 318 cases, with an extremely high fatality count of 280 deaths. A 1976 report by a World Health Organization (WHO) task force investigating the outbreak discusses extensive clinical and epidemiological information about the novel virus.[24] Therefore, when Ebola reappeared in 2013 in West Africa, the virus was known and tools had been developed to mitigate it, but they were not deployed. Colonialism has cast a long shadow on development across all of Africa. In West Africa, **leaders lacked the experience, support, and infrastructure necessary to confront Ebola, and the international community focused on containment and prevention of spread across borders**. This resulted in the absence of basic support and clinical care. In turn, local physicians feared the virus, which was heightened by the no-touch policy due to inadequate PPE. Moreover, **blame fostered resentment among physicians, patients, and families**. When an elderly woman died of Ebola in August 2015 in Sierra Leone, the government deployed its military and fenced in a village of nearly 1,000 civilians for three weeks, without extending additional healthcare. The director of the National Ebola Response Centre blamed the civilians, who needed to "stop doing what I call 'the silly things,'" things that included caring for sick family members and performing illegal cultural rituals after death.[21] Anthropologist Susan Shepler encountered widespread doubt among Sierra Leoneans that the virus even existed and the belief that it was fabricated to enrich corrupt politicians and allies. This stems from trauma experienced under self-serving governments spanning from colonial to contemporary leaders, who frequently reappropriated finances allocated to strengthen health services.

The absence of national health surveillance was exacerbated by the WHO, who failed to act despite repeated warnings from May to July 2014.[26] The creation of the United Nation's first health mission, the UN Mission for Ebola Emergency Response (UNMEER) was viewed by many as an admission of the WHO's failure to respond.[27] In October 2014, a draft internal review of the WHO's management of the outbreak leaked, in which they wrote that the agency should have recognized the ineffectiveness of traditional containment methods in a region with deficient health systems.[28]

However, the Director-General attempted to evade responsibility, stating, "The government has first priority to take care of its people and provide health care."[26] With unstable, severely under-resourced governments in West Africa, this is largely impossible. Additionally, against numerous warnings of a humanitarian crisis and danger, the WHO did not invoke the International Health Regulations (2005) (IHR), which is designed to frame national rights and obligations in public health emergencies.[29]

As the West African region suffers from severely poor health and welfare, lack of investment in health, high rates of preventable morbidity and mortality, limited laboratory infrastructure, and health surveillance, all of which aggregate risk of epidemics, it creates a **"public health desert"** in which Ebola and other pathogens prosper. With more robust systems and clinical care, the outbreak could have been limited and contained earlier. Proper care necessitates "emergency rooms, intensive care units, and operating rooms," Farmer notes, resources that these West African countries largely lack and are often absent from international recommendations to bolster health systems.[21]

According to Partners In Health (PIH), proper care for Ebola necessitates constant fluid maintenance, as 10 liters can be lost a day, and doing everything possible to help the defense system mount its immune response.[26] A response team of caregivers wrote "After spending much of the past five months treating patients with Ebola virus disease, we are convinced that it's possible to save many more patients. Our optimism is fueled by the observation that supportive care is also specific care for EVD– and in all likelihood reduces mortality. Unfortunately, many patients in West Africa continue to die for lack of the opportunity to receive such basic care."[30] In early 2015, Hastings, the largest Ebola Treatment Unit (ETU) in Sierra Leone, wrote a letter recording a gradual decrease in fatality rate over three months, from 47.7% to 31.5% to 23.4%, using therapeutic interventions coined "the Hastings Protocol" that involved aggressive fluid restrictions (multiple liters of lactate and dextrose saline daily and ORS), a range of antibiotics, vitamin K injections to reduce bleeding chances, antimalarial treatment, antidiarrheals and antiemetics, and nutritional supplements.[31] Supportive care offered by Hastings is cumbersome to administer in rural West Africa, which tends to be deficient in stable electricity, running and clean water, timely transfers from remote towns, and robust clinical treatment.[21]

In any epidemic, victims require care, empathy, and support. Farmer describes how **West Africans scarcely received any help beyond that from family and friends. He found that ETUs fell severely short of needs, neglecting aggressive supportive care and critical care.** In these facilities, patients received an estimated one to two minutes of medical attention per shift, one laboratory test (which was almost always the test for the Zaire species of Ebola), and rarely had basic vitals taken. Without clinical care and basic lab tests, when many of these patients experienced organ failure and required prompt medical intervention, it was nearly impossible to discern whether electrolyte abnormalities, hypovolemic shock, or some other fatal condition was at fault.[21] While experts advocated for ETUs to treat Ebola early with intravenous fluid and electrolyte replacement, experts from Medecins Sans Frontieres (MSF), a leading health NGO in the international Ebola response, denied its effectiveness and argued against aggressive treatment.

Despite evidence that oral rehydration salts (ORS) were ineffective for severe cases of Ebola, quickly into the epidemic, MSF announced the termination of intravenous fluid resuscitation and lab tests and recommended ORS as the only treatment for Ebola. In a discussion with Dr. Moses Massaquoi, a hospital administrator and the director of the Clinton Foundation in Liberia, Farmer heard of the unhappiness among the Liberian staff working in the ETUs, who were frustrated with the knowledge that they couldn't help patients without intravenous fluids.[21]

According to Guinea's Ministry of Health, 60% of cases nationally were connected to traditional burial rites.[13] Failure to abide by regulations is often boiled down to disobedience and persistence of cultural practices. While measures of containment can be effective at halting transmission, chances of success are significantly higher if they are paired with purposeful efforts to administer clinical care and work within the parameters of culture, not against it, as well as strive to reconcile barriers and distrust at their root.[21] This was not the case in the Ebola response in West Africa. **Medical authorities were not "welcomed warmly in the absence of medical care, social assistance for the afflicted and quarantined, and personal protective gear for those bound to care for them,"** Farmer argues. At the onset of a frightening epidemic, locals sought assistance in caregiving but received martial, restrictive, and prejudicial treatment, as well as disrespect and criticism of cultural standards rather than support to adapt them. Frequently, **distrustful West Africans were hesitant to abide by government recommendations** and take those with Ebola to ETUs. This reluctance derives from fear, as those infected often did not improve with treatment and were likely to perish in units due to lethality and lack of knowledge about the virus. Additionally, many held misconceptions that white people were stealing patients, originating from actions during the slave trade. Avoidance of hospitals has largely been attributed to superstitious rumors. However, mid-epidemic the CDC website advised avoiding hospitals as a preventative measure.[21] **Additionally, populations in rural West Africa face challenges in accessing health care and abiding by public health measures, like social distancing, due to dependency on agricultural and manufacturing sectors.**[21,33] Being confined for three weeks (the recommended Ebola quarantine period), when villagers often lack running water, struggle for sustenance, rely on daily wages from labor, and have no delivery services, is often not an option.[21]

Extractive colonial industries continue to work against West Africans. Though concerns were raised about bushmeat perpetuating Ebola, Farmer points out there were negligible efforts to provide PPE, including gloves and soap, to those handling bushmeat. Similarly, those performing burials, which have a significant risk of Ebola spread, lack health professionals to guide them in wearing PPE. This is ironic given that latex for PPE and palm oil (used to manufacture Palmolive soap) are native to West Africa and have been harvested since colonial times. Instead of placing blame, Farmer argues for the need to address pathogens and pathogenic forces that compel natives to eat unsanitary meat to survive, including diseases such as malaria but also malnutrition, increases in the cost of food, or being forced to flee into forests due to civil war.[21]

While the effects of colonialism are certainly damaging, efforts and developments have been initiated by governments and organizations to rectify its effects, such as the discovery of an effective Ebola vaccine.

Logistical barriers in low-income countries, such as lack of cellular service, barely accessible towns, and the need to refrigerate the vaccine at -80 degrees Celsius were overcome. Within a month of an outbreak in the Congo in 2018, 700 people received the vaccine in Mbandaka, DRC.[21] Disease responses since the height of the epidemic have been faster and more robust, with anthropologists, religious leaders, and local leaders asked to address mistrust within communities. UNICEF collaborated with both the government (Guinea-Bissau's Secretary of State of Social Communication) and the National Institute of Public Health to create a sensitization training with local leaders of islands neighboring Guinea to prevent cross-border cases. UNICEF and the Guinea government recognized that trusted traditional leaders and healers more effectively reach their communities, promoting preventative, healthy behaviors like delaying funerals, handwashing, and following up on symptoms with health services.[34] In 2018, the WHO's emergency committee organized 10 days after being notified of an Ebola Case in the Congo, compared to in 2014 when they did not meet until after 1,000 people had died in West Africa.[35]

The government hospital in Koidu, a city in the core of Sierra Leone's diamond sector, was debilitated and almost closed by Ebola's destruction. However, by the end of 2014, Partners in Health and Wellbody Alliance employed over 300 staff and brought general anesthesia, an x-ray machine, full-time electricity, and blood for transfusions. They established an Ebola lab led by well-trained Dutch technicians who trained many local lab techs. Despite the cost of these services, the Koidu hospital and clinic as well as other public hospitals provided them free of charge, which is often the only way impoverished, diseased people receive treatment. The Koidu hospital worked to mend distrust that caused locals to avoid hospitals. One American physician said, **"Over the past nine months, we've worked to address these deficiencies and to rebuild– or just build for the first time– that trust between us and the community,"** she said. "That started by taking on the also well-founded belief that if you go to the hospital, you might find help for your illness or injury and then have to pay exorbitant fees. Patients are now being screened at triage, vital signs are obtained with electronic monitors, and they're lining up outside clinic rooms and the operating theater."[21]

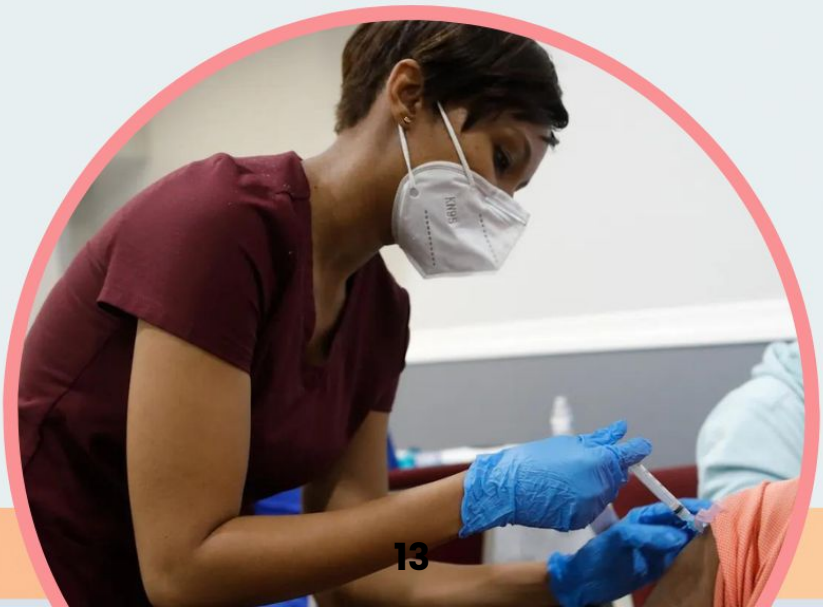
Addressing the social determinants that contributed to Ebola's spread is crucial. Evidence showed that poverty played a significant role in spreading Ebola in Monrovia, Liberia in 2014, with populations in shanty towns infected at 3.5 times the rate as those in more wealthy areas.[36] **Moving forward, investing in medical care for impoverished people would have far-reaching effects, and prioritizing sustainable development in urban slums and lower-income communities would decrease the risk of outbreaks.** While Ebola has crippled already weak healthcare systems, it could serve as the catalyst to strengthen systems beyond their previous states. To achieve the Millennium Development Goal of 80% health coverage, 43,565 doctors, nurses, and midwives would need to be hired across the three countries. This and further investment in clinical care are crucial to improve pandemic preparedness and meet basic needs.[37] Medical deserts in West Africa originated with generations of slavery and subjugation to nations that accumulated wealth and prosperity. Now that these more developed nations have created effective health remedies, making these available to nations hindered by long-standing inadequate healthcare is imperative to prevent future epidemics.

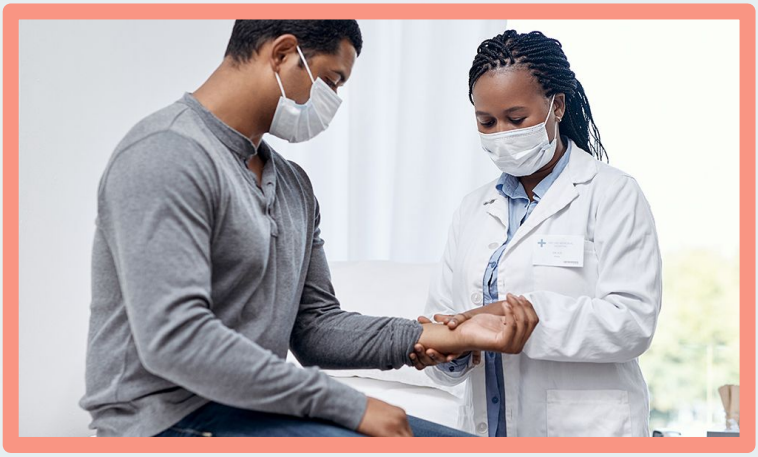
SUBTHEME #2

RACISM IN HEALTHCARE

Racism is not an apparition or a shadow from the past, it is a reality that at times seems omnipresent in its pervasiveness. It is both passive and active, direct and indirect, a perfect storm of structural violence whose roots of prejudice lie within the histories of medicine and healthcare. From experimentation on black bodies in the Tuskegee experiment and the unethical commandeering of Henrietta Lacks' cells in the United States to the gross disparities seen during the COVID-19 pandemic globally, racism has been and continues to be ubiquitous. As of November 2021, American Indian and Alaska Native, Black, and Latino people all had suffered from higher rates of hospitalizations and deaths related to COVID-19 compared with White people in the U.S.[38] A review focusing on clinical COVID-19 outcomes in the UK found that Black, Asian and other racial and ethnic minority groups experienced increased COVID-19–related disease severity and mortality compared with the White ethnic group majority.[241] These inequities result, in large part, from racial and ethnic minority populations' inequitable access to health care, which persists because of **structural racism in health care policy**.[38] It must be acknowledged that although the majority of racial inequity research in healthcare has been conducted in Western societies such as the U.S. and the UK, racism in health care is a global issue. As a result, the majority of the information in this subtheme pertains to Western nations, but the lack of research on this topic from non-Western societies reflects a greater demand for more information and should be considered heavily.

