The role of social science in conflict situations.

MUELLER-HIRTH, N.

2023

Handbook of Social Sciences and Global Public Health

Length of text: Word count in the range of 6000–8000 words (excluding figures and references).

The Role of Social Science in Conflict Situations

Natascha Mueller-Hirth

School of Applied Social Sciences

Robert Gordon University Aberdeen

Aberdeen

Scotland

n.mueller-hirth@rgu.ac.uk

Dr Natascha Mueller-Hirth is Senior Lecturer in Sociology at Robert Gordon University Aberdeen, Scotland. Her research utilises qualitative methodologies to examine issues around peace and conflict, violence, gender and development, primarily focusing on South Africa and Kenya. A particular interest is temporality and the politics of time in relation to conflict, peacebuilding and transitional justice.

Abstract

Conflict and violence are a major threat to the health of populations. In the last decade, violent conflict has increased significantly and has produced ever greater challenges to the health and well-being of people affected by conflict, which now often include varied demographics and a combination of harms and suffering. Considering diverse literatures from medical sociology, medical anthropology, and peace and conflict studies, this chapter advances three arguments. One, violence in conflict settings takes multiple forms, which must be considered to understand to health and well-being impacts of conflict. Two, social science contributions made explicit local understandings, lived experiences and people's own constructions of health across different conflict settings, which challenge a universalizing biomedical model and can inform context-appropriate interventions. Three, health can contribute to conflict resolution and peacebuilding, but health care systems can be weaponized, reinforcing structural forms of violence and existing tensions. It can be argued that the aim of public health interventions in conflict settings should be the well-being of all sectors of the population and social scientists are singularly well place to examine what well-being constitutes for people in their contexts and how it can be supported.

Keywords

Conflict, violence, peace, slow violence, structural violence, suffering, trauma, displacement

1. Introduction

It is not controversial to state that conflict and violence are a major threat to the health of populations. Health effects of conflict are well documented to include trauma, mental health, non-communicable and infectious diseases, child health, and sexual and maternal health. Effects can occur directly, as a result of fighting, and indirectly, through wider socioeconomic impacts. Health outcomes are unevenly distributed, with vulnerable populations especially at risk. However, despite a large body of literature in this area, Panter Brick (2010, p. 1) argued in a special issue of *Social Science & Medicine* on conflict, violence, and health that "issues related to the physical, emotional, and social consequences of violence still need to be pushed to the very top of international, national, and local public health agenda".

Public health refers to organized measures to prevent disease, promote health, and prolong life among populations. As a discipline, it has focused on socio-economic, cultural and political contexts of health and well-being, linking individual, community, and environmental (or societal) levels (Woehrle 2019). However, a biomedical model is prominent in public health understandings of conflict settings, emphasizing biological and biochemical explanations for ill health. Such a model has been criticized in the social sciences for giving insufficient consideration to social, environmental, psychological, and political dynamics that impact on the health and well-being of individuals, communities and societies during and after conflict, and for neglecting social injustice as a key factor in producing distress and suffering (Pedersen 2002).

The character of violent conflict has changed over time, with globalization having led to the emergence of so-called 'new wars', which tend to involve ethno-religious intra-state conflicts fought by networks of state and non-state actor (Kaldor 2013). New wars have seen larger numbers of victims of traumatic events, greater number of deaths among civilians and mass population displacement. What is more, violent conflict has spiked dramatically since 2010. Fragile and conflict-affected states have the worst health indicators and the weakest health systems (World Bank 2022), with over 60% of the world's child and maternal deaths occurring in such settings. At the end of 2021, the total number of forcibly displaced people was 89.3 million, forced to flee their homes due to armed conflicts, generalized violence or human rights violations (UNHRC 2022). The UN Refugee Agency (UNHRC 2022) notes that, in 2021, many displaced people faced additional challenges due to COVID-19, disasters, extreme weather and other effects of climate change.

Given these contexts, this chapter puts forward three main arguments with regards to the contributions of social sciences in understanding public health in conflict settings. It draws not only from medical anthropology and medical sociology but engages a wider canon of critical social sciences,

including peace and conflict studies, to outline key ideas and concepts that complement and often challenge the biomedical model of health and illness in conflict.

First, the social sciences contribute complex understandings of conflict that go beyond a conception of violence as direct and interpersonal. Violence takes multiple forms, and this chapter relates the concepts of structural violence, social suffering, and slow violence to health and well-being in conflict settings, and examines uneven effects of conflict in relation to gender and to disability. Second, social scientific knowledges have allowed the exploration of particular historical social and cultural contexts that are key determinants of health and illness in conflict situations. This chapter particularly focuses on social science contributions, gained through ethnographic research and other qualitative approaches, that have revealed specific and localized social and cultural experiences of suffering, healing and coping that cannot be understood through a universalized Western-centric model of trauma. As Pedersen (2002, p. 175) put it in a landmark article, "the medicalization of collective suffering and trauma reflects a poor understanding of the relationships among critically important social determinants and the range of possible health outcomes of political violence". Third, health can also be linked to conflict resolution and peacebuilding. Normatively, public health should have an interest in conflict prevention and in peacebuilding given the health and well-being impacts of violent conflict. Some scholars contend that equitable health services can foster a sense of shared identity across divides, can build trust in new governments and can restore accountability. However, health systems in conflict and post-conflict settings are not neutral but function as social and political institutions. As such, they can be linked with the interests of specific stakeholders and factions during times of conflict and weaponized, with devastating effects on some sections of a population.

