BMJ 1998;316:1549-1550 (23 May)

Editorials

Protecting children from armed conflict

The UN convention needs an enforcing arm

Once wars and other conflicts begin, **children** suffer abuse—physical, sexual, and emotional. This is despite international laws to protect them.[1] Recent studies on the psychological consequences of armed conflict have shown that the resultant unhappiness and mental disturbance is so great in **children** that it can rarely be repaired.[2-4] The answer therefore has to be prevention, and, if that fails, the international community needs to act rapidly to protect vulnerable **children**.

In conflicts over the past 10 years 90% of casualties have been civilians. Two million **children** have been killed and 4-5 million seriously injured (usually without analgesia, anaesthesia, or surgical facilities to treat them). Twelve million **children** have been made homeless, over one million orphaned, and countless psychologically traumatised. Three quarters of deaths from antipersonnel mines are among **children**.

United Nations Convention on the Rights of the Child (International Law in 1990)

In accordance with their obligations under International Humanitarian laws in armed conflicts, States Parties shall take all feasible measures to ensure protection and care of **children** who are affected by an armed conflict.—Article 38, pt 4

Inequalities in health care, and the poverty in which a huge proportion of the world's population lives (table 1),[5] are key factors in nurturing armed conflict, particularly within or between poor states. In 1996 there were 31 armed conflicts, 24 of them in countries with mortality rates among **children** under 5 years old of 5% or more. During conflict, 5% of child deaths result from direct trauma and 95% from starvation or illness. Armed groups frequently manipulate food supplies and target health facilities and professionals.

Most refugees from armed conflict have fled to disadvantaged countries that cannot afford to care for them, while advantaged countries are inclined to block their entry. By the end of 1997, 11 million people were refugees and 3.6 million internally displaced as a result of conflict.[6] In 1996, 2.5 million of these were unaccompanied **children**, who had either been separated from their parents or orphaned. **Children** under 5 are the most vulnerable in refugee camps, succumbing to malnutrition, gastroenteritis, acute respiratory infection, malaria, and measles.

Relative mortality in advantaged and disadvantaged countries

	Population (millions)	GNP per head (US$)	Mortality under 5 years (per 1000 live births)	No of deaths of children under 5/day/100 million people	Maternal mortality (per 1000 live births)	No of maternal deaths/year/ 100 million
Advantaged countries (n=25)*	830	24 498	9	30	0.1	163
Disadvantaged countries (n=71)†	2645	706	125	1110	6.7	21 754
All countries (n=190)	5696	4 498	90	600	4.3	10 956
Country at war (Afghanistan)	20	280	257	3670	17.0	88 484

* The 25 countries with the highest gross national product.

†The 71 countries where mortality in under 5 year olds is 5% or more.

Torture and sexual abuse of **children** are widespread, particularly in conflicts dominated by ethnicity. For example, during the Rwandan genocide almost every girl aged over 8 was raped. The consequences of sexual abuse include death, HIV infection, other sexually transmitted diseases, suicide, abortion without anaesthesia or antisepsis, genital injuries leading to infertility, and rejection by the child's community.

There are at least 250 000 child soldiers in the world, with tens of thousands under 15 years of age (R Barnem, Swedish Save the **Children**, personal communication, 1998). They are small, inconspicuous, expendable, and easily indoctrinated and terrorised into performing extreme acts. They can manage lightweight assault weapons, such as the AK47. Some **children** are sold to armed factions by starving families, while others are kidnapped.

In northern Uganda, an armed faction, the Lord's Resistance Army, raids villages, forcibly taking away 50-100 **children** at a time (6000-10 000 in total).[7] Girls are forced to become sexual slaves, and boys are tortured so that they will abuse and murder other **children** who refuse to obey the brutal requests of their adult commanders. This series of war crimes has created an army composed of violent child soldiers, but where is the international outcry?