Racism includes a complex array of social structures, interpersonal interactions, and beliefs by which the group in power creates a racial hierarchy that causes racial and ethnic minority groups to be disempowered, devalued, and denied equal access to resources.[38] One of the more overt examples of structural racism can be seen in health insurance inequalities. A recent study that considered income, race, and self-perceived health status found not only that racial identity is independently associated with lack of health insurance but also that low-income individuals with bad health had 68% less odds of being insured than high-income individuals with good health.[38]





Evidence shows that **racial and ethnic minority groups throughout the U.S. experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, compared to their White counterparts.**[39]

Rather than looking at the structural inequalities of health care that help to perpetuate realities like the ones mentioned above, blame for adverse health outcomes is often placed on the individual or community, such as attributing poor outcomes to bad lifestyle choices and poor health-seeking behaviors. Less obvious, more covert examples of structural racism would be racial biases or the misbeliefs and attitudes that are associated with certain races. For instance, UK adults belonging to ethnic minority groups who perceive racial discrimination or biases experience poorer mental and physical health than those who do not.[239] A report conducted by the Black Equity Organisation–an organization aiming to address inequity in Black communities in Britain–found that almost two thirds of black people who responded to a survey said that they had experienced prejudice from doctors and other staff in healthcare settings.[240]

Since the Jim Crow era (1875–1968), **racism has implicitly and explicitly been an integral part of the US government's structuring and financing of the health care system**. For example, in 1946, the federal government enacted the Hospital Survey and Construction Act, commonly known as the Hill-Burton Act, to provide for the construction of public hospitals and long-term care facilities.[38] Although the act mandated that healthcare facilities be made available to all without consideration of race, it allowed states to construct racially separate and unequal facilities.[38] In this contemporary period, **the inequity of structural racism continues to manifest in health care coverage and financing, which has created a two-tier system of racially segregated care in which racial minorities receive poorer-quality care.** Sure enough, ample evidence suggests that Black and Latino people receive lower-quality care compared with White people, even after insurance coverage and income are adjusted for.[38] Members of racial and ethnic minority groups are more likely to reside in areas that suffer from physician shortages, including shortages of primary care doctors, surgeons, and mental health providers, which is also a product of structural racism.[40] **One reason racial and ethnic minority communities are underserved is that they have been drained of vital health resources through public hospital closures and the flight of nonprofit hospitals from minority communities to predominantly White communities.**[41]

The following case studies will provide insight into some of the histories surrounding racism in healthcare and medicine as well as how certain health crises can unearth different inequities and inequalities in existing systems. It is imperative that health policy is informed by history so that global health can ensure health as a human right.

Case Study - Black Maternal Mortality: Exploring the Shadows of Gynecological Experimentation and Influence over Contemporary Black Maternal Health

There exists an intimate yet painful history associated with the Black female body in the United States. **Both the quality of health as well as the rudimentary existence of autonomy for Black women have unjustly been a point of contention since the age of slavery, through the Jim Crow era, and to the present day.** As it stands, Black women are 2.6 times more likely to die due to complications during and after childbirth compared to White women.[42] In 2021 alone, the maternal mortality rate for Black women was approximately 70 women for every 100,000 live births.[42] Comparatively, for White women, it was approximately 27 women for every 100,000 live births.[42] Black women are also more likely to experience life-threatening conditions like preeclampsia, postpartum hemorrhage, and blood clots, as well as increased incidence of other pregnancy-related complications like preterm birth and low birth weight.[43] Pre-eclampsia and eclampsia, which are cardiovascular diseases that induce high blood pressure, are the leading causes of black maternal deaths.[44]

Despite data and anecdotal evidence, there is a tendency in American society to dilute this critical and alarming issue to one of isolated, unfortunate tragedies. However, this issue is perpetuated by structural violence that has developed in the U.S. over centuries. Many harmful beliefs and stereotypes exist regarding black bodies and how black people experience pain. For instance, people have said:"Black people's nerve endings are less sensitive than white people's." "Black people's skin is thicker than white people's." "Black people's blood coagulates more quickly than white people's." [45] According to a study published by the *Proceedings of the National Academy of Sciences,* almost half of the medical trainees that were surveyed held one of these beliefs. These myths have damaging effects, shown by **many Black women feeling "disempowered" by their physicians, not being properly listened to about their medical concerns, and having pain and symptoms dismissed, which can lead to dangerous pregnancy outcomes.** In order for this issue to be addressed in its entirety, we must look back on the dark, formative years of obstetrics and gynecology, which reveals how the field of women's reproductive health has always viewed black women and women of color as sub-human.

James Marion Sims is often referred to as the "Father of Modern Gynecology." Sims developed pioneering tools and techniques related to women's reproductive health such as the vaginal speculum, which is used for dilation and examination. He also pioneered a surgical technique to repair vesicovaginal fistula, which was a common childbirth complication in the 19th century.[46] After a very limited amount of medical education—typical for the time period—Sims relocated to Montgomery, Alabama, where he built an 8-bed hospital in the slave-trading district. Amongst slave owners, he built a reputation for himself as a physician who could "patch-up" enslaved workers so they could "produce," which largely meant reproduce because, in slavery, reproduction was viewed as a commodity.

The enslaved Black women that Sims experimented on were only viewed as property and did not have the option to consent to the operations. Sims performed these experimental surgeries against the enslaved women's will and without anesthesia. During this time period, experimental c-sections were also performed repeatedly on enslaved Black women, and would often last for hours. From Sims' records, three of the names of enslaved women who forcibly underwent the experimental surgeries are known: Lucy, Anarcha, and Betsy. Anarcha and Lucy were 17 and 18 years old at the time. Anarcha was subjected to 30 repeated surgeries. For a long time, Sims' fistula surgeries were unsuccessful. However, once he "perfected" it, he went on to perform the same procedures on White women using anesthesia, which was new at the time.[46] Sims made the decision not to use anesthesia on the enslaved Black women he experimented on due to the belief that Black people didn't experience pain like white people did.

It must be stated that Sims' beliefs on anesthesia for fistula procedures were contradictory. Years after his initial tests, he said he still didn't believe in using anesthesia for fistula surgeries because "they are not painful enough to justify the trouble and risk."[47] But he also said the experimental surgeries on his enslaved subjects were "so painful that none but a woman could have borne them," and in his autobiography, he describes conducting fistula operations in Europe on wealthy women who were sedated.[47] In his autobiography, Sims himself noted the **agony and pain that the enslaved women experienced**, such as a woman named Lucy, writing that "Lucy's agony was extreme. She was much prostrated, and I thought that she was going to die.[46]

Many of Sims' statues remain erect around the country, an unfortunate testament to how habitual the erasure of Black women and their pain is. Furthermore, this history sheds light on the current state of Black maternal health within this country. **What does it say that Black women are expected to entrust their health and the health of their babies to a field that once viewed their bodies as experimental models?** As said by historian and author Dierdre Cooper Owens: "The history of this particular medical branch … It begins on a slave farm in Alabama… The advancement of obstetrics and gynecology had such an intimate relationship with slavery, and was literally built on the wounds of Black women."[48] **What does it say that many physicians within the U.S. still hold incorrect and racist beliefs regarding Black bodies in the context of medicine?**

The nation's health disparities have had a tragic impact: Over the past two decades, the higher mortality rate among Black Americans resulted in 1.6 million excess deaths compared to white Americans.[48] Black women are twice as likely to develop severe maternal sepsis as compared to their White counterparts.[48] Black women remain more likely to deliver preterm and to undergo C-sections. **These outcomes are mostly due to slow or missed diagnoses, which tend to be the result of bias, structural racism in medicine, and inattentive care that leads to patients, particularly Black women, not being heard.**[48] There remains a potent trickle-down effect from time periods such as the founding of gynecology, the eugenics movement, and healthcare segregation, that has contributed to structural racism, mistrust in the healthcare field, and a significant racial health gap.

As said by Professor Rana A. Hogarth of the University of Illinois, Urbana-Champaign: "We have to recognize that it's not about just some racist people or a few bad actors… People need to stop thinking about things like slavery and racism as just these features that happened that are part of the contours of history and maybe think of them more as foundational and institutions that have been with us every step of the way." [48]

Many of the steps towards addressing this issue and the history behind it lie in policy-making and education. [43] Much of this begins with **further diversification of the healthcare workforce and debunking many of the racist misconceptions that still exist pertaining to Black bodies in the context of medicine**. That being said, a new generation of medical trainees is putting equity front and center of their education, both by participating in the larger anti-racism movement through groups like White Coats for Black Lives—a group focused on addressing racism in medicine—and leading the charge to change medical curricula.[43] The movement for birth equity is also being led with growing momentum by community-based organizations (CBOs) focused on caring for Black moms and advocating for system change across policy and health systems.[43] Improving Black maternal health focus on regions known as medical deserts in which there are no readily available hospitals or clinics, which tend to be much more common in areas that are highly populated by Black people. One solution would be to **increase and expand access to midwives and doulas that can assist pregnant Black women**. There exists a rich history of midwifery in the U.S., particularly in African-American history. However, after the 20th century, midwives became increasingly undermined and discredited due to the medicalization of childbirth.[237] By expanding access to midwives, the issue of medical deserts can be addressed and expecting mothers may be able to foster a closer relationship with midwives and doulas as opposed to doctors. People who receive care from midwives are less likely to have a preterm birth, less likely to have a C-section, and more likely to breastfeed.[43] Doulas can play a critical role in reducing racial disparities in maternal health, and their services have been associated with fewer birth complications and a reduced risk of low birth weight infant.[43]

Although the past is ugly and wrought with pain, these atrocities must be addressed in order to better inform our present situation and curate a better outlook for Black maternal health and overall racism in health care. Solutions can and should be pursued in order to rectify the past atrocities that remain within healthcare systems. It is of utmost importance to recognize said histories for the betterment of black maternal and newborn health.

Case Study - Race-Based Physiological Myths Contribute to Implicit Bias, Worsening Global Health Outcomes

During his medical training, Dr. Oluwafunmilayo Akinlade encountered a Black man in his 40s who had fallen down the stairs several weeks prior and reported chest pain and breathing challenges. He had visited two other health facilities to no avail.[49] The first facility took an X-ray, which was negative for a fracture, and sent him home without pain medication even though it is well-established that X-rays are not sufficiently sensitive and may not detect 50% of rib fractures.[50] Upon his second trip to the emergency department (ED), providers decided the negative scan justified not investigating further. As a Black medical student, Dr. Akinlade was keenly aware of the concern of this patient's wife and three children and the agonizing pain he was experiencing. The CT scan Dr. Akinlade insisted his resident conduct exposed three broken ribs. Dr. Akinlade can't help but wonder how long it may have gone undiagnosed without his urging.[49]

Race-based physiological myths, disparities, and ubiquitous racial discrimination have long affected healthcare systems globally, including by resulting in what Dr. Akinlade observed: the widespread perception that Black people have a higher pain tolerance due to intrinsic differences.[51] Black populations are at higher risk for the majority of health issues, with higher death rates for eight of the 13 leading causes of death compared to their white counterparts.[52] Despite worse health outcomes and a doctor's sworn oath to "do no harm," if a Black and White patient present to a doctor with identical symptoms, evidence shows doctors are more likely to provide necessary treatment to white patients. Not only are White patients more likely to be offered necessary heart treatment, but they also have a greater chance of being referred to a heart specialist and receiving interventions to examine the heart's blood supply.[53,54] Significant racial disparities can also be seen in emergency care. National studies of ED care that adjusted for clinical factors found the needs of Black patients were less likely to be classified as urgent, they were less likely to have blood tests, CT scans, or x-rays ordered, 28% less likely to be admitted to the hospital, had fatality rates 1.26 higher, and had longer wait times and visits compared to white patients.[55,56]

Though unfounded, prominent scientists have long worked to establish genetic predispositions among Black people to explain worse health outcomes.[57] False beliefs, including that Black people have thicker skin, less sensitive nerve endings, or stronger immune systems, hark back centuries to j**ustifications for inhumane treatment through slavery and medical research**.[58,59,60] In the 19th century, racist undertones were more overt. An enslaved man, John Brown, described being subjected to painful experiments by Dr. Thomas Hamilton, a highly esteemed trustee of the Medical Academy of Georgia.

