REGIONAL GUIDE

2022 AMWHO INTERNATIONAL CONFERENCE

HUMAN HEALTH AND GLOBAL CONFLICT

INTRODUCTION

The American Mock World Health Organization's (AMWHO) Southeast Asia and Western Pacific Region (SEARO/WPRO) experiences a variety of public health issues to be addressed through health policy. In this Guide, public health institutions and infrastructure, necessities for life, and the burden of conflict will be explored through case studies in an effort to better recognize areas for improvement across the region.

PUBLIC HEALTH INSTITUTIONS AND INFRASTRUCTURE

CASE STUDY #1

The nation of Bangladesh is dealing with a variety of human rights issues that negatively impact the quality of life of its residents. Corruption, terrorism, financial misallocation, violence against women, and government inaction are prevalent.[1] One issue in particular is the lack of reliable public health systems and infrastructure.

Bangladesh strives to reach Universal Health Coverage (UHC) by 2032, which would give every citizen access to healthcare without suffering financial hardship[2]. This goal is difficult to achieve due to a lack of monetary resources and delivery mechanisms in the country[2]. Under the weight of infectious diseases and mismanaged coverage, Bangladesh's pluralistic healthcare system is cracking[3]. The system, which is highly unregulated, is composed of the government public sector, for-profit private sector, not-for-profit/NGO private sector, and international development actors[3]. Each of these entities is motivated by different factors, leading to different priorities being reflected in subsequent health policy. The financial situations of citizens play a significant role in access to and quality of healthcare. The affordance of private healthcare opens the door to a variety of options, ranging from private practices to large-scale hospitals, but is inaccessible for many Bangladeshis and often of low quality. Public healthcare is highly subsidized by the government and requires nominal payments from patients[3], encouraging low-income families to not seek medical care even when it is necessary; for reference, about 20% of people in Bangladesh live below the national poverty line as of 2019[4].

Moreover, while the government has the goal of achieving UHC, it severely underfunds public health; less than 3% of gross domestic product (GDP) is spent on health in Bangladesh, and that number is the lowest in South Asia[3]. As within the rest of South Asia, Western medicine practitioners must also compete with homeopaths and Ayurvedic specialists. Amongst all of those providers, however, are "quacks" (untrained practioners) and malpractioners[2]. These factors combine to cause people to seek less effective healthcare or suffer at home without any medical attention.

The negative effects of this are evident. The infant mortality rate is 35 per 1000 live births for the lowest income group, but only 14 per 1000 for the highest income group[3]. The marital age of first marriage is only 15.3 years for the lowest income group but 17.6 in the highest[3]. During COVID-19, corruption became so problematic that 218 relief-related incidents were reported, with government officials and public representatives being the primary perpetrators[5]. Officials forged medical equipment budgets, traded fake testing certificates, and provided imaginary results in the stead of trashed samples[5]. There is no doubt that Bangladesh has made significant progress. with 500 health complexes and 13,000 satellite clinics[2]. To continue working towards UHC, the intersection of the private sector with public health needs policy attention to reduce corruption and increase access. Health insurance options need to increase, and malpractices need to be regulated.

CASE STUDY #2

Southeast Asia has experienced some of the highest urbanization and socioeconomic growth rates in the world — albeit the measure still varies greatly, with as low as Cambodia's 35% urbanized population

to Singapore's 100%[7]. Even as the region develops at a rapid pace, it still holds about 40% of all the world's impoverished population: progress is not always equitable[7]. Not only that, but the region is also one of the most diverse in nearly every category (political, socioeconomic, cultural, etc.); while this can be beneficial in many aspects, it also creates disparities in cooperation and infrastructure[7]. Interestingly, the unique geology has also presented problems in health care delivery; the region has been known to be susceptible to earthquakes, typhoons, and floods of high magnitudes[7].