Importantly, the concepts of conflict, violence and peace all are contested. This chapter begins with the premise that violence is multiform and that this character shapes health and health outcomes, a claim which will be further evidenced in section 3. It reviews literature that pertains both to conflict and so-called post-conflict settings. This is because impacts on public health and health systems continue long after the formal end of conflict, and in occur in non-linear ways. Indirect mortality – such as that caused by the destruction of livelihoods and health systems, a lack of water, food and sanitation, inadequate food and water supplies – often continues long after fighting has ended. However, long term impacts, particularly on civilian populations, have been relatively ignored until recently (Garry and Checci 2020, Pedersen et al 2010). Moreover, given the recognition in peace and conflict studies that the boundaries between 'conflict' and 'post-conflict' are not clear cut and that there is no 'post-conflict' for women (Gobodo-Madikizela 2014, cited in Lambourne and Rodriguez Carreon 2016, p. 74) and indeed for other marginalized groups, the convention of rendering the term in inverted commas has been adopted here. Definitional issues around the concepts of conflict and of violence moreover call into question how peace can be conceived of. Johan Galtung's (1969) hugely influential framework here is important here, distinguishing between negative

peace as the absence of interpersonal violence and positive peace as the achievement of fairness, justice and social redistribution (that is to say the absence of structural violence). From a public health perspective, negative peace has health benefits, but it is positive peace that is characterized by healthy relationships and a holistic understanding of populations' well-being (Arya 2017, Woehrle 2019).

Before examining the three arguments in detail, a brief summary of the health impacts of conflict and violence is provided.

2. The health impacts of conflict and violence

In conventional accounts of health in conflict situations, it is common to distinguish between the direct and indirect health impacts of living in, and through, conflict. Impacts can further be characterized as occurring at an individual or at community level (Guha-Sapir and van Panhuis 2002). As Garry and Checci (2020) found in a recent review of the literature, health effects of conflict include trauma such as death, injury and maiming; mental health (such as anxiety, depression and trauma-related disorders such as PTSD); non-communicable diseases; sexual, reproductive and maternal health; and infectious diseases. For particularly vulnerable groups, such as children, mortality is further driven by indirect factors such as severe malnutrition and diseases such as malaria.

Literature in medical anthropology and public health has increasingly documented health and well-being effects on families and communities "beyond the immediacy of injury and death" (Rylko-Bauer, Whiteford, and Farmer 2009, p. 8). Such indirect impacts can result from displacement, infrastructure damage, the destruction of livelihoods, the deprivation of basic needs and food insecurity (see Aguirre, Perez and Burkett 2022, Pedersen 2002, Rylko-Bauer, Whiteford and Farmer 2009, for reviews). Conflict and violence moreover limit access to health care and disrupt preventive care and treatment services (Garry and Checci 2020).

Taking displacement and refugee movement as a brief example here of the complex and uneven heath impacts of conflict, displacement typically leads to malnutrition and a lack of shelter, sanitation and clean water. A breakdown of health care systems during conflict further decreases the availability of heath care, including material care, vaccination programs so on. Camps or temporary shelters with overcrowding expose refugees to infectious diseases and other health risks (Leaning and Guha-Sapir 2013). Displaced populations include a disproportionate amount of vulnerable people, such as children, orphaned children, widows and so on, and women and children are at greater risk of sexual violence in camps (Krause 2015, Meinhart et al. 2021). But displacement – and violent conflict more generally – also disrupts communities and their support systems and impacts people through the stress of living with fear and uncertainty. Social sciences contribution moreover highlights the long-term embodied impact of trauma and the role of

traumatic memories that keep violence alive long after it has occurred (Argenti and Schramm 2014, Rylko-Bauer, Whiteford, and Farmer 2009).

It is important to note that data collection, of any kind, in conflicts settings is difficult, because of factors such as infectious disease outbreaks, mass displacement, civil war and so on (Meinhart 2021, Panter Brick 2010, Stark 2011)

3. Understandings of conflict and violence

Violence, in conventional accounts, is predominantly understood as direct acts of harm that produce particular direct and indirect effects on individual and population health. Such an understanding neglects that there have been extensive debates in the social sciences about the nature of violence itself. Conflict settings include direct, or interpersonal, violence but produce or enhance poverty, marginalization, inequality and injustice. Conversely, violence not only characterizes conflict settings, but is too experienced during 'post-conflict' and even so-called peace times, through a range of forms of everyday violence. Feminist conflict scholars in particular have consistently highlighted not only the continuum of violence from 'exceptional' political violence to the everyday and structural violence that many women experience but also continuities of gender-based violence from war time to so-called peace time (Cockburn 2004, Wibben 2020). More recently, debates about the nature of violence have been explored in relation to health, as exemplified in the *Global Health in Times of Violence* volume (Rylko-Bauer, Whiteford and Farmer 2009; also see Pedersen 2002 and Rylko-Bauer 2022 for reviews).

In what follows, a brief outline is given of the concepts of *structural violence*, *social suffering*, and *slow violence*. Such reflections are not merely theoretical or academic; rather there are implications of these reconceptualizations of violence to the question of public health in conflict situations. Moreover, the nature of violent conflict itself has changed, with significant impacts on global public health. Finally, this section reflects on social science contributions to understanding the uneven effects of conflict on different sections of a population.

Structural violence

Sociologist and founder of peace and conflict studies Johan Galtung (1969) developed the notion of structural violence, alongside his important distinction between negative and positive peace that has already been introduced above. Violence is not only a direct act of harm or aggression but describes experiences of social injustice and systemic inequalities. Structural violence is the normalized and often unrecognized suffering caused by people's poverty, unequal life chances and the denial of their basic needs as a result of social structures and discrimination. The victims of structural violence have been shown, particularly in the work of medical anthropologists, to be most at risk of and primarily affected by infectious diseases such as

TB, AIDS and cholera (see Rylko-Bauer and Farmer 2016 for a review). Moreover, the impacts of conflict on health and health care systems are often mediated by pre-existing levels of structural violence (Rylko-Bauer and Farmer 2016).