How can doctors contribute to addressing these crimes against **children**? Advocacy is probably the most powerful tool available to the profession. To be effective, doctors need to remain abreast of political and legal issues affecting **children**'s wellbeing, while being prepared to offer both vocal and practical support to colleagues in war torn countries.

To prevent conflict, doctors should argue for urgent international action to eliminate the gross inequalities in maternal and child mortality between advantaged and disadvantaged countries. The meagre contribution made by advantaged countries to the aid budget of the UN should be reassessed. Despite a recommendation from the 1970 UN general assembly that advantaged countries should donate 0.7% of their gross national product as international aid, the United Kingdom—the 14th biggest donor—gives 0.27%, just over half the proportion it gave in 1979 (0.51%).[8] An increase in aid budgets by advantaged countries would have a huge impact on international child health and on the prevention of poverty and conflict.

Furthermore, doctors should argue for the development of a UN force which goes beyond peacekeeping and is designed specifically to protect **children**. [9] [10] In this way, by focusing on **children**, international aid can be depoliticised. As well as **protecting children**, their families, and aid workers, this UN force would ensure that aid reaches the intended beneficiaries rather than combatants. The Carnegie Commission and the UN Association have argued for the development of an international police force of this kind, [11] [12] and paediatricians will be aware of the invaluable role played by specially trained police officers in **protecting children** from abuse within families.

Finally, doctors should develop longterm links with colleagues in disadvantaged countries. Early retirement or study leave can be used to provide hands-on aid, educational materials, medical equipment, and moral support. Encouragingly, many doctors already participate in international aid work. The rest of the profession should reflect on the reality of being an ill or frightened child in Afghanistan, Kurdistan, Sierra Leone, or Sri Lanka, and contribute, through advocacy and action, to overcoming the unethical inequalities faced by **children** in much of the world.

David Southall, *Consultant paediatrician.*

North Staffordshire Hospital Centre, Stoke-on-Trent ST4 6QG (cai_uk@compuserve.com)

Kamran Abbasi, *Editorial registrar.*

BMJ

---

1. United Nations General Assembly. *Convention on the rights of the child.* New York: United Nations , 1989.

2. Machel G. *Impact of armed conflict on **children**. Report of the expert of the Secretary General of the United Nations.* New York: United Nations , 1996.

3. McCIoskey LA, Southwick K. Psychosocial problems in refugee **children** exposed to war. *Pediatrics* 1996; 97: 394-397[Medline].

4. Unicef. *State of the world's **children** 1996.* New York: Oxford University Press , 1996.

5. Unicef. *State of the world's **children** 1997.* New York: Oxford University Press , 1997.

6. United Nations High Commissioner For Refugees. *Report.* London: Office of the Representative for the United Kingdom , 1988(Reference 880.)

7. Human Rights Watch and Amnesty International. *The scars of death: **children** abducted by the Lord's Resistance Army in Uganda.* London: Amnesty International , 1997.

8. Overseas Development Administration. *British aid statistics.* London: ODA , 1996.

9. Southall DP, Carballo M. Can **children** be protected from the effects of war? *BMJ* 1996; 313: 1493[Full Text].

10. Plunkett MCB, Southall DP. War and **children**. *Arch Dis Child* 1998; 78: 72-77[Full Text].

11. Hamburg DA, Vance CR, Brundtland GH, Dayal V, Evans G, George AL, et al. *Preventing deadly conflict: executive summary of the final report. Carnegie Commission on Preventing Deadly Conflict:* New York: Carnegie Corporation of New York , 1997.

12. International Task Force on the Enforcement of UN Security Council Resolutions. *Words to deeds: strengthening the UN's enforcement capabilities. Final report.* New York: United Nations Association of the United States of America , 1997.

The UN and Child Advocacy International are looking for a psychiatrist to work in Uganda for 3 months, in trauma and counselling centres for **children**. Please write to: Professor David Southall, Child Advocacy International, 79 Springfield Road, Trent Vale, Stoke-on-Trent ST4 6RY

© BMJ 1998