Universal coverage has been the goal of many Southeast Asian countries for quite some time now, but their attempts have been in vain[9]. Vietnam and Indonesia both attempted to implement universal care; however, limited coverage and availability forced out-of-pocket spending to increase[9]. Additionally, the lack of skilled workers, beds available, and primary care created inefficiencies that limit access[9]. Even though high-income states such as Singapore, Japan, and South Korea are present, the lack of access to lower-income countries makes progress more difficult.

The lack of uniform health delivery systems between many Southeast Asian countries can be attributed as one of the main culprits to inefficiency[7]. As previously stated, diversity can be helpful in many ways, but not when it comes to infrastructure cooperation between regions, conflict in this area only brings disaster. Multiple health delivery systems between nations make delivering care immensely more complex — and costly. The complex network of private-for-profit firms does not help the situation[10]. Governments in many countries even have conflicts of interest with for-profit firms by participating in medical tourism, essentially competing against each other and stagnating progress[10]. Many have advocated for reform in favor of public-private partnerships for healthcare delivery, but with little change.[10,7]

What this essentially represents is lack of cooperation due to conflict of interest, much of which is due to geopolitical history of the region. For example, Singapore and Malaysia's relationship "is prone to a number of high-profile bilateral spats that receive considerable media attention."[9] As the resource explains, even as relations do seem to be improving, the delicate nature of their relationship makes progress difficult. Not to mention that talks between a high-income nation previously the victim of ethnic-bias and a low-income nation as the oppressor rarely come without previous tensions.
That being said, investment in local supply chains is one of the most important steps in improving care, but it cannot be done in an environment with multiple conflicts of interests [7,9]. Assistance in streamlining delivery systems may also be beneficial not only in cleaning up corruption in the area but also in eliminating wasteful spending[7]. Even simple investments such as improving basic amenities can increase access to primary care[8]. There is so much potential for regional collaboration, but the right environment needs to be set in place for that to occur.

NECESSITIES FOR LIFE

CASE STUDY #1

Asia houses the largest number of slum dwellers in the world - nearly half a billion people. However, of those slum dwellers, nearly 80% reside in Southern and Eastern Asia[2]. Slums are characterized by a lack of secure housing, absence of basic services, and overcrowding in residential spaces[13]. It is generally common agreement that slums are merely a necessary response to rapid urbanization - in particular, a response in which the capacity of every resource cannot keep up with population growth[15].

Slums seem to have implicit understanding among the world, but that understanding is often far from reality. Many see slums as stricken with poverty and solely reserved for the “low-laborers of society”. While the former may be true relative to many Western nations, the latter is far from reality.

Although living conditions in slums are some of the poorest in the world, economic activity in these areas is immensely high. One of the largest slums in the world, located in Mumbai, India, has an annual economic turnover of over $1 Billion USD[16]. It is very possible to find doctors, lawyers, educators, laborers, etc. in Mumbai’s largest slums, and in many others around the world as well; in Dharavi’s case, businesses from within the slum produce and ship goods as far as the Middle East, Paris, and New York. Slums can be considered their own ecosystem of society[16].

What this implies is that slum conditions are not necessarily a product of unemployment, lack of education, economic inactivity, or any other common attribution, but instead a product of lack of both supply and public support of nearly everything from housing to utilities to educational resources[15]. The response from many living in slums has unfortunately been through illegal means; “electricity theft” is a common tactic that occurs in the slums of Mumbai, MH, India and Ahmedabad, GJ, India[15]. Additionally, the methods that grant certain resources, particularly electricity, are often unsafe; open wires and other unsafe practices are present and injuries/casualties are common[15].

The conditions created can have dire effects on productivity and public health. Slum populations were hit particularly hard by the SARS-CoV-2 virus the past two years, and for obvious reasons. A recent report has claimed that 50% of Mumbai’s slum dwellers had the virus, while 16% of Mumbai residents outside slums had exposure[14]. With slum dwellers already having little to no access to utilities, the ability to carry out daily duties and prevent the spread of disease becomes increasingly more difficult to near impossible[14]. India’s notoriously difficult time with SARS-CoV-2 - B.1.617.2 (otherwise known as the Delta variant) is a common reference to the issue.