Social Suffering

Social scientists have drawn attention, over the last two decades or so, to the experiences of extreme hardship and suffering and what it does to people (Wilkinson 2005). Suffering, from this perspective, is "the effect of the social violence that social orders – local, national, global – bring to bear on people" (Kleinman 2000, p. 226). The concept of social suffering has been employed to understand public health in conflict settings (Giacaman 2018; Pedersen 2010). For example, Giacaman and colleagues studied the effects of suffering on the health of young Palestinians over several years (see Giacaman 2018 for a summary of this research program), drawing on the work around social suffering by anthropologists Das (2007) and Kleinman (2000). However, the psycho-political impact of ongoing adversity remains underexplored (Barber et al 2016; Ribeiro et al. 2009).

Slow violence

A more recent concept with the potential to deepen understandings of public health in conflict settings is that of slow violence, defined as "a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all" (Nixon, 2011, p. 2). Writing from the disciplinary context of the environmental humanities, Nixon's particular focus is on environmental and ecological destruction under capitalism, highlighting that the delayed repercussions of climate change, pollution, resource extraction and warfare often only become visible after decades. Examples of what Nixon memorably calls 'long dyings' include the ecological collapse of the Niger Delta as a result of oil extraction, radiation caused by depleted uranium ammunition used in the Gulf War, and 'developmental refugees' that are displaced by mega dams.

Davies' (2022) research with communities in the toxic landscapes of Louisiana's petrochemical industry demonstrates how structural inequality, such as Galtung's (1969) work brings to the fore, can mutate into slow violence. 'Cancer Alley', as the region has been nicknamed, is characterized by noxious chemical odors, a landscape that has been changed by pollution, and the perception by residents of health risks and ill-health such as respiratory disease. It is, as literature on environmental injustice has consistently shown, typically low-income communities or countries that host hazardous sites and bears the greatest environmental risks.

The concept of slow violence is highly relevant to thinking about violence and its critical health consequences: cancers and contaminations are caused by exposure to radiation or chemical pollution; resource extraction and climate change degrade the conditions for sustaining human life. However, when violence is reduced to single events or short, clearly defined periods of 'conflict', the health consequences

for people living with, suffering or dying from the long-term, delayed or accumulative impacts of environmental risks can be easily neglected.

The changing nature of conflict over time

In addition to considering different types and forms of violence, the changing character of armed conflict over time – and how this might impact heath – has also been noted (Garry and Checchi 2020; Kruk et al. 2009; Pedersen 2002). Globalization after the end of the Cold War has been said to lead to the emergence of 'new wars' (Kaldor 2013). These contemporary conflicts tend to differ from older ones in terms of actors (now fought by varying combinations of networks of state and non-state actors), goals (fought in the name of ethnic or religious identities), methods (territory is captured through political means, through control of the population and displacement) and forms of finance (internationally and sometimes privately funded conflict).

The health impact of such new wars has been viewed as complex, but it is generally acknowledged that the number of victims and survivors of traumatic events has significantly increased (Pedersen, 2002) and that deaths among civilian populations have risen (Garry and Checchi 2020). Conflicts have become increasingly multifaceted, with mass displacements, food insecurity and epidemics producing unique challenges and humanitarian crises (Garry and Checci 2020). Other health impacts of 'new wars' include frequent violations of cease-fire and of the neutrality of health services and relief operations (Pedersen 2002). Conflicts having become transnationalized which, as Berghs (2015, p. 747) argues, has resulted in conflicts no longer having any distinct territoriality: "global civilian infrastructure, resources and bodies are deliberately being targeted to spread messages of fear, and control or eliminate populations". This, in turn, means that the people that are affected by conflict include much more varied demographics, with children and young people, youths, women, fighters, disabled people and the elderly all affected, often with a combination of harms (Berghs 2015).

Uneven effects of conflict and violence

It is a key tenet of the sociology of health and illness that social factors influence health and produce health inequalities and inequities. Exposure to violence, and the health impacts of conflict, are unevenly distributed, as the discussion of three forms of violence above evidence. Social sciences, therefore, contribute to understanding the uneven and differentiated effects of conflict and violence on people's lives, and on health inequities in conflict and 'post-conflict' settings (Sinha and Liang 2021). This section concludes with a review of the literature on two social identities in relation to heath and conflict. The focus on gender and (dis)ability does not imply a lack of literature about, or lesser importance of, other social identities such as class, ethnicity, age, religion, sexuality, migration status and so on, nor does it mean that 'women' or 'disabled people' are homogenous groups. From an intersectional perspective, individuals' experiences are shaped by the combined interactions of different social locations or identities (Crenshaw

1991). These interactions occur within institutions, organizations and structures of power, of which health systems in conflict settings are one example, and they influence how helpful or harmful such systems are to individuals (Gkiouleka et al 2018, Meagher, Attal and Patel 2021). An intersectional framework is not yet widely used to understanding health in conflict settings.