These gruesome experiments rendered Brown unable to labor in the attempt to prove Black skin was thicker than Whites.[61] Another physician, Dr. Samuel Cartwright, argued Black people had a disease that made them "insensible to pain when subjected to punishment".[58] What was perhaps most ludicrous was that Cartwright argued slaves likely had a disease called drapetomania that led them to flee from enslavers.[61] Physicians, such as Philip Tidyman, sought to uncover "physical peculiarities" of Black people to "distinguish him from the white man."[59] Even more recently into the 20th century **researchers persisted in experimenting on Black populations under the misconception that they were more tolerant of pain.** These include military testing of mustard gas and other noxious chemicals on Black soldiers in World War II,[62] and the US Public Health Department collaborating with the Tuskegee Institute to examine untreated syphilis among Blacks from 1932-1972.[63]

Still today, researchers such as Harvard Professor, Roland Fryer, argue Black people whose ancestors survived the Middle Passage passed on a gene for salt retention that could explain higher rates of hypertension.[64] Dr. Arline Geronimus points out this has been refuted with substantial evidence, such as by comparing hypertension rates among Black Americans and Blacks in the Caribbean, who both experienced the Middle Passage, and observing that American Blacks have higher hypertension rates.[57] Misconceptions that Black patients experience less pain persist. A 2016 study of white medical students and residents found 73% held at least one inaccurate physiological belief about African Americans which correlated with rating Black patients' pain lower and recommending less accurate treatment. 40% of first and second-year students endorsed the statement "Black people's skin is thicker than white people's" [63] Numerous studies have shown treatment to differ by race, such as one that found Black patients received an average of six milligrams of morphine daily for postoperative pain, while White patients received 22 milligrams.[65,66] These suggest that **false beliefs in biological differences between races influence medical decisions through racial bias and cause disparities in evaluating and treating pain.**[60]

A study by the American Medical Association (AMA) concluded that the misconception that Black people are more likely to abuse drugs also contributes to prescribing less pain medication.[67] Cartwright's legacy upholds misconceptions of pain tolerance, notably with his invention of the spirometer, a tool to measure pulmonary function. The spirometer, as it exists today, is designed with a "race correction" that incorrectly assumes that Black people have 20% less lung capacity than white people, which Brown University Professor Lundy Braun says continues to be taught in the medical curriculum as a scientific fact.[61]

However, growing evidence suggests that Black people experience greater, not less, pain than White people.[67] In 2006, Dr. Geronimus developed the "weathering hypothesis" to describe the physiological damage that occurs with the allostatic load of chronic exposure to discrimination and racism and the stress they induce.[68] Given these effects, there must be greater attention on remedying racial biases in healthcare and increasing attention on Black patients. **Providers' implicit racial biases were correlated with Black patients' ratings of poor communication and care**.[70] A meta-analysis found Black patients were 22% more likely to receive no pain medication compared to White people.[71] Despite some physicians reporting no explicit racial preference for patients, a study at four medical centers nationally revealed these **physicians held implicit preferences for white patients and implicit stereotypes that Black patients were less cooperative.**[72]

The impact of implicit bias on healthcare disparities, of which pain perception is a contributing factor, can be mitigated by **increasing physician awareness of their susceptibility and strategies to reduce instinctual stereotyping in medical decision-making**.[72] Implicit Association Tests (IATs) have been shown to identify biases and promote self-reflection.[73] Individuating, which directs physicians' attention to specific information about a patient to reduce the impact of identity, has been effective at decreasing racially based decisions. Perspective-taking is another well-documented strategy that involves intentionally envisioning another's point of view.[74] For example, upon showing nurses pictures of White and Black patients in pain, they recommended higher amounts of pain medication for White patients, but equal amounts when asked to imagine how the patient would feel.[75]

Education programs to decrease misinformation and mitigate implicit bias are essential. Within the last three years, six states have enacted implicit bias training for health care providers.[76] Additionally, biases could be reduced through structural changes, as disproportionately few physicians globally, including in the US, are Black.[74] Reducing individual discretion by using standard and objective measures can also be effective, such as through a blood test that is currently being developed containing biomarkers to detect pain.[77]

SUBTHEME #3

ETHNIC PERSECUTION AND HEALTH

Global health is a field that is devoted to prioritizing the improvement of health and health equity for all people. One such factor that drives health inequity is ethnic persecution. **Ethnic persecution is the violation of human rights based on a person's ethnicity.** Outside of prejudice, some extreme cases of ethnic persecution can lead to mass detention, forced labor, forced sterilization, and forced assimilation. Ethnic persecution is prevalent throughout human history and we continue to see it today with various populations such as the Uyghur population in China, the Roma, the Israeli-Palestinian conflict, and the Rohingya in Myanmar.

Persecution begins with the process of "othering," which is the act of honing in on the differences present in one group, and using those differences to dismantle any sense of comradery or connectedness. Once these differences are emphasized, the "other" group is identified as inferior, thus setting the stage for structural violence. An extreme example of persecution in history would be the Holocaust, which led to the systematic persecution and genocide of 6 million Jewish people[78] in addition to the Roma, Sinti, people with disabilities, and homosexual individuals. Ethnic persecution as a public health issue is especially concerning. Not only can victims of persecution have their physical well-being compromised due to things such as forced sterilization, physical trauma, assault, and sexual violence, but the prevalence of adverse mental health issues, such as post-traumatic stress disorder (PTSD), anxiety, depression, are extremely high. One such example of othering and persecution is the recent genocide of the Rohingya in Myanmar. The Rohingya are a mostly Muslim minority that make up one-third of the population in a region of Myanmar called Rakhine State.

Although they have been in the region since the 15th century, Rohingya continue to be viewed by the Buddhist majority of Rakhine state as "Bengali immigrants."[238] This labeling is an example of the othering process that denies the Rohingya their status as fellow citizens.[78] Since the early 1980s, government policies have stripped Rohingya of citizenship and enforced a system where they were first isolated and marginalized and then targeted for genocide.[78]

Persecution can also create environments of forced displacement, as is the case with some Rohingya, thus making victims more vulnerable to communicable diseases, poor nutrition, injury, and untreated chronic illnesses. The following case studies focus on two ethnic groups that are currently being persecuted. It is absolutely crucial that the global health community views ethnic persecution as a public health issue, just as all human rights violations should be viewed. The material that will be discussed within these studies is both sensitive and serious.

Case Study - Romani Ethnic Persecution, Links to Chronic Illness and Mental Health Disparities

The Roma—also known as the Romani, Gypsies, Travelers, and Sinti—are one of the oldest ethnic minorities in Europe, numbering approximately 12 million today.[79] Scholars believe that the Roma people migrated from the Punjab region of northern India over 1,500 years ago, entering Europe between the 8th and 10th centuries.The Roma are a nomadic people who received the name "Gypsies" from the early belief that they originated from Egypt.[80] Roma identity is often portrayed as stereotypically exotic, strange, or "outsider gypsy," with the term "gypsy" being used in a derogatory way. All across the diaspora, the Romani face huge disparities in health care access and quality. **The long history of persecution and racism that the Roma have faced manifests itself in the present day, and has contributed to poor outcomes in chronic diseases and mental health afflicting the Romani**, all of which will be detailed in this study.

For centuries, the Roma have been persecuted and scorned across Europe. Zigeuner, the German word for Gypsy, is derived from a Greek root that means "untouchable."[80] The Roma were often enslaved throughout history or pushed to the lower castes of the social hierarchy. The 20th century saw some of the most violent acts of hatred toward the Roma throughout Europe. During World War II, the Romani were among the groups that the Nazi regime judged as "racially inferior." Often referred to as the **"forgotten victims"** of the Holocaust, the Romani were subjected to internment, sterilization, concentration camps, deportation, and genocide.[81] Some scholars estimate that the full death toll of the Roma may be upwards of 500,000 victims.[81]

The Romani diaspora in Europe continues to face racism and persecution. They are often labeled as being "lazy" or "criminal" and the prejudice that they face bleeds into every aspect of their lives: in the sectors of education, law, employment, and healthcare. A 2015 survey found that 30% of Roma people reported discrimination in the healthcare system.[82] **Discrimination of any sort in the healthcare system plays a role in increasing morbidity and mortality through unequal treatment that impact the caliber of care.**[83] Many Roma feel that cultural stereotypes lead to differential treatment based on ethnicity.[83] Within the Romanian public healthcare system, for example, many Roma report being neglected by doctors and nurses, which leads to acute exacerbation of underlying conditions.[83] This is emphasized for chronic diseases such as hypertension, diabetes mellitus, and end-stage renal disease. It was found that being of Romani ethnicity is an independent risk factor for end-stage renal disease, with an 8.5% higher 3-year mortality rate in Roma compared to non-Roma people.[84] Additionally, in many maternity wards across Europe, the rates of obstetric and gynecologic complications of pregnancy, such as hemorrhage, infection, exogenous failure to thrive for neonates, and psychological consequences such as postpartum depression and postpartum psychosis are much higher in Romani women as opposed to other ethnicities.[85] Life expectancy for the Roma tends to be 10 years less than their non-Roma counterparts.[82]

The main risk factors that are related to poor health developments and outcomes for the Romani include the following: **poor housing, environmental pollution, unemployment, and poor health literacy**. A 2016 survey conducted by the Fundamental Rights Agency under the European Union revealed that approximately 80% of Roma either live in or are at risk of poverty.[86] Millions of Roma are forced to live in isolated slums that often lack clean water and are accompanied by poor ventilation. These factors can increase the risk of developing pulmonary or cardiovascular disease. **Roma seem to be systematically excluded from key aspects of health care, such as preventive, primary, and specialized health services as well as pre- and postnatal health care, and instead increasingly rely on emergency services.**[87]

In addition to the high prevalence of chronic diseases and illness, **the Romani also suffer from disproportionately high mental health disparities due to ongoing discrimination.** A study in Romania and Bulgaria found that Romanian/Bulgarian Roma children experience a higher burden of mental health problems than non-Roma children.[88] A study in the UK found that a significantly greater proportion of Roma adults suffer from anxiety and depression than non-Roma. Roma experience exclusion from public spaces and secure hygienic accommodation, with some even being subject to forced eviction or deportation.[89] **Acute marginalization can lead to family support networks and cultural identity becoming fragmented, making Roma more vulnerable to anxiety, depression, substance abuse, and self-harm.**[89] Despite what is known about the disproportions of mental health and mental illness between Roma and non-Roma, the Roma have historically and continue to be underrepresented in psychology research and psychological therapies.[90] Such disparities and marginalization are accentuated by unfair social policies and individual experiences of discrimination, as well as less access to the opportunities granted by income, education, employment, and safe and stable housing.[88]

There is clear emphasis placed on the genetic, biological, or lifestyle choices as the major causes of inequities between Romani and non-Romani people. This is done as opposed to attributing disparities to existing systems of structural violence, a term used to describe how social structures and institutions inflict harm on individuals and their well-being. It is extremely important to realize this pattern and make distinctions because **there is a clear desire to shift the blame towards the victims, the Roma, rather than holding a biased system accountable.** Moving forward, anti-Roma racism must be addressed globally in all manners and sectors: in public life, language and microaggressions, policy, health care systems, etc. Health literacy amongst the Roma population must be improved, which begins with addressing the poor education systems that Roma children have access to, which is primarily due to segregated school systems. It is known that **quality education can help reduce poverty, and develop and improve healthy behaviors like self-advocacy.** That being said, in most countries, only about 20% of Romani children complete primary school, 18% enroll in secondary school, and less than 1% attend university.[91] For Roma girls, the education retention rate is even lower due to child marriage and rigid gender roles. Thus, it is imperative to address anti-Roma racism beginning at the policy level, as racism is being exercised overtly and covertly and both forms are impacting the health of the Roma.

Case Study - Uyghur Persecution Effects on Health

As the Chinese Communist Party (CCP) has forcibly assimilated Uyghurs and other Muslim minorities into the majority ethnic group, Han Chinese, repressive surveillance has escalated in the Xinjiang region in recent years, drawing significant medical concerns.[92] Under the guise of what the CCP terms a "vocational education training program" intended to "counter terrorism and extremism" among Uyghurs and other minorities,[93] the CCP has overseen the mass incarceration of one to three million Uyghurs.[94] **Human rights, including the right to the highest attainable standard of health, have been violated by persecution of ethnic minorities, particularly through internment camps.** According to a UN report, the legal framework China has developed to justify placing people in internment camps based on religious and extremism clashes with human rights standards by being vague, arbitrary, and partisan. The report additionally documents severe health-related human rights abuses in the implementation of the camps, including blood tests, injections, medications, torture, and forced gynecological procedures. The investigation showed psychological torture induced widespread stress and anxiety and worsened mental health among Uyghurs and other minorities.[95]

Efforts to suppress Uyghur and Turkic Muslim births spurred many experts to begin describing the Chinese government's assaults as a genocide.[92] Since then, an independent legal analysis conducted at the Newlines Institute for Strategy and Policy found China's actions to violate all components of the UN's Genocide Convention.[96] Prior to 2014, Xinjiang was one of the fastest-growing regions in China, with Uyghur birth rates growing by 19.2% compared to 12.65% among Han populations between 1978 to 2015. Mid-2014, the reverse trend began to occur, coinciding with the government's "Strike Hard" campaign against "religious extremism" and "splitism," which they argued was caused and heightened by the slightly higher ratio in birth rates in Xinjiang (Zenz, 2020).[92,97] The constancy of the Han Chinese population in contrast to clear declines in Uyghur and other minority Muslim populations indicates a ruthless ethnic and religious cleansing occuring. An AP investigation revealed that women in detention camps were forced to undergo pregnancy checks, implantation of intrauterine devices (IUDs), sterilization, and abortion.[98] In 2014, 2.5% of IUDs inserted nationally occurred in Xinjiang. By 2018, this proportion rose dramatically to 80% despite Xinjiang representing just 1.8% of the national population.[97] In 2019 and 2020, the Xinjiang Health Commission's family planning allocated $16.7 million and $19.5 million respectively towards providing free "birth control surgeries," directed toward the goal of sterilizing or placing IUDs in at least 80% of women of birthing age.[97] The design of Chinese IUDs to be irremovable without specific surgical instruments and the punishment that occurs if self-removed,[99] heightened the gravity of this forcible control measure.