CASE STUDY #2

With a population of over 1.3 billion[17], India is home to many malnourished children. Malnutrition has to do with deficiencies, excesses, or imbalances in a person’s energy/nutrient intake[24]. Child and maternal malnutrition is responsible for 15% of India’s total disease burden[18] and 69% of deaths in Indian children under 5[24] and is thus significantly related to the public health of the country as a whole.

Among the most prominent causes of child malnutrition in India is mothers’ health; malnourished mothers are more likely to give birth to malnourished children, but over half of Indian women of childbearing age are anemic or otherwise undernourished[19]. Social constructions of the region also play a role, with low caste children being at higher risk of developing childhood malnutrition than upper caste children due to having less food diversity (about 50% of children are likely to be stunted if they consume less than three food items), poverty, and disease spread[19]. Even when children in rural areas and slums do have access to somewhat stable food sources, a lack of sanitation infrastructure and sanitary behaviors can encourage diseases that prevent their bodies from adequately absorbing and retaining necessary nutrients.
For example, it is commonplace in many rural areas to dump fecal waste in bodies of water. When residents use that water as a bathing pool or trusted drinking sources, they are exposed to millions of pathogens. The consequences are severe: diarrhea, for instance, kills thirteen children in India each

hour[20], and the contaminated water bodies create mosquito breeding sites that further India's severe malaria and dengue fever problems.

In addition to behavioral issues like waste dumping, improper sanitation infrastructure affects child malnutrition and public health. In 2014, Prime Minister Narendra Modi kickstarted the Swachh Bharat Abhiyan (which translates to the Clean India Movement) with the primary goal of achieving an Open Defecation Free India through the provision of sanitation infrastructure (mostly toilets) in rural India[21]. The practice of open defecation promotes the spread of pathogens that increase the risk of child malnutrition. According to the Indian government in 2019, the Movement had "prevented 300,000 deaths and averted 200 million diarrheal cases every year"[22]. However, it upheld many infrastructure issues as well. For example, even where toilets *were* provided, poor people and children suffered. In a rural Valsad, Gujarat district, only 233 of 17,646 toilets provided were functional[23]. In other areas, functional toilets became unusable due to the wastewater not being transported and treated effectively: some villages reported faulty or missing water connections in their toilets, and others were left with soak pits that were incomplete[23].

The goals of Swachh Bharat Abhiyan can be effectively met through financial and government focus on universal access to sewerage systems and toilets, piped water supply to ensure wastewater transport and treatment, policy action to make sanitation more equitable, and community engagement to educate citizens on the root causes of their sanitation issues and how they can change their behaviors to solve them.

Malnutrition, especially during the childhood stage, implicates long term developmental and health risks. Improving sanitation in India can in turn improve childhood malnutrition statistics, making access to adequate sanitation a necessity for life in the country.

BURDEN OF CONFLICT

CASE STUDY #1

Myanmar, also known as Burma, is a majority-Buddhist Southeast Asian country that borders Bangladesh, Laos, China, India, and Thailand. The country is also home to many ethnic minorities, including Rohingya Muslims. After gaining independence from Britain in 1948, Myanmar was under military rule until a new government established civilian rule in 2011[17]. After the results of a general election in early 2021, the country's armed forces opposed the winning party and claimed election fraud[18]. As the new parliament was set to open, a successful military coup d'etat occured on February 1, 2021[17]. Commander-in-chief Min Aung Hlaing and his military rule have faced international backlash for targeting ethnic minorities and degrading the country's way of life[17]. Since the military takeover, unrest has infiltrated Myanmar through violent protests[18]. Even before the coup, Myanmar has suffered civil wars for years. This internal conflict has had an immense negative impact on public health.

In 2009, Myanmar had the lowest health sector expenditure in the world at 0.2% of Gross Domestic Product (GDP), with 50% of children being stunted and the national life expectancy being only 56 years[19]. There are clear disparities in public health between socioeconomic groups and ethnic groups, with Rohingya Muslims being among the most affected.