Armed conflict directly kills, injures, and harms more men than women, given that combatants are predominantly male (Plümper and Neumayer 2006). When women's experiences during conflict are considered, it is typically in relation to sexual violence. The recognition of the role of sexual violence in armed conflict as a public health issue is crucial and the prosecution of sexual violence in international criminal law marked significant progress towards gender justice. However, feminist conflict scholars have argued that the emphasis on sexual violence occurs at the expense of other harms women experience during violent conflict, such as physical violence, structural violence, displacement, violations of land rights and so on (Pankhurst 2016). Women have been shown to suffer more severely from the indirect impacts of conflict outlined above, such as damage to health and other infrastructure, food insecurity and damage to livelihood (Meagher, Attal and Patel 2021; Plümper and Neumayer 2006). In already marginalized communities, gender, poverty and violence interact in dynamic and productive ways that are exacerbated during conflict (Fiske & Shackel 2015). After conflict, female but also male refugees face diverse challenges including sexual and gender-based violence in camps and settlements (Cockburn 2004, Krause 2015). Literature on male experiences of sexual violence in conflict remains rare (Clark 2019).

Conflicts reduce access to maternal and reproductive health services, worsening maternal health outcomes (Garry and Checci 2020). Qualitative research additionally highlights the complex social, political and cultural issues that shape gendered access to healthcare and experiences of well-being. For example, in a critical ethnography of obstetric services during Shia–Sunni conflict in Gilgit, Pakistan, identity or cultural affiliation in the context of sectarian violence were shown to be a key factor in access to medical services. Varley (2010) describes a 'politics of childbirth' in multi-sectarian settings, where Sunni physicians were named on Shia hit lists and Sunni women had severely limited access to obstetric care, for fear that the men, who took women to hospital and waited outside until birth, would be vulnerable to Shia attack (Varley 2010). Such research highlights the need for detailed and intersectional understandings of gender in its interactions with health and what might constitute appropriate interventions in conflict settings.

While gendered impacts have been considered to an extent, the impacts of conflict on disabled people have been largely ignored or, alternatively, have been viewed within western ideas of 'rights' or a biomedical model of public health interventions (Berghs 2015, Berghs 2016). Instead of focusing on social protection, resilience or prevention of violence within societies, the emphasis has been on forms of biomedical or epidemiological measurement, assessing the so-called 'burden' of disability and cost-

effectiveness (Berghs and Kabbara 2016). A qualitative study with ex-combatants in the Colombian civil war shows that they tended to reject disability rights discourse and disability identity overall (Velarde et al. 2022). Ex-combatants with disabilities were highly vulnerable to poverty and faced additional stigma and discrimination, which limited their opportunities for social, economic, and political reintegration in the aftermath of conflict.

4. De-medicalizing and localizing health and illness in conflict situations

A biomedical model of health and illness in conflict situations focuses mainly on biological factors, individual pathologies and physical trauma. Social scientists have contended that social, environmental and psychological factors and socio-economic relations and dynamics, such as class and gender, are key determinants of health. As Pedersen (2002, p. 186) argues, "the neglect of the social origins of pain and suffering often results in immodest claims of causality, in the medicalization of social problems and ultimately leads to the maintenance of social inequalities". Developing and employing more nuanced and diverse understandings of the nature of violence and its interactions with health, such as were presented in the previous section, provide one way of challenging this universalizing Western biomedical model. Medical anthropology in particular has made explicit local understandings and lived experiences of health across different conflict settings and provide insight into impacts of conflict on the mental health and well-being of specific groups and communities.

This argument is well illustrated in relation to the anthropological literature on trauma and its critiques. Medical anthropologists have evidenced the relevance of cultural analyses in global mental health, demonstrating that there are many different ways in which people and communities live through and cope with trauma and suffering and that individual and collective factors shape responses to violence and conflict. In particular, there have been calls for greater attention to individual and community resilience and how this can allow good health despite exposure to recurrent violence (Barber et al. 2016; Panter-Brick 2010). This literature demonstrates that "the presentation, attribution, classification, prevalence and prognosis of mental disorders varies greatly between cultures" (Summerfield 2008, cited in Giacaman 2018, p. 17). The concept of post-traumatic stress disorder (PTSD) dominates in research on conflict-related trauma, suggesting that exposure to war-related violence is the main driver of poor mental health. In the social sciences, it is more widely accepted that not all distress or trauma in violence-affected settings is directly related to armed conflict (Panter-Brick 2010; also see Miller and Rasmussen 2010 for a review of the divide between trauma-focused and psychosocial frameworks). Western and privileged constructions of trauma, mental health and existing diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) have been increasingly contested in the critical social sciences for not adequately capturing the ways in which mass trauma is experienced and continues (Andermahr, 2015, Benjamin and Carolissen, 2015; Pedersen 2002). For instance, trauma theory mostly adheres to an event-based model

which does not necessarily capture non-Western contexts, the experiences of marginalized groups or those exposed to structural and everyday violence and daily stressors (Andermahr, 2015; Miller and Rasmussen 2010). Universal classification systems do not adequately offer diagnostic and discursive criteria for such complex experiences of distress.

By contrast, anthropological and ethnographic studies have explored contextually and locally relevant experiences of ill health and highlighted people's own alternative constructions of mental health difficulties. This research is important since it can inform context-appropriate interventions. For example, Pedersen et al.'s (2010) study of the experiences of violence-affected indigenous peoples in the Ayacucho highlands in Peru finds highly context-dependent expressions of suffering, pain and fear as a result of exposure to violence, which do not easily map onto the universal category of trauma. In an aforementioned research program in Palestine, a particular local expression of distress – in which participants described themselves as *muhattam* or *mudammar* (feeling broken or destroyed in Arabic) to convey their suffering – was experienced, rather than depression or trauma-related stress that are usually used to assess the effects of war on mental health (Giacaman 2018). Such studies importantly also give voice to experiences of resilience, agency, or hope, rather than only to those suffering (Witter et al. 2017; Panter-Brick and Eggerman 2018). In practice, public health interventions that can target war-related trauma, suffering that emerges from structural violence, and local community resilience are needed in conflict and 'post-conflict' settings.