Violations of family-planning regulations and inability to pay fines is the most cited reason for detaining people.[98,100] In 2016, Gulnar Omirzakh, a Kazakh, received a demand from the government that she have an IUD implanted after the birth of her third child. Despite complying, four government officials came to Omirzak's house two years later and gave her three days to either pay a $2,685 fine for having over two children or be sent to a detention camp. These hefty sums exceeded what Omirzak's and other impoverished families could afford.[98] Another Muslim woman in Xinjiang, Qelbinar Sedik, forcibly had an IUD implanted despite nearing 50 years old and only having one child.[101] Before the US Congressional-Executive Commission on China, Mihrigul Tursun, a Uyghur mother of triplets, testified that she and other women were forced to take drugs and experience injections that resulted in irregular bleeding and amennorhea.[102] Later, U.S. doctors identified sterilization as the cause.[97] Tursun also described electrical shockings and other horrific actions in the camps, including being chained to 40-68 women and confined in a 420 square foot cell lacking toilets and having only a small ventilation gap.[103,104] In just three months, she witnessed nine deaths.[104] Population control campaigns have been relatively effective and induced fear among Uyghurs, with birth rates between 2015 and 2018 declining over 60% in Hotan and Kashgar, predominantly Uyghur regions.[98] Draconian punishments like surgical birth control represent crimes against humanity of persecution, imprisonment, and severe deprivation of physical liberty, according to the Simon-Skjodt Center for the Prevention of Genocide from the U.S. Holocaust Memorial Museum.[105] **Restricting women's bodily autonomy infringes on sexual and reproductive rights and induces trauma that can severely damage mental health.**[106]

Physical and physiological violence occurs within camps, with survivors reporting being beaten, whipped, hung from ceilings and walls, solitarily confined, shocked electrically, raped and sexually assaulted, and deprived of sleep and food for lengthy periods.[107,108] UN human rights experts have investigated allegations of organ harvesting from ethnic and religious minorities, including Uyghurs, detained by the CCP. Forced blood tests, organ examinations, and harvesting occur reportedly without consent, with the most common organs removed being hearts, kidneys, livers, and corneas. **The targeted nature of the harvesting conducted by medical professionals led the UN to state concerns of "discriminatory" medical abuse.**[122] Testimonies from former inmates describe how the CCP gave no heed to the health of detainees, ignoring health complications and needs. RFA reports a husband's concern for his wife, Patigual Dawut, who was detained despite recently having her pancreas removed, undergoing heart surgery, and being in a car accident that resulted in three other surgeries. He feared she was not receiving her medications.[109] Survivors also testify to sexual assault, with an interview by the BBC alleging systematic rape and torture.[110] Other former inmates report being forced to receive injections or to consume unknown pills that resulted in nausea and exhaustion and, for some, halted menstruation.[101] Every night, Tursunday Ziyawudan, a woman imprisoned for nine months in 2018, recalls masked men taking women, including herself, from their cells to a "black room" around the corner where they were gang-raped or electrically shocked. You become their toy," Ziyawudan told the New York Times, "You just want to die at the time, but unfortunately you don't."[101] Women in Xinjiang generally feel unsafe, even in their homes.[101] The CCP's staunch denial of these women's allegations further ostracizes them from society.

While detention was initially reserved for Muslim extremists, the CCP quickly expanded to target anyone who displayed harmless aspects of Muslim identity, such as having a long beard.[111] Police officers told Radio Free Asia they are given arrest quotas for Uyghurs, with the officers of one town having a target of 40% of locals.[112] The camps aim to reshape detainees' political opinions and remove their Islamic faith. Detainees were forced daily to listen to lectures warning against extremism and Islam and take high-stakes quizzes that could result in staring at a wall for hours if not answered correctly. They were forced to repeat indoctrination, such as through chanting "We will oppose extremism, we will oppose separatism, we will oppose terrorism" in training that spanned over two hours, and criticize their religious history in front of other detainees.[113]

Ironically, though allegedly treating Uyghurs for psychological issues, the CCP are **inflicting real psychological harm by likening religion to a pathology they are trying to cure.** Upon returning home, some Muslim students were told their relatives were being treated due to being "infected" by the "virus" of Islamic radicalism.[114] The upheaval caused by the removal of family members was augmented by intense cultural and religious repression. A CCP audio recording sent to Uyghurs on WeChat used a medical analogy to justify detainment, as those taken "have been infected with religious extremism and violent terrorist ideology, and therefore must seek treatment from a hospital as an inpatient… If we do not eradicate religious extremism at its roots, the violent terrorist incidents will grow and spread all over like an incurable malignant tumor."[115] A government document in Hotan, a region in southwestern Xinjiang, explained education in camps as "free hospital treatment for the masses with sick thinking."[116] The CCP's forced treatment, institutionalization, and prohibition of minority populations from making decisions represent violations of human rights by denying dignity/humanity and restricting autonomy, which can have severe implications on mental health.[117] One Kazakh detainee, Omir Bekali, reported having suicidal thoughts after 20 days in the camp, even though he spent the seven months prior in prison. Bekali recalled being demanded to stare at the wall for five hours for not obeying orders and deprived of food for an entire day when sent to solitary confinement. According to Bekali, the pressure of criticizing and condemning himself and his ethnic group repeatedly was "enormous"; "I still think about it every night until the sun rises. I can't sleep."[113]

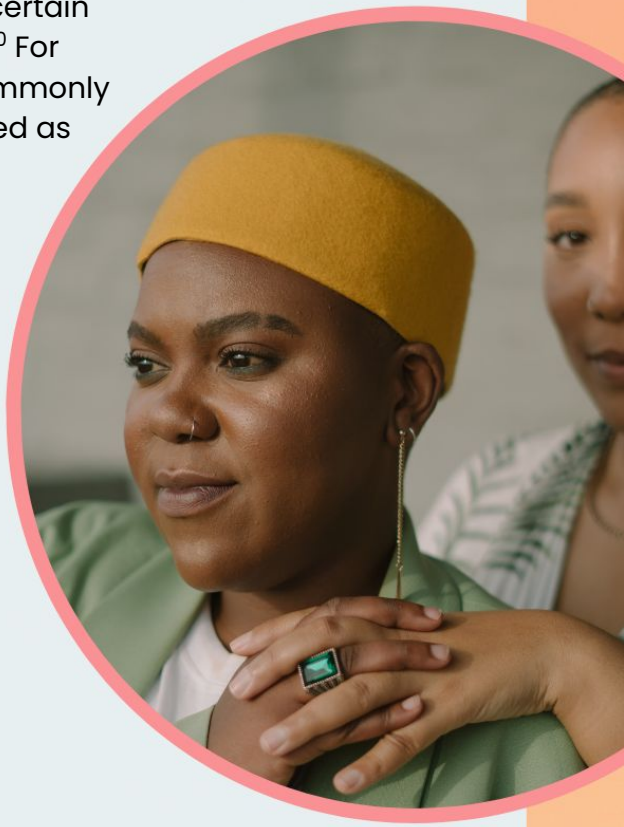
Globally, **Uyghurs in the diaspora struggle to grapple with the severe repression occurring, with reports of insomnia, depression, and paranoia.**[115] An Uyghur scientist designed a survey of Uyghurs living abroad, finding many cited insomnia, being less productive at work, and higher irritation. A quarter reported suicidal thoughts.[118] An Uyghur woman in Canada whose sister was detained said, "I cannot concentrate on anything. My mind is off. I cannot sleep. I lost a lot of weight because I don't want to eat anymore."[119] Given the CCP is quick to castigate Uyghurs who travel internationally, some living abroad harbor a sense of guilt that their family bears repercussions due to being associated with them. After going 197 days without being able to contact his father in Xinjiang, a graduate student in Kentucky reported being "afraid for my dad's life." He marks the days on his bedroom wall, living under the burden of believing his dad was sent to a camp due to him attending university internationally.[115]

Notes of optimism come with the mobilization of community leaders, therapists, and volunteers to support Uyghurs globally. The Uyghur Wellness Initiative developed a group of therapists to work pro-bono with Uyghur communities in the United States. In Belgium, counselors who assisted survivors of the Bosnian genocide provide training for Uyghur women. Leaders responsible for these mental health initiatives have found responses from Uyghurs to be generally positive, **offering connection in the midst of extreme isolation**. However, cultural stigmas against therapy have proven to be a barrier to reaching Uyghurs.[118] Due to the CCP's suppression of information, there are significant hurdles to research and monitoring, limiting bodies such as the United Nations, that are designed to provide accountability for human rights violations. Moreover, detainees receive significant threats by the CCP against speaking about their experiences.[120] Thus, mistreatment is likely worse than is known. Though the UN members and the UN High Commissioner for Human Rights (OHCHR) have issued statements condemning the CCP's persecution of Uyghurs, the WHO has largely remained silent on the health impacts caused by repression.[121] Looking forward, human rights frameworks within the WHO's mandate can be leveraged to place pressure on the Chinese government to refrain from medical abuse.

SUBTHEME #4

GENDER, SEXUAL, AND QUEER VIOLENCE

Multiple movements emerged in the 20th century with differing goals, but all stemming from centuries of marginalization. Women's and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) rights movements both emerged as radical revolutions that challenged deep-seated social norms. By protesting traditional gender roles and identities, the women's liberation movement helped empower the gay liberation movement to advocate for the rights of sexual minorities. In fact, the Gay Liberation Front (GLF) established in New York City in 1969 viewed patriarchy and heterosexism as the primary hurdles to sexual and personal freedom.[127] Both movements also struggled to encompass an umbrella of identities and experiences by being intersectional. The exclusion of women of color, lesbians, and queer people are notable examples, speaking to the tendency to ostracize certain identities even within minorities advocating for progress.[140] For instance, rapes of enslaved women by white men that commonly occurred in pre-civil war United States were not categorized as assaults.[126]



Until recent decades, sexual harassment and abuse were largely overlooked and viewed as the defilement of a man's property instead of a crime against women.[126] Despite some improvements, women and sexual and gender minorities (SGMs) continue to experience violence that has detrimental health effects at higher rates than the general population. Though 'sex' and 'gender' are frequently treated synonymously, conflating the concepts can not only disparage those who have differing sex and gender, but also limit the ability to identify, investigate, and punish gender persecution. Gender-based crimes victimize people perceived as violating dominant gender narratives that promote culturally assigned gender roles. Such crimes qualify as gender persecution when they involve violent methods, such as rape, enslavement, torture, or murder.[142]

A sexual violence act is committed without consent and is often a form of gender persecution, motivated by gender discrimination.[142] **Females and LGBTQ+ populations experience sexual violence at disproportionately high rates, with one-third of women globally being victims of physical and/or sexual violence.** Health consequences of intimate partner violence (IPV) and sexual violence are extensive; risk of injury is raised, with 42% of women experiencing IPV reporting an injury and there is an increased likelihood of unintended pregnancies, abortions, gynecological problems,

sexually transmitted diseases, fatalities, and mental health problems.[144] Placed in a subjugated or inferior position with limited agency, women have often been compelled to engage in sex work to support themselves or their families.[136] **Gender poverty, higher unemployment rates, little control over finances, and lower education rates all raise the vulnerability of females to human trafficking that regularly involves violence.**[133] Discrimination causes women to disproportionately work in low-skilled and low-paid positions that are often underregulated and lack legal protection, which increases the risk of violence, including in the form of exploitation, forced labor, manipulation, and debt bondage. Without stable governments during crises, women and girls become more vulnerable to exploitation.[133] Since 1999, international courts and movements such as "Me Too," have exposed how institutionally pervasive sexual violence is, as it frequently involves bystanders.[136] Not only does gender-based violence compromise the rights of women and girls, but the lack of accountability perpetrators face, such as for Female Genital Mutilation (FGM), heightens fear and disempowers. Still, in some nations, women do not hold equal rights as men and often lack the legal abilities to hold men accountable for attacks, which emboldens violent acts.

Healthcare for SGMs has historically been extremely deficient and more harmful than beneficial. This can be seen through the American Psychiatric Association's (APA) classification of homosexuality as a mental illness as late as 1973.[123] Eventually, the APA concluded homosexuality was not a mental illness, but that pervasive homophobia may infringe on necessary care and generate stress that can harm mental health.[137] **Medicalization of homosexuality persists in parts of the world, insisting that homosexuality is a condition to be "cured" with therapy.**[132] The AIDS epidemic catalyzed some health professionals to learn that LGBTQ+ populations have unique health needs by highlighting the consequences sexual behavior can have.[128] However, LGBTQ+ individuals still face social, economic, and structural conditions, including discrimination, stigma, and exclusion that adversely impact health outcomes, access to, and interactions with the healthcare system.

