Strategies to Protect Children from the Effects of War*

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Editor's Note: The following is extracted from a UNICEF report, and if published in future in full form, we will, of course, acknowledge in our next issue.

Introduction

My Name Is Today, a poem written by D. Morley and H. Lovel,[1] reflects the fact that children do not have unlimited time available for their development, for their education, or for enjoying a period in their lives when they are uninhibited by the pressures and knowledge of adulthood. International and civil wars are not decreasing in prevalence or barbarity.

Can the world devise strategies to protect children from the devastating and too often permanent effects of these adult activities? We are not sure but offer the following based on our experiences as paediatricians working with UNICEF in the former Yugoslavia.

Some of the Effects of War on Children[2]

War will usually have disastrous effects on children, including:

Loss of parents or relatives and close friends (by death, kidnap, disappearance at the front line). In some wars this may affect 25 to 50 percent of children. In addition, some children may witness death, kidnap, torture, or severe injuries to other persons (and the children's parents may be totally unaware).

- Loss of home and security.
- Loss of family pets.
- Intimidation, abuse (emotional, physical, sexual, neglect, or all four), torture, and kidnap.
- Pressures to join the army (sometimes from their peers) for excitement, for "something to do," for revenge because of aggression. They may be detained or forced to join the army.
- Poverty, including sometimes extreme hunger or cold.
- Serious injuries, including amputations, burns, hearing loss.
- Serious psychological disorders such as anxiety, depression, sleep disorders, disruptive and aggressive behaviour, school phobias, psychomotor disorders.

Reactions To What Has Happened And What Might Happen To Them In An Uncertain Future

Children's reactions depend on many factors, including the age and maturity of the child. As an example, adolescents are already at a vulnerable period in their lives. The natural formation of their identity, the development of an independent and self-supporting existence, the need to cope with aggressive and sexual impulses are difficult in the best of times. During war, such children may lack supportive family structures, including role models – through missing, absent, or dead parents. Their community is disrupted, moral and cultural values are questioned, and distinctions between right and wrong are blurred. Unlike younger children, adolescents do not usually adopt play or fantasy to help them cope. Although adolescents are more able than younger children to talk about their problems, they (especially boys) may be unwilling to do so.

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Children are prone to feel guilt. They may feel vulnerable and hopeless. Although they may have been forced to grow up and adopt an adult role, they may remain emotionally immature. Adolescents can be prone to self-destructive behaviour, including suicide. They take risks and may engage in self-abusive acts such as drug dependence and smoking. They may withdraw, feel hopeless, and expect the worst to come (sometimes tragically true). They may become aggressive or even delinquent.

Strategies of Support

From our experience, we consider that first and foremost children must be protected as much as possible from the effects of war. This protection should aim to include the whole environment of the child within the family. Logically, the following might be attempted:

- Evacuation of all children with their mothers (where possible).
- Enforcement of the rule that war is to be between armies only. Inclusion of targets where civilians might become injured must be regarded as a war crime.
- Creation of truly safe areas (zones of protection for children).

We consider the third option the only practical one in today's world. Child protection must adhere to the same principles, whether it involves abuse of a child in the home or the community, or acts of one state against another. The child must be separated from the abuser, and regrettably this may require superior force.

Safe Areas

At present, there are no effective safe areas within the many war zones around the world. There should be an international mandate to designate a number of areas (each with a high density of population and based on the availability of sufficient UN forces) to become zones of protection for children to live in whilst adults finish their conflict.

Each area must be cleared of all structures (whether military or administrative) that could make it a military target, thereby removing all justification for incoming shells, bullets or rockets. Soldiers returning home on leave would need on entry to hand weapons to UN protection forces. The importing of heavy weapons into the safe area by defending local armed forces must be prevented at all costs. Only UN forces would have arms, and they must handle them as discretely as possible in the presence of children.

Within each area should be a protective force of international personnel, including soldiers and staff such as teachers, health care workers, and psychologists who will provide for the needs of the children and their families. Each safe area must have protected rights of passage for incoming aid.

Hospitals, health centres, and schools would attempt to function as normally as possible, together with such programs as psychosocial care. Within each of these settings, international workers would be available to help local counterparts. Since the area would be relatively safe, incoming professionals should be able to function better, knowing that their lives are not as threatened as is generally the case at present.

Children must be able to play in the open without fear. They should not have to live in basements or bunkers. A strong international and local civilian police force should minimise black-market activities as well as other crime.

Outlying, smaller towns or villages will continue to be difficult to protect. Families within them must be allowed to make their own decisions regarding when they should, for safety reasons, leave their homes. Within the safe areas it would be appropriate to assemble, in advance, temporary accommodation for future displaced families. UN forces should protect families during any journeys they would make into or out of the safe areas. Safe areas must be selected so that they do not encourage ethnic cleansing (fascism).

International forces must not place themselves in danger of being taken hostage. Within each safe area should be a UN agency whose sole function is to coordinate all incoming aid. We recognise that at present no such agency exists.