There are wider issues around long-term mental health in 'post-conflict' settings that center around transgenerational and collective trauma (Somasundaram 2014). From a biomedical perspective, the linkages of trauma exposure to lifetime psychological disorders, such as lifetime anxiety, depression of PTD, is well documented in the literature (see for example Bunting et al. 2013, Yehuda et al. 2008). Long-term psychological impacts can moreover affect children and other relatives of those directly affected by violent conflict, even if there was no direct trauma exposure, as evidenced clinically in Holocaust survivor children and other populations (Bowers and Yehuda 2016). However, there is an increasing literature on the transgenerational transmission of trauma within anthropology and memory studies (see for example Argenti and Schramm 2014; Bell 2006; Jakob 2017; Kildron 2009). Past unaddressed traumas have been discussed in terms of ghosts and hauntings (Wale, Gobodo-Madikizela and Prager 2020), drawing on earlier work by Gordon (1997). Hauntings here are understood as "a way in which repressed or unresolved social violence is making itself known" (Lawthers 2021, p. 4). Lawthers (2021), drawing from qualitative research with victims and survivors of the Northern Ireland conflict refers to 'the haunting of the unresolved past' to discuss the failure to comprehensively deal with the legacy of the conflict as a reason for high levels of mental health problems and transgenerational trauma in present-day Northern Ireland.

5. Health, health systems and peacebuilding

The idea that health can enhance peace building efforts is well established. The International Red Cross and Red Crescent Movement and organizations such as Medicine Sans Frontiers (MSF) exemplify the notion that medical co-operation between health care professionals of all parties in a conflict can be a force for peace (Arya 2007; Guha-Sapir and van Panhuis 2002). In some cases, cooperation has led to the implementation of humanitarian cease-fires: in El Salvador in the 1980s regular ceasefires allowed the mass immunizations of children (Arya 2007). This example highlights the idea, in the humanitarian community, that health is a 'super-ordinate' value that is shared across divides of political affiliation, ethnicity or religion (Kruk et al. 2010).

Health systems researchers have recently begun to focus their attention on fragile and conflict-affected states (Woodward et al 2016). Their research shows that, at a systems level, there are vulnerabilities before violent conflict might occur, as states direct their spending away from health care to the military (Kruk et al 2010). During violent conflict, local and national health systems, like individuals, are affected by direct and indirect impacts – from being targets of fighting or looting and staff being attacked to the loss of health personnel (Kruk et al 2010). In the 'post'-conflict' era, there are huge challenges too: limited government capacity, weakened management systems and human resources, the destruction of infrastructure and issues around medical supplies all impact the recovery of health systems (Waters, Garrett and Burnham 2009).

This time does however also present the opportunity for reform, development and perhaps peacebuilding, by reducing the risk for conflict reoccurrence (Cometto, Fritsche and Sondorp 2010). Equitable health services – services that are available to all irrespective of social status or affiliation – have been argued to foster a sense of shared identity across divides (Marmot, 2007), which might contribute to reducing the likelihood of future conflict. In addition, it has been claimed that health systems – as social and political institutions – can build trust in the government and restore accountability (Kruk et al. 2010). They can serve as a means of mobilizing people and communities around social solidarity (Rylko-Bauer, Whiteford, and Farmer 2009). For this reason, early investments in the 'post'-conflict health system might not only have health benefits but wider state building and development benefits too (Bertone et al. 2019, Cometto, Fritsche and Sondorp 2010). Resilient health systems that can effectively respond to crises are characterized by awareness (information systems), diversity (capacity to address a broad range of health challenges), self-regulation (ability to isolate health threats while delivering core health services), integration (bring together diverse actors, ideas, and groups to develop solutions) and adaptation (ability to transform in ways that improve function in the face of highly adverse conditions) (Kruk et al. 2015).

Viewed from a social capital lens, health care systems then have the potential to contribute to peacebuilding efforts by uniting people across divides and serving the community as a whole. However, there is similarly the potential to weaken such efforts, for example when health care professionals are

perceived to be aligned with particular interests or factions. The ideal of equity in health care is frequently sacrificed in order to demonstrate quick results and in the face of huge demands and challenges (for example around access, geography, logistics). Such programmatic decisions then undermine the potential of healthcare in building trust and strengthen existing grievances and social cleavages (Brewer 2010). The complexities of working in conflict situations and the need to work through existing power structures in order to access populations mean that health workers and organizations might legitimate some actors or finance them, reinforcing structural violence and disempower local people (Arya 2007). As Arya (2007, p. 369) suggests, '‘‘positive' developmental or health outcomes might produce 'negative' peace-building consequences, which may in turn impact […] health work". It has moreover been argued that there are knowledge gaps that emerge from the largely biomedical training healthcare professionals receive (Arya 2007) and that tools from the peacebuilding field, such as conflict mediation and prevention, would be helpful for health workers during violent conflict (Wiist et al 2014). Finally, health care workers' opportunities and challenges for peacebuilding are – like experiences of health and illness in conflict more widely – gendered (Njiru 2020).