Given that SGMs are stigmatized globally, **the rate they experience violence, including rape, sexual assaults, robbery, and aggravated assault, is significantly higher compared to cisgender and heterosexual populations**, with a study finding the rate of victimization of SGMs is 71.1 per 1000 people, while it is 19.2 per 1000 among those who are not SGMs.[130] Lesbian, gay, and bisexual identities are associated with higher rates of lifetime victimization, including increased childhood abuse and partner victimization and sexual abuse during adulthood.[124] Violence rates are higher among those identifying as transgender, with almost half reporting interpersonal violence, such as verbal harassment or assault, within the last year.[134] Transgender and gender-diverse populations face additional challenges, such as misgendering and structural stigma, and frequently require hormone replacement therapy or gender-affirming surgery, which is often difficult to obtain.[131] Transgender individuals often face societal, familial, or clinical resistance as well as financial and stress burdens[131].

They regularly need to undergo a psychological evaluation to meet treatment requirements, which suggests that they are not in a sufficiently sound condition to make reasonable medical decisions.[129] Structural stigma within the healthcare system is demonstrated by the Diagnostic and Statistical Manual of Mental Disorders (DSM), which **miscodifies gender dysphoria as a pathology and discredits transgender experiences by labeling them as mentally ill.**[129] A third of transgender individuals who visited a healthcare provider in the previous year reported at least one negative experience due to their identity.[134]

Health disparities among LGBTQ+ populations occur due to increased violence, the burden of microaggressions and minority stressors, and less access to specialized healthcare and treatments. Despite more attention on acute traumatic events, many individuals report more harm from the cumulative burden of daily stressors.[143] Ilan Meyer conceptualizes the minority stress model to explain how stigma, prejudice, and discrimination create hostile environments that lead SGMs to have higher rates of stress and mental illnesses.[139] In turn, the Biopsychosocial Minority Stress Model proposes that unique minority stress experiences contribute to harmful health behavior factors, heightened psychological distress and sleep irregularity, and immune dysregulation.[125] Though some LGBTQ+ people can conceal their identity more easily than other minority groups, concealment can be psychologically detrimental and perpetuate further distress and exhaustion.[135] Internalizing negative societal attitudes of homophobia and transphobia as well as fearing rejection are common stressors.[14]

LGBTQ+ individuals are twice as likely to experience a mental illness, and 2.5 times more likely to experience depression, anxiety, and substance misuse, compared to heterosexuals.[123] Those who identify as LGBTQ+ are at higher risk for PTSD, with estimates that up to 48% of LGB populations and 42% of transgender and gender-diverse populations align with PTSD criteria. PTSD rates drop steeply among the general population to 4.7%.[143] **Rates of depression, anxiety, and suicidal feelings are higher among LGBTQ+ youth and are associated with experiences of stigma and discrimination, such as denial of identity at home or bullying by peers at school.**[141] Additionally, significant stress can derive from structural discrimination towards LGBTQ+ people in local, state, and federal legislation and policies that offer less protection and rights, as well as institutions, including employment, housing, education, and healthcare. In more than 20 states, LGBTQ+ populations can be denied from entering businesses.[143] This lack of protection of vulnerable populations can enable and perpetuate violence. By tailoring clinical care and public health interventions to LGBTQ+ individuals' needs, clinicians and public health officials can better address and treat health issues prevalent among SGMs. Resenting positive steps taken to increase in knowledge on LGBTQ+ care, the American College of Physicians developed “The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health" to reflect clinical and social developments and equip providers with knowledge on how to administer care to SGMs.[138]

Case Study - Prevalence of Gender-Based, Queer Violence and Femicide in Latin America

Gender-based violence (GBV), Femicide, Feminicide and Queer-based violence is a grave issue worldwide. **Femicide is a hate crime that is defined as the intentional killing of a woman or girl. The term *Feminicide* is an extension of Femicide that encompasses and holds accountable the institutions that are involved in upholding structural violence against women, calling it a mass or a state crime**. Latin America in particular has among the highest rates of gender-based violence in the world,[149] and many of the perpetrators are never brought to justice.[147] Honduras suffers from the highest rates of GBV in the region followed by the Dominican Republic and El Salvador. At least 4,473 women were victims of Femicide in Latin America and the Caribbean in 2021.[148] Due to difficulties identifying and documenting sexuality- and gender-based crimes and high levels of impunity, the majority of cases of violence against LGBTQ+ community members remain in the dark.[146] The governments of El Salvador, Guatemala, and Honduras have failed to effectively address violence and have allowed discrimination against lesbian, gay, bisexual, and transgender (LGBTQ+) people, leading many to seek asylum in the United States.[145] The violence faced by women and those of the LGBTQ+ community constitutes an extremely pressing matter for global public health. **Much of the violence not only impacts the physical well-being of said groups, but also greatly influences mental well-being and, in extreme cases, can lead to death.** Premature mortality is an overarching public health issue and extreme cases of premature death in the forms of murder and femicide are quite apposite in places such as Honduras. This study will address the threats and acts of violence that women and members of the LGBTQ+ community face, the impacts on physical and mental health, and what is currently being done to address these issues.

The recent spiral of violence in the lives of women and lack of protection can best be understood by examining normalization of structural, political, symbolic, and everyday gender violence .[152] High levels of GBV persist in a climate of chronic generalized violence. The obvious threat of criminal groups, gangs, and corruption belies the less perceptible threat of an embedded patriarchal and sexist culture.[152] **Violence towards women is most prominent through two mediums known for machismo culture: domestic life and gang activity.** The pervasiveness of this culture is a crucial element in the legitimization of gender-based violence since it perpetuates the belief that women are lesser beings subject to male authority and domination.[156] Machismo—the Spanish term that refers to a strong or aggressive sense of masculine pride that can be laced with cultural misogyny—is ubiquitous in Honduras and most of Central America.[156] Patriarchal and sexist beliefs are the cultural norm, and traditional gender roles are strictly enforced.[156] **Domestic and intimate partner violence is pervasive and normalized within society, and the state lacks the will and the resources to properly protect women from it.**[156]

According to a USAID report, 50% of women in western Honduras reported having experienced GBV, with the most frequent form being emotional violence. Victims of GBV are more vulnerable to poor long-term mental health outcomes such as anxiety, depression, suicidal behavior, substance misuse, and post-traumatic stress disorder (PTSD). **GBV encompasses both sexual violence and femicide, and the former gives rise to health concerns of sexually transmitted diseases and unwanted pregnancies in a country where abortion is heavily penalized.**[156] In Honduras alone, the Femicide rate is 10.4 women for every 100,000. Violence against women has been shown to be linked to long-term, chronic health issues such as arthritis, asthma, chronic pain, digestive issues (i.e. stomach ulcers), heart problems, irritable bowel syndrome, nightmares, issues sleeping, migraine headaches, sexual issues, stress, and immune system problems.[153] Women who have suffered physical violence at the hands of an intimate partner are 16% more likely to suffer a miscarriage and are at a 41% elevated chance of having a preterm birth.[153]

Honduras' cultural misogyny reaches extreme levels when it intersects with gang culture.[156] Gangs use violence against women to enforce their control over the population and the territory under their domain, as well as the illicit markets in which they operate.[156] Subsequently, **many women and their families are driven to either endure or flee the country altogether, a decision which renders them even more vulnerable to sexual violence and victimization by criminal gangs, police, and smugglers, as they make their way to other countries.**[156] In fact, the chronic state of violence in Honduras, especially in the form of domestic violence, is associated with the high levels of displacements and migration in the country.[156] Violence against women is ultimately an expression of the systematic and pervasive patriarchal and misogynistic ideas that permeate Honduras' society and state. It reflects the unequal power dynamics between men and women in the region.[156] Crimes committed against women in gang-controlled areas are more likely to go unpunished and unreported, and girls and women associated with gangs– whether voluntary or not – are prosecuted and subject to additional abuses, including sexual assault, beatings, disappearances, and femicide.[156] In 2022, as recorded by national media, 297 women were victims of femicide. The National Emergency System registered 38,332 reports of domestic violence and 59,147 reports of intimate partner violence.[156] Every 18 hours, a woman is a victim of violent death in Honduras.[150]

Shifting gears to another vulnerable population of the study, **LGBTQ+ persons in El Salvador and Honduras face discrimination by society, and are often targets of violence by gangs and organized crime, as well as state forces.**[146] In Honduras, the CATTRACHAS Lesbian Network (Red Lésbica CATTRACHAS) has recorded 277 violent deaths of LGBTQ+ persons since 2009, marking an escalation of violence against LGBTQ+ persons.[146] In 2022, 43 LGBTQ+ persons were murdered, including three activists The CONADEH, Honduras's National Human Rights Office, reported that almost 90% of crimes against LGBTQ+ persons go unpunished.[151] Although being a part of the LGBTQ+ community in Honduras is not illegal, the battle for LGBTQ+ rights is both public and private. It is public that many individuals face violence from the national police, armed forces, government officials, schools, unknown assailants, and family members.

Within the LGBTQ+ community in Honduras, many are pressured to seek asylum in other countries due to the dangers of living in Honduras as a queer individual. **Violence against the LGBTQ+ community in Honduras stems from "conservative religious sentiment, machismo, rampant impunity, and social pressure on police to 'cleanse' undesirables".**[155] In addition to the emotional and physical trauma that LGBTQ+ members face in the country, mental health issues such as anxiety, depression, suicidal behavior, drug and alcohol abuse, and self-harm emerge as well.

Consequently, in the case of GBV physical and symbolic violence perpetrated by both sides becomes deeply ingrained in the everyday life of women and girls in Honduras.[156] Similarly, for members of the LGBTQ+ community, the violence that they face is completely disregarded by Honduran leadership and officials. Moving forward, not only do changes need to be made in both law and policy toward protecting the human rights of the minority, but social changes within the general public atmosphere must be made as well. It is the **deep-seated structural violence that sends a message to women and LGBTQ+ members who seek justice in unequal institutions that their lives are not valued and that their complaints are not taken seriously, a message that serves to normalize abuse and gender inequalities but also to silence the marginalized**.[152] There is systemic disregard by authorities for sexual- and gender-based violence, which further victimizes women and LGBTQ+ members and normalizes this type of violence in society. Abuse, sexual assault, and domestic violence are a widespread norm in both public and private spheres, yet there is little support from state institutions for victims to escape vulnerable situations.[156] These issues are direct contributors to adverse health outcomes which span from emotional, mental, and physical traumas to premature death. Issues of violence against women and the LGBTQ+ community are prevalent worldwide and should be at the apex of the global health mindset.

Case Study - Female Genital Mutilation

Female Genital Mutilation (FGM), or female circumcision, is one of the most overt, extreme forms of discrimination that exists today. The practice is internationally recognized as a violation of human rights, including in the Universal Declaration of Human Rights, the Convention on the Elimination of all Forms of Discrimination of Women, and the Convention of the Right of the Child. The practice of FGM is concentrated in a range of ethnic groups across over 28 African countries.[158] Over 3 million African women are at risk for FGM annually.[164] There is evidence that many females in Western nations who also undergo the procedure receive it in home countries, often in Africa.[169,163] **FGM is a human rights issue that stems from and is perpetuated by historical subjugation of women and powerful social norms that devalue the livelihood, health, and welfare of females, reflecting pervasive gender inferiority**.[170] UN agencies predict that altering beliefs of women's rights across nations practicing FGM is required to dismantle it.[176]

As an experienced Sudanese physician, Nahid Toubia observed firsthand how FGM contributes to higher childhood and maternal mortality and morbidity in many African nations with poor health services.[172] According to the WHO, FGM holds no health benefits and only induces permanent harm through partial or total removal of female genital organs for non-medical reasons, which impairs and reduces functioning. The damage of FGM depends on the severity of the mutilation/cutting, which the WHO categorizes into four types. Type 1 is a clitoridectomy, which means the partial or complete removal of the clitoris and/or the surrounding skin of the clitoral hood. Type 2 entails excision of the inner labia with or without removal of the outer labia, in addition to the removal of the clitoris. Infibulation, or Type 3, may or may not include removal of the clitoris, and involves diminishing the size of the vaginal opening with a covering seal made through cutting and relocating the inner or outer labia. Type 4 encompasses all other harm done to female genitalia for non-medical purposes.[177]

The majority of FGM procedures are conducted by a traditional practitioner employing non-sterile tools like scissors, razor blades, and broken glass without any pain medications. Sensory tissue of the clitoris is confined to a neurovascular region of a few centimeters. Thus, removing just a small proportion of tissue (Type 1 and 2) holds high risk. As an experienced physician in Sudan and having examined related literature extensively, Toubia has not encountered a case where solely the skin around the clitoris was removed without also harming the clitoris.[172] Typical acute complications of FGM include hemorrhage, anemia, and significant pain that can result in shock and death.[168]

Elongated bleeding can manifest in anemia and inhibit growth, especially in impoverished children. Local infections of the wound and systemic infections are frequent. Adverse effects of abscesses, ulcers, prolonged healing, septicemia, tetanus, and gangrene are also reported.[172] Long-term complications are more commonly reported after infibulation due to blockage of urine and menstrual blood. Chronic pelvic and urinary tract infections can result. A neuroma, or nerve tissue tumor, can occur due to enclosing nerve endings of the scar and result in dyspareunia, or painful intercourse.[172] It is also imperative that females who have undergone infibulation receive deinfibulation prior to intercourse and pregnancy to minimize childbirth risks.[159]