The targetting of any UN-designated safe area must be regarded as a war crime, since it indicates direct aggression against children.

Primary Health Care

With depletion of medical staff, community health care takes on greater relative importance. After a period of inaccessibility to health care, screening programmes could identify health needs; they could also dispel claims for needs (perceived or otherwise) that do not exist, thereby preventing the waste of scarce resources. Mobile health clinics can be valuable when primary health care facilities have been destroyed.

Health Education and Health Records

Health education is particularly important and scarce during war, leaving depleted medical staff with restricted access to literature and training. Conflict also brings new medical/surgical problems, thus creating the need for outside help. The international community has an abundance of trained personnel who are willing (and even keen) to work for relatively short periods in war zones, particularly if there is adequate protection. Although aid agencies are used to long-term programmes for disadvantaged countries, in our experience, short-term international consultants, through training and practice, can make large improvements in the health of children. In addition, intelligent local non-medical workers can be recruited and trained to perform essential tasks such as immunisation.

Many people become displaced during war – often at great distances from the storage site of their health records. Sometimes these records are destroyed or taken from them. Unfortunately, rapid resolution of conflicts is not usual, and medical records become essential, particularly for the children.

The development and use of parent- and young person-held record and advice booklets (PHRA) were, in our experience, particularly helpful. These booklets, translated from English into the local language, placed power in the hands of the parent and young person. They contained information on medical histories, immunisation, growth records, health education (including pregnancy and breastfeeding, drugs, HIV infection) and accident prevention, hygiene, home treatment of common illnesses, etc. They also contained a section to be filled in by doctors and nurses during intercurrent illnesses. In the absence of a functioning health care system, the PHRA may help to minimise health problems and accidents. In addition, the use of posters, the media, and a child-to-child approach may all be valuable.

Provision of the latest guidelines for hospital and community paediatrics, translated into the local language, can help keep local paediatricians and family doctors up to date with the latest developments. This is particularly relevant in situations where medical libraries have been destroyed and war has been present for some time.

Secondary Health Care

Secondary health care is essential for children in war-torn countries. Field hospitals might be required if facilities have been destroyed or captured. Equipment donated to existing hospital facilities must be coordinated (as described above) and be easy to use and maintain. Sufficient disposables must be provided. Manuals for using equipment must be translated into the local language, and training must be available for the local professionals.

International paediatricians, even working for relatively short periods of time such as one month, can provide invaluable support to local professionals who are often tired and demoralised. Such support has to be given gently and with an understanding of the different opportunities for training that may have been available to visitor and resident.

It is essential to recognise that children with serious medical or surgical problems that were not caused by war cannot wait long for treatment. In the absence of appropriate local hospital facilities, other countries must provide for medical evacuation. Such children must be accompanied by a parent and

dependent siblings and returned home as soon as the condition has been treated adequately. Receiving countries must be given detailed and precise information.

Sometimes medical evacuation can be circumvented by sending specimens for analysis to other countries and providing local treatment based on the results. In addition, some children have special needs; support services such as physiotherapy and speech therapy must be provided by internationals.

Urgent cases requiring medical evacuation must be implemented without hindrance by military or bureaucratic hurdles.

Child Activities/Resources

Resources such as toys, footballs, artificial grass, and other play areas can improve the quality of children's lives when they are trapped by war. Such facilities should be easy to set up in the safe areas. Additional behaviours aimed at helping these children include:

- Avoid the separation of children from their families, friends, and community.
- Listen with care and sensitivity to their concerns.
- Encourage them to talk about their position in the conflict. Try not to judge right and wrong. Encourage them to design a peaceful solution.
- Maintain normal routines, thus helping to engender security.
- Encourage them to express their feelings through art, writing, and storytelling.
- Encourage them to share their experiences with their peers and adult role models, such as teachers and community leaders.
- Encourage them to think about rebuilding their community when peace arrives.
- Encourage them, if old enough, to help in hospitals, in schools where there are younger children, and with UN and NGO international organisations.
- Stress the importance of schooling.
- Support the maintenance of discipline and structure by teachers in the schools.
- Encourage moral and ethical group discussions about the conflict. Encourage thoughts of peace and reconstruction.
- Encourage sports and other communal activities, such as music, theatre, etc.
- Provide teaching about accident prevention, in particular about road safety and about avoiding mines and firearms. (In safe areas, parents should not have weapons.)
- Promote self-help peer groups.

Specific Medical Problems That May Affect Children

Secondary Eneuresis: Never punish. Provide clean clothes before bed each night. Reduce fluids at night. Reduce exposure to violent discussions or television in the evenings. Provide fluid sensor alarms, if available. Provide sufficient desmopressin tablets and nasal spray.

Nightmares: Children are awake afterwards – therefore reassure. Next day, encourage discussion of contents. Encourage them to think nice thoughts before going to sleep.

Night Terrors: Children are asleep – therefore do not try to awaken them. Remain with them until they fall asleep or until awake.