Ethnographies of health systems are a rapidly growing area in medical anthropology, focusing on how people produce, engage, and use policies, programs, and systems to shape, enact, and resist global health agendas (see Closser et al. 2022 for a review). Qualitative research with healthcare workers has further complemented the health systems literature in order to examine their experiences during conflict. For example, Witter et al. (2017) employed a life histories approach to capture the voices of mid-level cadres in Uganda, Sierra Leone, Zimbabwe and Cambodia. Located in remote areas, such health care professionals are often ignored as they are removed from the centers of power in their countries. Working through conflicts, epidemics and prolonged political-economic crises, staff faced huge personal dangers, such as abduction, fear of death and injury and community stigma, as well as professional impacts such as stress and overload, lack of equipment and supplies, and worsening living conditions. Health staff showed considerable inventiveness and resilience in their coping strategies, from physical self-protection (such as sleeping in the bush in Uganda), psycho-social strategies (often religion) and work-related coping strategies.

6. Conclusion and Future Directions

This chapter has reviewed social science contributions to understanding public health in conflict settings. In order to do so, diverse literatures from medical sociology, medical anthropology, public health and peace and conflict studies have been considered. Drawing on this scholarship, three arguments have been advanced. First, that the social sciences contribute complex understandings of violence and conflict. Violence in conflict settings takes multiple forms and impacts populations unevenly. The concepts of structural violence, social suffering, and slow violence draw attention to the multiple ways in which the

health and wellbeing of populations is affected. These can easily be overlooked when violence is viewed as pertaining to single events, clearly definable periods, or direct acts of harm. Given the changing nature of violent conflict, reconceptualization of violence and its health impacts is timely: conflicts have become increasingly multifaceted, with mass displacements, food insecurity and epidemics producing unique challenges and humanitarian crises, and violent conflict has spiked dramatically since 2010 (World Bank 2022).

Second, social science contributions have allowed the exploration of the specific historical, social and cultural contexts that are key determinants of health and illness in conflict situations. Medical anthropology, in particular, has made explicit local understandings, lived experiences and people's own constructions of health across different conflict settings and has enabled deeper insights into the social, economic, bureaucratic, and political forces that impact health and healing. This chapter, by way of an example, discussed such scholarship in relation to mental health phenomena and harms. In challenging a universalizing Western biomedical model of trauma, findings from social science research can inform context-appropriate interventions. It is noteworthy that, until recently, there has been a relative lack of research that focuses on communities and their resilience in the face of direct and structural violence and social suffering. Effective public health strategies need to target the impacts of violence in its multiple forms as well as communities' agency, support systems and existing well-being strategies.

Third, this chapter reviewed scholarship in relation to health's and health systems' potential to contribute to conflict resolution and peacebuilding. Health as a shared value can bring communities together across divides, but health care systems can also be weaponized, which can reinforce structural forms of violence and existing tensions, as social science research has demonstrated.

As just noted, greater knowledge about specific experiences of and strategies for health and well-being is important in designing effective public health interventions and for health systems to respond well to crises. In order for such knowledges to be shared and to impact policy, further mixed methods research is needed, which can develop measures qualitatively from local contexts and then test these across populations. Intersectional approaches and frameworks are also needed to understand how social locations combine to produce health inequalities in conflict settings, what constitutes appropriate interventions and how to improve access for wider groups of people.

This need is further amplified by the changing nature of conflicts and wars. Given that civilian populations are increasingly targeted in new wars and given the humanitarian crises that emerge from such conflicts, further work that explores the political determinants of health and its weaponization is required. Similarly, insights from the social science scholarship on the long-term impacts of conflict, particularly for civilian populations, should be integrated into public health programs, and further research in this area is needed.

Finally, as Garry and Checci (2020) have argued, well-being and not merely survival of people should be the goal of public health. Such a demand aligns well to the conceptions of violence and peace explored in this chapter. Just as an absence of direct violence is important, positive peace comes from the absence of structural violence (Galtung 1969), so too the absence of disease is not enough, and well-being should ultimately be the aim of health interventions in conflict and 'post-conflict' settings. The contributions of social scientists to examining what well-being constitutes for different people in different settings are instrumental in this regard.

It is predicted that the number and complexity of fragile and conflict-affected situations will further increase, with the World Bank (2022) defining fragile settings as countries with high levels of institutional and social fragility, identified based on indicators that measure the quality of policy and institutions, and conflict-affected situations as countries affected by violent conflict based on number of conflict-related deaths relative to the population. At the same time, environmental and climate change is a 'threat multiplier' that places increased stress communities and livelihoods. This stress can jeopardize peacebuilding processes or increase the risks of violent conflict, especially in already fragile and conflict-affected contexts (United Nations & World Bank 2018). The value of the social sciences in such contexts is that it can illuminate the complex interactions of structural, slow and direct forms of violence and how they affect people's health and well-being, and inform context-specific holistic interventions.

References

Aguirre, D. L., Perez, C., & Burkett, E. K. (2022). Stability, security, and the social determinants of health. *Global Security: Health, Science and Policy*, 7(1), 13-23.

Andermahr, S. (2015) Decolonising trauma studies: Trauma and postcolonialism – Introduction Editorial *Humanities 4*(4):500-505

Argenti, N., & Schramm, K. (2010). Introduction: Remembering violence: Anthropological perspectives on intergenerational transmission. Berghahn Books

Arya, N. (2007). Peace through health?. In *Handbook of peace and conflict studies* (pp. 383-410). Routledge.

Arya, N. (2017). Peace and health: bridging the north-south divide. *Medicine, conflict and Survival*, *33*(2), 87-91.

Barber, B. K., McNeely, C. A., El Sarraj, E., Daher, M., Giacaman, R., Arafat, C., ... & Abu Mallouh, M. (2016). Mental suffering in protracted political conflict: Feeling broken or destroyed. *PLoS One*, 11(5), e0156216.

Bell, D., 2006. *Memory, Trauma and World Politics: Reflections on the Relationship Between Past and Present.* New York, NY: Springer.