A study of 28 birthing centers in African countries found females with FGM are significantly more likely to have obstetric complications, including a caesarian section, postpartum hemorrhage, prolonged hospital stay, infant resuscitation, stillbirth, low birth weight, or fetal death.[157] Without deinfibulation, the head of the fetus may be restricted from exiting the womb and powerful contractions can lead to perineal lacerations. Contrastingly, if contractions are weak and delivery is delayed, the probability of fetal death increases, and necrosis in the septum between the vagina and bladder can lead to a vesicovaginal fistula, a urinary incontinence that is highly stigmatized.[172] Unfortunately, deinfibulation rarely occurs in low-income countries with inadequate health services and cultural stigma against undoing infibulation medically.[159] **A surge in refugees and immigrants from Africa demands that health providers globally become informed on FGM and its repercussions for patients.** For example, a cesarean section can be unnecessary if deinfibulation is conducted. [172]

The lack of literature on the psychopathology of girls who receive FGM[175] is likely due to apathy towards the issue and the burial of psychological effects under social norms rather than the absence of trauma. For many African girls, the cultural value FGM carries and the desire to satisfy parents and follow social pressures conflict with fear, trauma, and pain from the procedure. While administering clinical care in Sudan, Toubia found that many infibulated women experienced chronic anxiety and depression stemming from stress and fear related to their genital conditions, dysmenorrhea (pain while menstruating), and possible infertility.[172]

Over centuries, the practice of FGM has become deeply embedded in some cultures through historical tradition, tribal belonging, social status, marriageability, and religion, a systematic review found.[165] A manifestation of this cultural entrenchment can be seen in Type 1, which is often called by its Arabic name, "Sunna," translating to duty.[161] Though such a medically destructive cultural practice can not be justified, in order to seek its abandonment, it is crucial to become familiar with the reasons FGM is so entrenched in many societies. According to Toubia, FGM "is the physical marking of the marriageability of women" because it allows control of their sexual pleasure through the clitoridectomy and their reproduction via infibulation.[172] Given the economic and political instability rampant in many African nations, women frequently face extreme pressure to marry. **Moreover, defending cultural identity can outweigh self-interests, especially in many former-colonial African nations, among immigrants who can feel dwarfed by a dominant culture, and because change is arduous for those lacking social power (as women in a patriarchal power structure) to strive for.[172]**

Evidence shows women frequently feel proud to receive FGM and view it as an important ritual despite the harm it induces.[165,166] This is due to the tendency for women to positively associate the practice with social status, marriageability, and cultural identity.[172] False perceptions that FGM has benefits appear tied to the belief that cutting female genitals makes them cleaner.[158] **It will require significant educational campaigns and support to shift toward abandoning the traditional practice.**

Fortunately, FGM rates have reduced globally, causing an adolescent girl to have one-third less chance of receiving FGM than 30 years prior. However, attachment to the practice varies, with 98% of Somalian females receiving FGM in contrast to just 40% of Nigerians desiring to maintain the practice.[170] Anti-FGM laws and court cases ruling on them have deterred against performing FGM by communicating state expectations, reiterating the illegality of the practice and defining it as a human rights violation.[158] However, **prevention efforts must accompany legislation to tackle pervasive cultural traditions**. For example, Burkina Faso introduced legislation criminalizing FGM in 1996 with imprisonment and/or a fine.[174] While FGM declined from 83.6% in 1999 to 76.1% in 2010 [161], levels in Burkina Faso are still dangerously high. UNICEF found prevention efforts that are participatory in nature to be most effective. Successful efforts entailed educating families on the health dangers of the practice and forming relationships with local and religious leaders while encouraging communities to realize problems and develop solutions themselves.[174]

Partnering with the Senegal government and UNICEF, the community-based non-governmental organization (NGO) Tostan launched the human-rights-based Community Empowerment Program (CEP) in 1991 that involves 1,500 communities in 11 regions of Senegal. Each community designates a management committee to oversee, initiate projects, and address needs through CEP sessions spanning 30 months. One of the biggest outcomes has been a shift away from FGM by empowering groups with an understanding of human rights.[171] **Communities share this knowledge and organize meetings with neighboring villages in an attempt to discourage them from the practice.** Meetings have led to significant progress, with 1,527 communities making 18 public declarations renouncing FGM of 2004, representing an estimated 30% of those who practiced FGM in Senegal in 1997.[174] When the women in his village announced they would abandon FGM, 70-year-old religious leader and CEP participant Demba Diawara concluded that for this to come to fruition, their community needed to reach out to the 12 neighboring communities his villagers intermarry with. Ultimately, this intermarrying group publicly declared their decision to abandon FGM in favor of the health and well-being of females in the community, prompting CEP participants in other communities to initiate such discussions themselves.[174] An independent analysis of CEP across 20 villages where it was implemented compared to 20 where it was not found that 85% of women who disapproved of FGM reached this stance after participating in the program. Prior to participating, 7 of 10 women said they intended to have their daughter undergo FGM. This declined to 1 in 10 women who participated in CEP and 2 in 10 women who did not participate but lived in villages that received the interventions.[162]

Relieving social and economic constraints motivating FGM is also essential, as parents desiring the well-being of their daughter through marriage were more likely to choose FGM. One parent in this study said, "If my daughter finishes school, learns how to drive a car, and gets a job, she doesn't need a man whether she's circumcised or not." [233] Additionally, despite a lack of evidence that can directly source FGM to Islam, many Islamic scholars endorse the practice.[167,165] The illiteracy of many parents considering FGM serves as a barrier to autonomous decision-making, causing them to turn to Imams who often also support FGM.[165] Therefore, improving access to quality education and literacy programs, particularly among females, in many African countries is essential to eliminate the practice of FGM by spreading awareness of its dangers. **Ultimately, with the health ramifications of gender violence through FGM being substantial while offering no established health benefits, nations globally must condemn the practice and its violation of female rights and support community-centered efforts to dislodge cultural entrenchment.**

SUBTHEME #5

MIGRANT HEALTH AND RELIGIOUS PERSECUTION

Throughout history, conflicts have been waged between different identity groups, such as ethnic, religious, or political, where one group claims superiority or a right over another and often justifies persecuting them. Today, 1.8 billion people globally reside in areas affected by conflict.[192] **Beyond direct injuries and fatalities, power struggles frequently displace and undermine the well-being of less dominant populations, including by disrupting health systems, limited medical supplies, the collapse of social and economic systems, migration of healthcare workers, and increases in epidemics and poverty.**[192]

Dangerous conflicts causing refugees and migrants to move between nations create a vacuum of responsibility for their healthcare, despite the fact that health is a human right. Native countries typically abstain from providing basic services, including healthcare, to the group they are persecuting while host countries are often hesitant to provide services for non-citizens. In just 2022, 1,473 attacks on healthcare were recorded in conflict-affected areas, which rob populations of critical care, threaten healthcare providers, and endanger entire healthcare systems.[189]

On an optimistic note, while health can deteriorate due to conflict, it can also engender peace by serving as a neutral, mutual interest that unites hostile groups to work towards initiatives, such as vaccination.[192] **Refugees who have been persecuted often have their treatment disrupted, which raises the likelihood of drug-resistant infection.**[186]

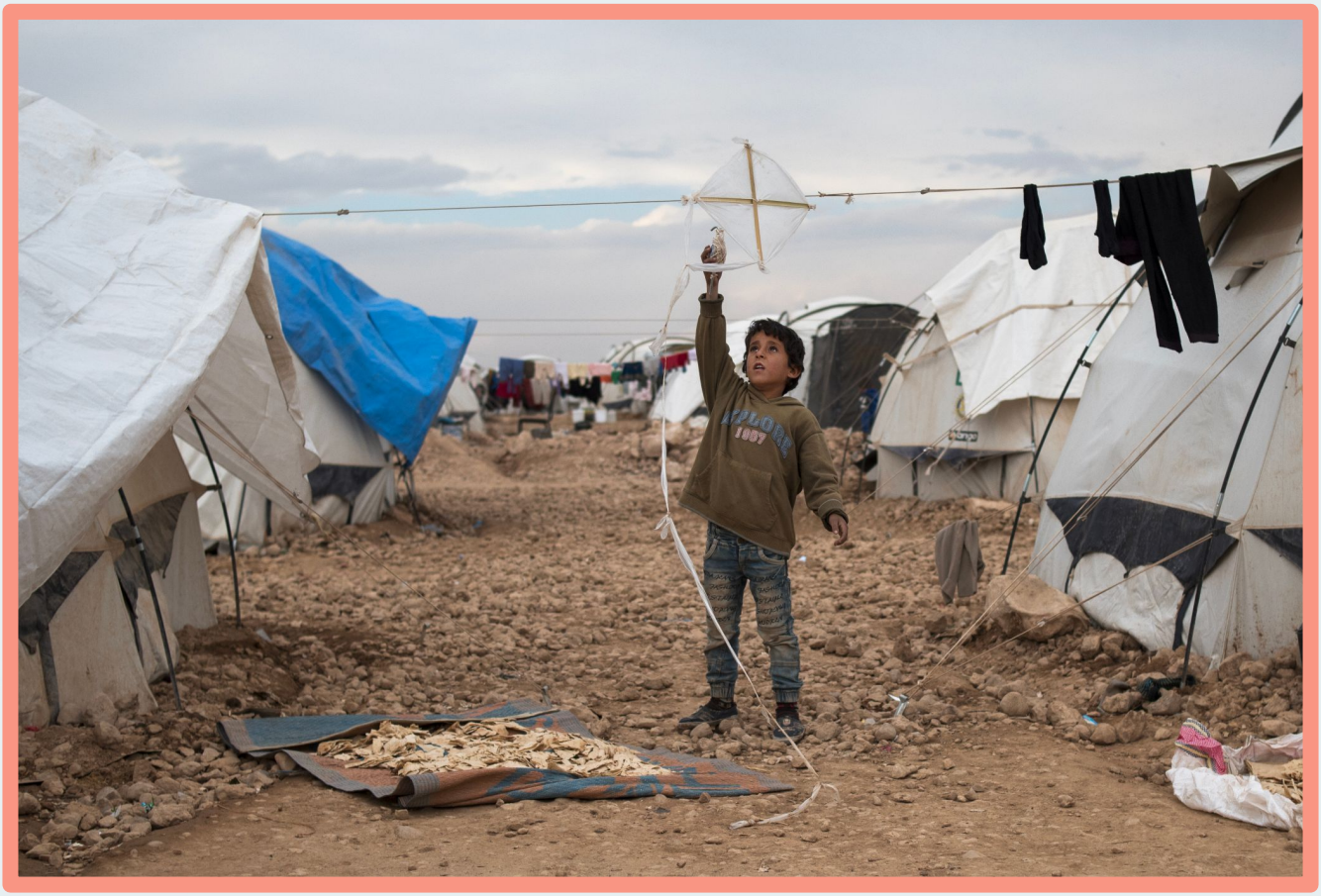
Due to adverse conditions, the health of refugees and migrants is frequently jeopardized, resulting in three times the risk for non-communicable diseases, infectious diseases, and mental health disorders.[178] Violence often involved in persecution imperils health. Children are more susceptible to exploitation, abuse, sexual violence, and forced recruitment as child soldiers.[183]

Evidence shows that nearly all who are impacted by traumatic experiences, including those impacted by conflict and persecution, have a higher susceptibility to social and psychological problems. The WHO categorizes social and mental health problems as pre-existing, such as poverty and mental illnesses, emergency-induced, such as acute stress reactions and loss of livelihood, and humanitarian response-induced, such as overcrowding and unawareness of food distribution.[191] Challenges are often heightened by poverty, displacement, and violence.[180] The German Chamber of Psychotherapists reported in 2015 that out of refugees coming to Germany, over half had a psychological illness, with depression and post-traumatic stress disorder being most common, 70% witnessed violence, and over half were victims of violence.[184] Many of these mental health illnesses go undiagnosed and misdiagnosed due to cross-cultural differences and linguistic limitations that impede the ability to collect information from patients and distinguish between typical stress responses and illnesses.[187] The asylum adjudication process also places immense stress on victims of persecution, elevated by the fact that 79% of initial applications are rejected and families can be torn apart.[188] To be adjudicated as a refugee, an asylum seeker holds the burden of proof despite often facing difficulty recounting painful memories, language barriers, or lacking an attorney to prepare them. For instance, forcing a victim of torture who has PTSD to endure cross-examination in which they are asked to describe persecution and violence can be traumatizing and exacerbate mental health issues.[181]

During migratory journeys or in refugee camps, refugees and migrants typically experience poor sanitary and living conditions, including through the use of contaminated water that increases vulnerability to infections such as vaccine-preventable diseases.[180] The WHO reports the most frequent health problems in refugee camps as hypothermia, burns, and gastrointestinal illnesses.[190] Clinicians report higher levels of upper respiratory tract infections and skin diseases, which have proven to be correlated with molds, poor ventilation, and crowding.[234] Smoke from open fires also contributes to more respiratory infections, and raises the risk of lung cancer and cardiovascular disease.[180] The reliance of some refugee communities on livestock can increase the risk of infectious disease, as livestock zoonoses are prevalent in low and middle-income countries (LMICS).[186] Moreover, most refugees and migrants flee through the sea, which is extremely dangerous; just in 2015, 4,000 lives were lost crossing the Mediterranean.[180]