Reduced School Performance: Talk about problems, especially just before going to bed. If due to the intrusion of stressful memories,

encourage them to talk. Do not punish poor performance. Provide positive reinforcement ("I know it is hard for you to do well at school, but I am proud of you for trying"[2]).

Anxiety: Honest, patient responses. Support.

Aggression: Try to provide opportunity to express feelings verbally. Avoid aggressive response. Withdraw attention and request they leave the group. At home, they should go to their room for awhile. Increase physical exercise. Never use physical punishment.

Depression: Find out why by discussion. Share sadness if appropriate. Integrate with peers. Ensure exercise, food, and sleeping times. Build self-confidence.

Severe Depression: Be alert to danger of suicide.

Grieving: Parents should be advised to consider displaying their grief. Grieving should be allowed in children if possible before they have to take on an adult role. Stages: (1) shock/denial – do not collude; (2) anger – allow expression and accept criticism; (3) Sadness – allow discussion. Photographs can help. Inform school.

Risk-Taking: Parents to oppose it even if they are rejected as a result. Confront with potential consequences to those they love. Keep structured home environment with rules. Adult role model can help. Be firm but caring. Show you love them all the time. Discourage them from joining the army.

Psychosomatic Pains: Help by talking. Ensure medical cause excluded. Don't allow the symptoms to result in attention or sympathy. Do not allow psycho-somatic pains to result in missed school.

Addiction: Watch for restlessness, inability to sleep, slurred speech, lost or overspent money.

Sexual Violence: Defined as "sexual intercourse or other sexual acts performed on another person without his/her consent." During war it is a life-threatening experience meant to hurt, control, and humiliate. It invades a person's innermost physical and emotional integrity. It occurs in boys and girls, but is grossly under-reported (particularly in boys).

Children are particularly at risk for sexual violence if unaccompanied or unsupported. Such violence may occur in a number of situations (in prison; in exchange for arms, for refugee status, for food, money, or threats against other family members; by armed gangs when violence is a major feature, including hitting, genital and other mutilation; as organised prostitution; within families (incest, perhaps in part as a response to stress).

Sexual violence has permanent psychological effects. It also may result in HIV infection and other sexually transmitted diseases, mutilation, pregnancy (leading sometimes to subsequent non-medical abortion, infanticide or rejection of the child, or self-mutilation by the victim), and miscarriage of an existing pregnancy. It is grossly under-reported, particularly in certain cultures and religious communities.

Security is the most important element in preventing sexual violence (further support for "safe areas"). Personal security such as whistles and alarms should be provided. Organisations should ensure that (a) there are established guidelines to protect children (particularly adolescents); (b) there is recreation and exercise available for all as a means to overcome intense frustration and boredom; (c) the organisation's members meet regularly to discuss security; (4) the organisation involves community and religious leaders in protection and treatment; (5) investigation of all complaints of violence and threats of violence are treated confidentially, with protection for all witnesses and victims; (6) there are legal processes in place, from both national

and international perspectives; (7) there is provision of medical and psychosocial support for the treatment of victims; (8) women have major presence in the organisation; and (9) victims have suitable medical and social support of the same sex, unless requested otherwise.

Sexual violence is a violation of the Rights of the Child (Articles 19 and 34). The EU and UN War Crimes Commission in 1993 estimated that between 10,000 and 20,000 persons in the former Yugoslavia have suffered sexual violence. Many of these victims were adolescents. The Commission on Human Rights for the former Yugoslavia has also stated that rape in the context of ethnic cleansing is a "grave breach of the Fourth Geneva Convention (Article 147) and, as such, is a war crime. "

Post-Traumatic Stress Disorder: The symptoms include (1) recurrent memory phenomena, including flashbacks (sensory reliving of trauma, smell, taste, sight, sound), nightmares, intrusive thoughts; (2) hyper-arousal (sleeping problems, irritability, aggression, concentration problems); (3) somatic symptoms (fatigue, sickness and abdominal pains, headaches, diffuse aches and pains); (4) anxiety reactions (panic attacks); (5) sadness and grief (depression, loss of appetite, loss of interest in previously enjoyed activities, suicidal thoughts); and (6) avoidance of situations reminding victim of trauma (phobias, emotional numbness, body numbness).

Post-traumatic stress disorder needs to be managed by both a general psychosocial programme involving the training of teachers to help the large proportion of the population of children usually affected and by individual psychiatric and psychological support for those individuals most serious disturbed. These latter problems are as important to address as the serious medical or surgical problems described earlier. In some instances, children with severe psychiatric symptoms (e.g., following the loss of both parents) may need evacuation for treatment, along with supporting relatives.

Immunisation: Regular immunisation schedules may be disrupted and should be aggressively pursued inside and outside the safe areas. An adequate cold chain must be established.

Loss of Glasses: This may mean an effective loss of vision, a major problem for a developing child A retinoscope is an easy-to-use device which can screen children for visual acuity problems, allowing prescriptions for glasses to be made up, if necessary, in another country.

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