Benjamin, A. & Carolissen, R. 2015. 'They just block it out': Community counsellors' narratives of trauma in a low income community. *Peace and conflict:Journal of Peace Psychology.* 21(3):414-431

Berghs, M. (2015). Radicalising 'disability' in conflict and post-conflict situations. *Disability & Society*, 30(5), 743-758.

Berghs, M. (2016). *War and embodied memory: Becoming disabled in Sierra Leone*. Routledge.

Berghs, M., & Kabbara, N. (2016). Disabled people in conflicts and wars. In *Disability in the global south* (pp. 269-283). Springer, Cham.

Bertone, M. P., Jowett, M., Dale, E., & Witter, S. (2019). Health financing in fragile and conflict-affected settings: What do we know, seven years on?. *Social science & medicine*, *232*, 209-219.

Bowers, M.E., & Yehuda, R. (2016). Intergenerational Transmission of Stress in Humans. *Neuropsychopharmacology* , 41:1, 232244

Brewer, J. D. (2010). *Peace processes: A sociological approach*. Polity.

Bunting, B.P., Ferry, F.R., Murphy, S.D., O'Neill, S.M., & Bolton, D. (2013). Trauma Associated With Civil Conflict and Posttraumatic Stress Disorder: Evidence From the Northern Ireland Study of Health and Stress. *Journal of Traumatic Stress*, 26, 134141.

Clark, J. N. (2019). The vulnerability of the penis: Sexual violence against men in conflict and security frames. *Men and masculinities*, *22*(5), 778-800.

Closser, S., Mendenhall, E., Brown, P., Neill, R., & Justice, J. (2022). The anthropology of health systems: A history and review. *Social Science & Medicine*, *300*, 114314.

Cockburn, C. 2004. "The Continuum of Violence: A Gender Perspective on War and Peace" In *Sites of Violence: Gender and Conflict Zones*, edited by Winona Giles and Jennifer Hyndman, 24–44. Berkeley: University of California Press

Cometto, G., Fritsche, G., & Sondorp, E. (2010). Health sector recovery in early post-conflict environments: experience from southern Sudan. Disasters, 34(4), 885-909.

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, 43(6), 1241-1299.

Das, V. (2007). *Life and words: Violence and the descent into the ordinary*. Berkeley: University of California Press.

Davies, T. (2022). Slow violence and toxic geographies: 'Out of sight' to whom?. *Environment and Planning C: Politics and Space*, *40*(2), 409-427.

Fiske, L., & Shackel, R. (2015). Gender, poverty and violence: transitional justice responses to converging processes of domination of women in eastern DRC, northern Uganda and Kenya. *Women's Studies International Forum*, 51, 110-117.

Galtung, J. (1969). Violence, Peace and Peace Research. *Journal of Peace Research,* 6 (3):167–91.

Garry, S., & Checchi, F. (2020). Armed conflict and public health: into the 21st century. *Journal of Public Health*, *42*(3), e287-e298.

Giacaman, R. (2018). Reframing public health in wartime: From the biomedical model to the "wounds inside". *Journal of Palestine Studies*, 47(2), 9-27.

Gkiouleka, A., Huijts, T., Beckfield, J., & Bambra, C. (2018). Understanding the micro and macro politics of health: Inequalities, intersectionality & institutions-A research agenda. *Social science & medicine*, *200*, 92-98.

Jakob, L. (2017). Suffering and liberation in the age of therapy: Germany's 'grandchildren of the Second World War'. *Ethnography*, *18*(4), 450-470.

Kaldor, M. (2013). In defence of new wars. *Stability: International journal of security and development*, *2*(1).

Kidron, C.A., 2009. Toward an Ethnography of Silence: The Lived Presence of the Past in the Everyday Life of Holocaust Trauma Survivors and Their Descendants in Israel. *Current Anthropology*, 50(1), pp.5-27.

Kleinman, A. (2000). The violences of everyday life. *Violence and subjectivity*, 226-241.

Krause, U. (2015). A continuum of violence? Linking sexual and gender-based violence during conflict, flight, and encampment. Refugee Survey Quarterly, 34(4), 1-19.

Kruk, M. E., Freedman, L. P., Anglin, G. A., & Waldman, R. J. (2010). Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: a theoretical framework and research agenda. *Social Science & Medicine*, 70(1), 89–97.

Kruk, M. E., Myers, M., Varpilah, S. T., & Dahn, B. T. (2015). What is a resilient health system? Lessons from Ebola. *The Lancet*, *385*(9980), 1910-1912.

Lambourne, W., & Rodriguez Carreon, V. (2016). Engendering transitional justice: A transformative approach to building peace and attaining human rights for women. *Human Rights Review*, 17(1), 71-93.

Lawther, C. (2021). Haunting and transitional justice: On lives, landscapes and unresolved pasts. *International review of victimology*, 27(1), 3-22.

Leaning, J., & Guha-Sapir, D. (2013). Natural disasters, armed conflict, and public health. *New England journal of medicine*, 369(19), 1836-1842.

Marmot, M. (2007). Achieving health equity: from root causes to fair outcomes. *The Lancet*, 370(9593), 1153–1163.

Meagher, K., Attal, B., & Patel, P. (2021). Exploring the role of gender and women in the political economy of health in armed conflict: a narrative review. *Globalization and Health*, 17(1), 1-9.

Meinhart, M., Seff, I., Troy, K., McNelly, S., Vahedi, L., Poulton, C., & Stark, L. (2021). Identifying the impact of intimate partner violence in humanitarian settings: using an ecological framework to review 15 years of evidence. *International journal of environmental research and public health*, 18(13), 6963.