With the largest refugee crisis currently since World War II, host countries must be equipped with strong healthcare systems to accommodate needs. However, **rather than protect and care for populations fleeing persecution and other perilous conflict, many countries abdicate their responsibility** and focus on policies to control refugee and migrant intake. Due to the trend of lowering refugee quotas globally, many asylum seekers who do not receive protection through refugee status do not have access to any healthcare. Even when one receives basic healthcare services, barriers such as legal status, language, lower income/finances, lack of health insurance, and discrimination persists.[192] Anti-immigration legislation has been shown to worsen the health of those they aim to improve. For example, immigration authority raids in the US have been linked to lower birth weight of Latino babies compared to their US counterparts.[185]

The challenge of managing non-communicable diseases amidst arduous journeys and with inaccessible healthcare in new countries causes many to continue to go untreated, which often increases the severity to the detriment of long-term health. Additionally, migrant women regularly struggle to access prenatal care and vaccinate their children.[180] Mental health struggles emerging from persecution may also be exacerbated by a lack of social cohesion and support networks in their host country.[186]



Ensuring the right to health globally entails not only increasing the accessibility of health services to refugee and migrant populations, but tailoring efforts to their needs. For instance, refugees have disproportionately high levels of infectious or noninfectious diseases, may have unfamiliar tropical diseases, and may lack vaccinations when arriving in host countries.[187] An influx of medical professionals must therefore be dedicated to screening for and treating these diseases and vaccinating. Physicians can also assist in the asylum adjudication process by testifying to physical and psychological harm. Physicians for Human Rights (PHR) is an example, as they have an Asylum Network whose primary purpose is to conduct these evaluations.[182] Ultimately, to prevent health from deteriorating due to conflict and persecution, **global health governance must develop infrastructure to invest in the healthcare of persecuted communities.**

Case Study - Differential Treatment Between Refugee Populations and Healthcare Distribution in Light of Russo-Ukranian War

"This is not the refugee population we have been used to…These people are Europeans…These people are intelligent, they are educated people…This is not the refugee wave we have been used to, people we were not sure about their identity, people with unclear pasts, who could have been even terrorists." This was said by Bulgarian Prime Minister Kiril Petkov in regard to the differential treatment between refugee and migrant populations in light of the Russo-Ukrainian War. This statement and the actions of many other nations such as Poland, Hungary, and Slovakia, echo the unspoken sentiments shared by much of Europe, or rather, by the world: white or European refugees are acceptable, and those outside of this category are not. In fact, it is not just the acceptance of refugee populations that is different, but it is the very way in which they are viewed around the world and portrayed in the media. There are approximately 6.2 million Ukrainian refugees as it stands now, with 60% of this population being welcomed and hosted by Poland.[201] There are approximately 30 million refugees worldwide. The purpose of this case study is to bring light to the racial and ethnic bases for the differential treatment of various refugee populations by the world and how this differential treatment influences healthcare access, disease incidence and exposure, physical and mental health problems, assault, etc. It must be stated that **the purpose of this case study in no way is meant to devalue or criticize the help and support that Ukrainian refugees deserve**; the purpose is to emphasize that all refugee populations at risk are deserving of help and support.

This case study will provide brief context of the Russo-Ukrainian War in addition to other wars and conflicts that are shaping the refugee crisis in North Africa, the Middle East, and Europe. The Russo-Ukrainian war is one that has been brewing for decades. In light of the end of the Cold War and the gradual dismantling of the Soviet Union, the North Atlantic Treaty Organization (NATO) — which was formed in order to provide protection and security amongst its allies against the Soviet Union—expanded into former Soviet Union territory when Poland, Hungary, and the Czech Republic joined. In 2004, seven more countries joined NATO, moving the alliance deeper into the old Soviet sphere of influence.[202] At this point, Belarus, Georgia, and Ukraine were the last post-Soviet countries remaining between Russia and NATO. Georgia and Ukraine both had intentions of joining NATO, thus making them a prime target of Russia. In 2013, Ukraine was going to sign an association agreement with the European Union, but the pro-Russian Ukrainian government at the time refused.[202] This resulted in thousands of Ukrainians flooding the streets in protest.

The Ukrainian president at the time, Viktor Yanukovych, was driven out of office and the country as a result. Thus, President Vladimir Putin lost major political influence over Ukraine.[202] To counter this loss, the Russian president launched military forces to invade and annex Ukraine's Crimea peninsula. Russian-backed separatists then captured the regions of Donetsk and Luhansk and declared them independent of Ukraine. For years, Putin held these regions in order to prevent Ukraine from moving closer to the West. In 2021, after denying any plans of invasion, Putin demanded that NATO stop expanding and move its military borders back. Western leaders rejected his demands and on February 21st 2021, Putin stated his decision to "protect the sovereignty of the regions of Donetsk and Luhans" and launched a full-scale invasion of Ukraine. Since the start of the invasion, there have been hundreds of thousands of casualties, including both soldiers and civilians. There are nearly 5.1 million internally displaced people within Ukraine and upwards of 6.2 million refugees. As reported in 2022, the global refugee population's primary nationalities include Syria, Afghanistan, the Democratic Republic of Congo, Myanmar, Sudan, Somalia, and Ukraine.[196] Some of the additional crises afflicting the northeastern hemisphere that are contributing to the refugee crisis include the war in Syria and the recent earthquake in Turkey and Syria, the Somali Civil War and current drought, the Taliban insurgency in Afghanistan, the Civil war and hunger crisis in South Sudan, and religious persecution in Myanmar.[199]

Since the beginning of the invasion of Ukraine, non-Ukrainian refugees were observed to be treated much differently from their global counterparts. **Arriving from the Middle East and Africa, non-Ukrainian refugees are often "otherized."[195]** This was first demonstrated during wide-scale evacuations within Ukraine when it was reported that African students and other Foreign nationals studying in the country faced racial discrimination at the border. Some were ordered off buses to make room for native Ukrainians and others were stranded in border towns or threatened by border police.[194] Some were forced to walk to the borders of neighboring countries to get away from the conflict. Media portrayal of the war and Ukrainian refugees further contributed. Al Jazeera journalist Virginia Pietromarchi notes, "Bloody conflicts in Syria, Somalia, and other places have not received the wide-reaching international media coverage—or urgent international government action—that the invasion of Ukraine has inspired." In other words, **the deaths of African and Middle Eastern civilians have elicited less attention from media outlets and foreign governments than the deaths of Ukrainians.[195]** The war in Ukraine has been painted as a novelty, whereas other conflicts within the hemisphere that have also contributed to the refugee crisis are painted in a mundane, customary way. Currently, Ukrainians benefit from the unprecedented implementation of the Temporary Protection Directive, which allows Ukrainian refugees to reside, seek employment, and attend school in the EU for three years, with no official asylum approval necessary.[195] Ukrainians enjoy more lenient entry requirements, refugee reception centers that offer essentials, easier travel within the EU, and free public transportation and phone services.[195] They can even enter Slovakia and Poland, countries that displayed potent anti-refugee sentiments during the 2015 Syrian refugee crisis, without legal documents.[195] In 2016, Hungarian leader Viktor Orbán described migration as a "poison," yet he recently exclaimed that Ukrainians are "welcomed by friends in Hungary."[195] EU nations have opened their arms and borders to Ukrainian refugees with unprecedented generosity.[195]

In contrast, non-Ukrainian refugees have been physically assaulted by Polish and Belarussian patrolmen; left to freeze in the winter; detained in unhygienic camps in Greece; "trapped in limbo" between Poland and Belarus; assaulted with tear gas and water cannons near the Greece-Turkey border; and bombarded with xenophobic and anti-migrant rhetoric, especially in Poland, Hungary, and Slovakia. The EU refused to activate the Temporary Protection Directive in 2015, incentivized other nations to thwart the flow of refugees, and **neglected to discipline border patrol agents who violated the rights of asylum seekers**.[195] Non-Ukrainian refugees who are able to overcome the obstacles faced at the border are met with prolonged unemployment due to the asylum applications that they must file that their counterparts cannot. Furthermore, according to Hanne Beirens, the Migration Policy Institute think tank director, the prioritization of Ukrainian refugees restricts the resources available to other refugees, such as housing and language courses, which creates a "two-tiered system" of refugee integration. With fewer resources invested in non-Ukrainian refugees, it may take longer for their asylum cases to be processed, prolonging unemployment, living precarity, and limited access to resources.[195]

Underscoring the justification of this differential treatment is both Islamophobia and racial prejudice. Ukrainian refugees are primarily Christian, while refugees from Syria and North Africa are mostly Muslim. Therefore, the latter must contend with heightened xenophobia, and numerous studies highlight discrimination against Muslim asylum seekers.[195] Approximately 18,000 Europeans from 15 countries were given profiles and asked whom they would grant asylum. **The study found a "consistent bias against Muslim asylum-seekers,** who were 11 percentage points less likely to be accepted than otherwise similar Christians."[195] Part of the issue of Islamophobia is that there is the pervasive and incorrect belief that Middle Eastern refugees are violent terrorists. As political scientist Lamis Abdelaaty describes, "Europeans see Ukrainians as White and Christian, similar to the way that many in European countries see themselves." Eastern Europeans are especially welcoming of Ukrainians, with whom they share a sense of fraternity.[195] Contrarily, due to racial, religious, cultural, and ethnic differences, some Europeans feel less sympathy for other refugees. Furthermore, to many white and Christian Europeans, an influx of Middle Eastern and African Muslim refugees threatens power dynamics rooted in racial and religious hegemony, while incoming Ukrainians primarily strengthen them.[195] Clearly, the geopolitics and the prejudice that is intertwined with the war on Ukraine are quite complex.

As mentioned, the prioritization of Ukrainian refugees has also restricted the resources and aid that are available to other refugee populations, including healthcare resources. Mental health especially is a serious concern, as many people who are refugees experience post-traumatic stress disorder (PTSD), anxiety, depression, etc. The UNHCR has noted that Syrian refugees are experiencing extreme mental and psychological disorders related to the violence that they've witnessed, the stress of displacement, poverty, and general uncertainty.[200] Conditions within refugee camps tend to be very poor, creating a breeding ground for many communicable diseases such as tuberculosis (TB), hepatitis B, hepatitis C, HIV, cholera, etc.

Another aspect of health care delivery that is often neglected for refugee populations is vaccination. The vaccination status of refugees, asylum seekers, and migrants from outside Europe will be different from their host countries, with vaccination commonly being more comprehensive in European countries. Vaccination schedules across European countries vary greatly, moreover, migrant immunization policies are not harmonized. This leads to refugee, asylum-seeking, and migrant children falling through the cracks of the systems, where in one country they are too young to be immunized and in the destination country they are too old.[197] **As it stands, refugees from Ukraine have acquired the same health entitlements as citizens,** thus paradoxically being in a better position than other refugee populations, which gives rise to feelings of unfairness by other migrants.[197]

When making health policies it is important to be aware of the consequences of treating different groups of people entering the country differently, which could result in unfair inequalities and conflicts.[197] **Discrimination in all its forms is a direct violation of human rights.** All refugee and migrant populations who are under duress are deserving of support, aid, and healthcare, regardless of their religion, race, or ethnic and cultural background. While the war on Ukraine has brought light to the issue of differential treatment, it is imperative that both nations within the European Union and those worldwide actively implement policy that discourages such exceptionalism.

Case Study - Inadequacies of Unequal Palestinian Healthcare

The Israeli-Palestinian conflict represents one of the most intractable issues in history, with animosities flowing since the establishment of the Israeli state in 1948. Long-standing displacement, conflict, refugeehood, and occupation have caused the Palestinian health system in the West Bank and Gaza Strip to chronically suffer from underdevelopment due to numerous restrictions including fragmentation, a permit regime, obstacles to movement, limited infrastructure, and provider shortages. Health inequities arise from these restrictions on care and access in occupied territories, causing Palestinians to struggle to realize the right to health. **Juxtaposed with the advanced neighboring Israeli healthcare system, the poor state of the Palestinian health system is more alarming.** When both sides can agree to coordinate, Palestinian patients are referred to Israel for treatment and procedures unavailable within their system.[232]

The Geneva Convention and other international treaties, such as Article 12 in the International Covenant on Economic, Social, and Cultural Rights (ICESCR), obligate occupying powers to provide health resources and infrastructure for populations under their occupation.[211,228,206] Many human rights experts argue that this international law bestows Israel, an occupying power, with the responsibility to attain the highest standard of health for Palestinians.[221, 217] A recent report on Article 12 in the ICESCR reinforced this obligation, yet stated Israel's duty is "depending on its level of control and the transfer of authority".[206] However, Israel's control varies across the occupied territories, with the West Bank being divided into three administrative levels ranging from complete Palestinian Authority (PA) control in Area A to complete Israeli control in Area C, which covers 60% of the region.[204] Moreover, Israel's withdrawal from the Gaza Strip and the ascendency of Hamas, an extremist group committed to destroying Israel, has spurred debate on whether Israel is still an occupying power there. The UN claims Gaza is an occupied territory as, despite Israeli soldiers not being stationed there, they have "effective control" by maintaining a complete blockade and restricting border movement.[207] Further complicating this is that the 1993 Oslo Accords shifted responsibility for the Palestinian healthcare system from Israel to the PA, who then formed the Palestinian Ministry of Health (MoH).[226] The ESCR report stated that the occupying power should not interfere with "the exercise of such rights in those fields where competence has been transferred to the Palestinian authorities".[206] Yet, though the Accords were designed as a step in transitioning to Palestinian sovereignty, full liberation was not achieved due to the rise of more extremist groups on both sides.[218] **While the Accords imparted autonomy to Palestinians over their healthcare system, they did not transfer control over critical resources.** Thus, in many ways, Israel maintains power over occupied territories, harming the Palestinian economy and limiting Palestinian institutions' ability to meet health needs.