Today, there are 980,000 refugees and asylum-seekers from Myanmar in neighboring countries[20]. Among those, about 890,000 Rohingya refugees are living in refugee camps in Bangladesh[20]. These refugees face a variety of public health concerns. A 2018 study reported that 51.5% of Rohingya refugees in Bangladesh had hypertension, 14.2% had diabetes, 36,930 had injuries, and they were also exposed to risk factors like tobacco and indoor air pollution[22]. In addition to these non-communicable diseases, infectious diseases are also common among Rohingya refugees. Unexplained fevers, acute respiratory infections, diarrhea, diphtheria, and measles are among the major health problems they face[22]. It is inferred that tuberculosis is also highly prevalent, given that Myanmar is among the top 30 countries with the highest tuberculosis burden[4] and about 97,000 new cases are detected annually[23]. There is a significant lack of access to prenatal care for pregnant women, and mental health problems are also prevalent[23].

In Myanmar itself, the maternal mortality rate is 380 per 100,000 births, which is almost four times the rate of neighboring Thailand[23]. Childhood malnutrition has been made worse by the conflict, and there is a high risk of infectious diseases like diarrhea, hepatitis A, typhoid fever, and AIDS[5]. Myanmar has 60% of all Asian malaria deaths, and many of the antimalarial medicines available are fake[23].

While these are all serious public health concerns plaguing Myanmar and its refugees, there is minimal foreign assistance due to the oppressive regime. The internal conflict has placed a heavy burden on the little preexisting public health infrastructure, with those in rural areas receiving minimal care. Displaced Rohingya refugees, described by the United Nations as "the most persecuted minority in the world"[22], are arguably the most affected in terms of public health. Outside government and NGO assistance is absolutely imperative to combat the public health crisis caused by internal conflict in Myanmar.

CASE STUDY #1

India and China hold nearly 36% of the world's population[24] . Two of the greatest powers in the world bordering on another does not exactly lead to the best of relations. India and China have been at odds for some time now - and public health has taken damage from it[24] .

2021 marked one of the deadliest border clashes between the two powers in over four decades[22]. Even after agreeing to a simultaneous military disengagement of their contested border in the Ladakh region early in the year, tensions remained remarkably high[22].

Doctor's have felt the brunt of conflicts such as these[24] . One doctor from the Ladakh region recalls the usage of satellite phones as the only means of communication, with internet and traditional landline/wireless communication unavailable in the midst of such conflicts[24] . The inefficiency has had dire effects on the ability to administer care[24] .

In the Ladakh region, a recent report from the Indian Ministry of Health has revealed some startling statistics on the living conditions of citizens around armed matters[28] . In the report, nearly 30% of households do not have access to "improved drinking water sources" (defined generally as drinking sources protected from contaminants) and nearly 85% of households do not have access to improved sanitation facilities[25].

The resource push into handling such conflicts has proven to be a drain on orthodox health infrastructure. The constant movement of civilians around conflicts has translated their status into

nomads; gathering health data and providing consistent preventative care has proven a challenge[4]. Notably, both nations attribute the cause of their respective health crises to the actions of each other, furthering conflict[28].

Other issues in the region stem from the geography of such conflicts. Regions such as Ladakh are notoriously difficult to live in as is, with the high altitude causing residents to have increased likelihood of developing acute mountain sickness, high altitude pulmonary edema, and high altitude cerebral edema, among others[28]. Although these are geographical, lack of proper health delivery methods makes the situation even more dire.

Politics has also infused conflict in the region. In the coming years India will hold the position of Chair of the World Health Organization, member of the United Nations Security Council, as well as hold the presidency of the G-20 conference[25]. China, who holds a permanent seat on the United Nations Security Council, has significant weight over India in security matters in the International stage[25]. Politics that cause dire health outcomes, and more notably unnecessary politics/health outcomes, is unacceptable.

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