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*, 70(1), 7–16

Murray, C. J., King, G., Lopez, A. D., Tomijima, N., & Krug, E. G. (2002). Armed conflict as a public health problem. *BMJ*, 324(7333), 346-349.

Njiru, R. (2020). Peacebuilding through health work: Opportunities and challenges for women community health volunteers in Kenya. Women and Peacebuilding in Africa, 136-157.

Nixon, R. (2011). *Slow Violence and the Environmentalism of the Poor*. Harvard University Press.

Pankhurst, D. (2016). 'What is wrong with men?': revisiting violence against women in conflict and peacebuilding. *Peacebuilding*, *4*(2), 180-193.

Panter-Brick, C. (2010). Conflict, violence and health. *Social science & medicine*, *70*(1), 1-168.

Panter-Brick, C., & Eggerman, M. (2018). The field of medical anthropology in Social Science & Medicine. *Social Science & Medicine*, *196*, 233-239.

Pedersen, D. (2002). Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being. *Social Science & Medicine*, 55(2), 175–190.

Pedersen, D., Kienzler, H., & Gamarra, J. (2010). Llaki and nakary: idioms of distress and suffering among the highland Quechua in the Peruvian Andes. *Culture, medicine, and psychiatry*, *34*(2), 279-300.

Percival, V., Richards, E., MacLean, T., & Theobald, S. (2014). Health systems and gender in post-conflict contexts: building back better?. *Conflict and Health*, *8*(1), 1-14.

Plümper, T., & Neumayer, E. (2006). The unequal burden of war: The effect of armed conflict on the gender gap in life expectancy. *International organization*, *60*(3), 723-754.

Ribeiro, W. S., Andreoli, S. B., Ferri, C. P., Prince, M. and Mari, J. J. 2009. Exposure to violence and mental health problems in low and middle-income countries: a literature review *Rev Bras Psiquiatr*, 31(Suppl. 2): 49-57.

Rylko-Bauer, B. (2022). Medical Anthropology Of Political Violence And War. *A Companion to Medical Anthropology*, 180-197.

Rylko-Bauer, B., & Farmer, P. (2016). Structural violence, poverty, and social suffering. *The Oxford handbook of the social science of poverty*, 47-74.

Rylko-Bauer, B., Whiteford, L. M., & Farmer, P. (Eds.). (2009). *Global health in times of violence*. Santa Fe, NM: School for Advanced Research Press.

Sinha, S., & Liang, J. (2021). *Health Inequities in Conflict-affected Areas: Armed Violence, Survival and Post-Conflict Recovery in the Indo-Bhutan Borderlands*. Springer Nature.

Somasundaram, D. (2014). Addressing collective trauma: conceptualisations and interventions. *Intervention*, 12(1), pp.43-60.

Stark, L.; Ager, A. A (2011). Systematic Review of Prevalence Studies of Gender-Based Violence in Complex Emergencies. *Trauma Violence Abuse*. 127–134.

The World Bank (2022) Fragility, Conflict & Violence. https://www.worldbank.org/en/topic/fragilityconflictviolence/overview

United Nations & World Bank (2018). *Pathways for peace: Inclusive approaches to preventing violent conflict*. Washington: The World Bank

UNHRC (2022) Refugee Data Finder. https://www.unhcr.org/refugee-statistics/insights/explainers/forcibly-displaced-pocs.html

Varley, E. (2010). Targeted doctors, missing patients: obstetric health services and sectarian conflict in northern Pakistan. *Social Science & Medicine*, 70(1), 61–70.

Velarde, M. R., Lord, J. E., Stein, M. A., & Shakespeare, T. (2022). Disarmament, demobilization, and reintegration in Colombia: Lost human rights opportunities for ex-combatants with disabilities. *Journal of Human Rights*, 21(1), 18-35.

Wale, K., Gobodo-Madikizela, P., & Prager, J. (2020). *Introduction: Post-conflict hauntings. In Post-Conflict Hauntings* (pp. 1-25). Palgrave Macmillan, Cham.

Waters, H., Garrett, B., & Burnham, G. (2009). Rehabilitating health systems in post-conflict situations. In *Making Peace Work* (pp. 200-227). Palgrave Macmillan, London.

Wibben, A. T. (2020). Everyday security, feminism, and the continuum of violence. *Journal of Global Security Studies*, *5*(1), 115-121.

Wiist, W. H., Barker, K., Arya, N., Rohde, J., Donohoe, M., White, S., ... & Hagopian, A. (2014). The role of public health in the prevention of war: Rationale and competencies. *American journal of public health*, 104(6), e34-e47.

Wilkinson, I. (2005). *Suffering: A sociological introduction*. Polity.

Witter, S., Wurie, H., Chandiwana, P., Namakula, J., So, S., Alonso-Garbayo, A., ... & Raven, J. (2017). How do health workers experience and cope with shocks? Learning from four fragile and conflict-

affected health systems in Uganda, Sierra Leone, Zimbabwe and Cambodia. *Health policy and planning*, 32(suppl_3), iii3-iii13.

Woehrle, L. M. (2019). Connecting health and peacebuilding in theory and practice. *Peace Review*, 31(2), 168-177.

Woodward, A., Sondorp, E., Witter, S., & Martineau, T. (2016). Health systems research in fragile and conflict-affected states: a research agenda-setting exercise. *Health research policy and systems*, *14*(1), 1-14.

Yehuda R, Bell A, Bierer LM, Schmeidler J (2008). Maternal, not paternal, PTSD is related to increased risk for PTSD in offspring of Holocaust survivors. *J Psychiatr Res* 42: 1104–1111.