Israel wields great influence over the Palestinian healthcare system through regulation of healthcare budgets, checkpoints, building permits, pharmaceutical imports/exports, water, land, and the movement of people and goods. [217,235] **Occupation has severely constrained the Palestinian economy,** resulting in scarce funding to invest in and develop health and sanitation infrastructure and provide determinants of health, such as water, electricity, shelter, and food. For example, loose regulations result in overcrowded refugee camps and poor-quality housing.[230] The constant threat of housing demolitions and the development of more displacing settlements contributes to a stressful environment.[224] Despite the assurance by the Israeli government that it would halt nearly all demolitions during the pandemic, demolitions increased 40% from November 2020 to October 2021.[229] Reducing structural determinants of poor health in the occupied Palestinian territories (OPT) is crucial to improve overall health and protect human rights.

Fragmentation of the Palestinian MoH, especially with two separate health systems in Gaza and the West Bank, leads to **heavy reliance on external organizations,** including nongovernmental organizations, the UN Relief and Works Agency for Palestine Refugees, the Palestinian Military Medical Services, and private organizations.[221, 217] Severe fragmentation, corruption, and dysfunction can be seen in their governing body, and that elections in the PA have not been held in 17 years.[223,219] Many Palestinians not only do not support the PA, but view it as weak, untrustworthy, and hostile to their goals, with Israel contributing to its ineffectiveness[223] such as through withholding millions in tax revenues.[213] In their report on Israel, the ESCR committee reported concerns that, despite high population growth in occupied territories, the proportion of GDP allocated to healthcare only increased by 0.4% between 2000-2017, leading to insufficient medical resources, lengthier waits, and high prevalence of hospital-acquired infections.[206] A WHO report revealed inefficiencies in MoH budgeting, with 61% earmarked towards curative inpatient and outpatient care (higher in the government sector, at 85%), which significantly decreases resources available for general and preventative care. Additionally, finances allocated towards outsourced services are rising, representing 25% of the MoH budget from 2000-2013. The WHO further recommended decreasing the health burden of individual households, as 40% of the income among the poorest fifth of Palestinians was directed towards medical bills.[210]

Essential medicines, equipment, and supplies are frequently absent in many Palestinian healthcare facilities, with only 55% of essential medicines available in the Central Drug Stores of the Ministry of Health in Gaza.[232] **With state-of-the-art security and defense technology, Israeli attacks disproportionately impact Palestinian healthcare facilities compared to Palestinian attacks.** Palestinian healthcare facilities are also often collateral damage in attacks, with 750 attacks from 2019-2022 and 105 health providers injured in the 2022-2023 year.[232, 230] A review by Rosenbloom and Leff found severe deficiencies in emergency care in the Palestinian healthcare system for trauma, myocardial infarction, and stroke. Employing a human rights-based framework, the review highlighted key principles of the right to health that relate to emergency care: nondiscriminatory treatment, providing essential medicines, and developing a national healthcare system. However, structural racism resulting from occupation has contributed to shortcomings in resources and system organization due to restrictions on movement, essential drugs and equipment, and developing a national healthcare [1]

system, thereby **violating these three pillars and impeding Palestinians' ability to realize the right to health.**[22] The OPT has eight times less specialist doctors compared to Israel.[235] However, due to challenges for clinicians outside Israel to gain visas to work in Palestinian universities and the healthcare system, their newly formed Department of Family and Community Medicine, which has been pivotal to achieving WHO health coverage goals, has struggled.[209] Access to healthcare differs depending on whether Palestinians hold an ID from East Jerusalem or the West Bank, and a refugee or non-refugee ID.[230] Palestinian physicians are also extremely undertrained, with a study revealing that no physician in emergency medicine had been trained in a residency program and only 17% of nurses had experienced some emergency medicine training.[236] As a physician attending a Palestinian Medical Relief Society (PMRS) clinic, Emma Keelan was keenly aware of the lack of training some PMRS providers had, contrasting starkly with highly trained Israeli providers she had worked with. She discussed the impact teaching sessions could make in transferring benefits to the Palestinian health system.[235] Keelan also volunteered at a PHR clinic and noted the difficulty she experienced in reaching the clinic. While an ultrasound machine was available for gynecological exams, a urine dipstix or ECG machine were rarely at hand, and she learned to carry her personal equipment when she could, specifically a blood pressure cuff and glucometer.[235]

The COVID-19 pandemic has continued to highlight health disparities between Palestinian and Israeli populations, Palestinians' reliance on Israel, and weaknesses of the Palestinian healthcare system.[222] **Albeit confronting the same virus, Israel held the upper hand** in health workers, infrastructure, and eventually vaccines, reflecting economic and power imbalances.[208] The incompetence of the MoH to manage their health system has caused their vaccination rates to lag severely behind Israel's, which represent a global example of a highly efficient vaccine distribution.[208] Moreover, the Oslo Accords require all medical supplies allocated to Palestinians to be approved by Israel.[208] Several moments have seemed like precursors to cooperation, such as when the COVID-19 vaccination rate was 60% in Israel compared to under 10% in the OPT and Israel agreed to transfer vaccines to the PA as a loan. However, **the hope of cooperation amidst a public health crisis was transient,** as the vaccines had such a short expiration date that the PA returned them.[205] During the pandemic, non-cooperation has destructive effects, ultimately contributing to disease spread, delayed vaccination, and less focus on pandemic management due to tensions.[208] For nearly 2 million people, the OPT had 87 ICU beds with ventilators.[216] Poor public health circumstances, such as poverty and crowding magnify inadequacies of healthcare by limiting the ability of many to engage in preventative measures, such as social distancing.[222] According to an NGO analysis, over half of East Jerusalem neighborhoods lack the ability to execute water, sanitation, and hygiene campaigns in public places.[228] Though it clearly had a negative impact, the extent of the pandemic's impact on Palestinians is uncertain, given that the PA recognized severe shortcomings in their health system to address the pandemic and largely suspended non-urgent care.[222] Medical referrals for Palestinians were reduced disproportionately, falling 51% in the Gaza Strip from 2019 to 2020. This likely holds dangerous health repercussions, as medical referrals are critical to filling voids in the Palestinian system, with the most cited reason being cancer care.[232] In Gaza, 23 of 49 primary healthcare facilities have been shut down to try to reallocate constrained resources to COVID-19 responses.[228]

Despite the deep-seated conflict, many Israeli and Palestinian medical providers desire medical cooperation to improve the crippled Palestinian health system, yet hostilities and steep security, economic, and political barriers limit their ability to do so. British clinicians working with Palestinians through the Foundation for Family Medicine in Palestine (FFMP) to progress healthcare have heard from Israeli providers who wish to assist their efforts but are hindered by an Israeli military ban on traveling to Palestinian Authority A Zones where Palestinian medical schools reside.[209] Likewise, some Palestinian providers are interested in collaborating, but the PA's policy of non-cooperation with Israeli medical professionals and institutions reinforces separation.[214] The refusal of both sides to cooperate on health concerns has tragic repercussions. For instance, though Israel agreed to transport a baby from Gaza to a hospital in Tel Aviv for immediate cardiac surgery, the PA refused to plan the hospital transfer with Israel, and the baby died because of this hesitancy.[214] In two recent reports, the WHO monitored obstacles to healthcare in the OPT, finding that 160,000+ Palestinians in the Israeli-occupied Area C and the Seam Zone of the West Bank rely on unstable access to mobile clinics, 93% of ambulance transfers to east Jerusalem are delayed, and there are an estimated 600 barriers to health access, such as checkpoints in the West Bank.[230] **Amidst escalating hostilities in Gaza recently, there has been an increase in refused or delayed permits which have devastating consequences**, like the death of waiting patients and the performance of vital medical procedures on children without the company of their parents. From 2022-2023, 33% of patients and 62% of companion permit applications were delayed or denied respectively, with 35% of permit applications from 2019-2021 not approved quickly enough to keep hospital appointments.[230, 231] Governance by Hamas in Gaza has also reduced cooperation, including by challenging Israeli health providers in providing assistance.[214]

Restrictions of movement largely stem from barriers surrounding the OPT which, according to Israeli officials, are constructed due to threats. The "Separation Wall," which is 708 kilometers long and 8 meters tall, is one such barrier dividing the West Bank from Israel. Though the Israeli state considers the wall to be a protective measure, it has been declared to be against international law[212] and, from a medical perspective, limits healthcare access by impeding liberty of movement of patients, providers, ambulances, and medications.[235] Steep travel expenses, long commutes to hospitals, and the need for permits to cross checkpoints isolate rural communities and limit health access among impoverished, elderly, and disabled populations.[235]

In addition to controlled movements and inadequate services and healthcare, residents of refugee camps live under constant threat of further restrictions/closures. After an Israeli soldier died in an attack at the Shu'fat refugee camp's primary checkpoint, the camp and surrounding areas in East Jerusalem were nearly entirely closed by Israel through their separation barrier from October 8 to 11, 2022.[215, 230] Access to basic health services was limited, as patients, ambulances, and health workers, including Muhanned, a paramedic with the Palestine Red Crescent Society (PRCS), were restricted. Given an increase in violent disputes and no way to transfer injured civilians to hospitals, Muhanned decided to provide medical assistance to those he could inside homes and small clinics.

Despite caring for a child while wearing his PRCS vest and carrying his first aid kit, soldiers targeted him with rubber bullets. The WHO reported delays in ambulance access and that six ambulances were restricted from caring for patients with seizures, an injury, chest pain, abdominal pain, a patient requiring dialysis, and a woman in delivery. **Accessing primary and outpatient care beyond the camp was impossible due to the closure of checkpoints.**[232]

Though confronting some true security threats, such as from Hamas, Israel cannot be exempt from complying with international humanitarian obligations related to the health of those in the OPT. When Palestinian and Israeli narratives and histories are inextricably tied to the land they both view as holy, health must be reframed as a possible connector. Epidemics, such as COVID-19, in which Palestinians and Israelis have a shared interest in transboundary control, can and should serve as a catalyst to confront health with a united front.[208] **The Israeli occupation has had devastating effects on Palestinians and, at the very least, protecting the fundamental right to health of the population they are occupying should supersede conflict.**

CONCLUSION

Despite steady improvement in the health of many populations and healthcare systems globally, **the health of oppressed populations deviates from the mainstream**, as they often do not experience the benefits but rather are negatively affected by prejudices undermining health. To reduce healthcare disparities and inequalities, historical wrongs and biases that have burdened healthcare systems must be excavated and addressed. Until we grapple with oppressive, exploitive, and kleptocratic governance throughout history that perpetuated systems of colonialism, slavery, and dichotomized and subjugated groups by features of identity, including gender, race, ethnicity, and religion, lingering effects will persist.

Since its onset over three years ago, disparities in the impact of the COVID-19 pandemic have brought to light globally systemic and structural inequalities of racism, xenophobia, discrimination, and other social determinants that determine a population's health. Some of these inequities are historically rooted, while others expose modern-day oppression. **The pandemic also serves as a powerful example of health interdependence by showing both the importance of global health collaboration and solidarity and pervasive barriers to achieving unity.** Representing a most basic, fundamental right, health must serve as a bridge to override or supersede clashing narratives particular communities claim.

To ensure the health and well-being of populations in the face of prejudices or oppression, **health must be placed on a pedestal above political turmoil and divisions.** Additionally, global health governance must be developed to intervene on behalf of preserving the health of targeted/persecuted populations. At the foundation, the problem is inequality in power that can be traced to historical roots. Power imbalances and prejudices shape health access, determinants, and experiences. Dismantling oppressive power requires more than activism by marginalized populations themselves, as poor health often coincides with poor social determinants of health and restricted power. Specific healthcare accountability and monitoring mechanisms must be implemented to safeguard health when jeopardized by state misconduct. However, to avoid falling into neo-colonialist practices, these mechanisms must be designed to amplify the voices of affected populations and understand their needs rather than speak on their behalf. Attention must be drawn to the negative effects of historical and current persecution and trauma on mental health as well.

The American Mock World Health Organization International Conference represents a unique opportunity for delegates to advocate for their respective nations and engage in dialogue on topical issues. Rectifying historical and contemporary prejudices and oppressions undermining global health will demand delegates to practice reflection, open-mindedness, and compassion, both internationally and intranationally: How do health inequalities within their own nation hark back to historical wrongs and oppression? How can delegates empathize with and ameliorate the suffering health of oppressed populations? How might delegates sideline financial and geopolitical interests in order to band together in solidarity and prioritize the health of a group facing prejudices? **The nature of this historical and contemporary issue is too behemoth and pervasive for industries and organizations to address alone.** Righting historical inequalities and oppression that continue to manifest in health disparities today requires delegates to consider paths to cooperation in order to implement policies that uplift marginalized populations and shield them against tyrannical powers.

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Editor's' Note: The writing of this theme guide was finished in August 2023. SInce then, there have been and will continue to be developments in many of the current events discussed in this theme guide.

AMWHO