IMPACT OF EXPOSURE TO ARMED CONFLICT ON THE PHYSICAL HEALTH OF PALESTINIAN SCHOOL CHILDREN

Nabil Shibli
PHD Student
Varna Free University, Bulgaria

Abstract: A child's exposure to violence through armed conflict leads to certain upsets in the mental health of the child. Countless children live in areas where armed conflict has been reported. As a result of the ongoing conflict between the Palestinians and the Israelis, the vulnerability of children and adolescents has caused them to be a target to the negative effects exposure to violence has on the mental and physical health of this population. Even though the conflict has been ongoing for more than half a century, the size of the problem has yet to be evaluated. Moreover, a strategy to address this problem to allow children to deal with their frustration and any other symptoms they may suffer from is still absent.

This study in collaboration with HBSC aims to assess the impact of the issue facing Palestinian children. This assessment includes a questionnaire to evaluate the mental effects of conflict on school children from a representative sample of Palestinian students. Identifying the exact way in which witnessing violent acts affect the mental state of school children can act as a rough indication of how further plans should proceed. The results obtained from this study may start to improve the quality of life of the Palestinian youth, and the Palestinian population in general.

Keywords: Childhood, conflict, violence, affect, identity, frustration.

1. Introduction

Health Behavior in School-Aged Children (HBSC) is a study conducted to investigate the mental and physical health of adolescents in many countries across the world [1]. The collection and analysis of youth health data assist to inform and influence relevant health education policies and intervention strategies both nationally and internationally. HBSC is a cross-national school-based survey involving 35 countries in Europe and North America, under the auspices of the World Health Organization (WHO) - European Regional Office. Using a community-based health promotion approach, it focuses on the psychosocial and cultural influences on health in three domains: family, school, and peer relationships [2].

Adolescent health and well-being are significant issues to be addressed for the Palestinian community. The Palestinian youth are continuously being exposed to the unstable periods of social transitions of the ongoing peace process between the Palestinians and Israelis. Children in the West Bank and Gaza have also been sharing other social problems related to the process of modernization of their culture that poses specific challenges to the promotion of health and well-being among youth.

Armed and violent conflict is affecting the lives, well-being, and quality of life of almost 1.5 billion people around the world [3]. In 2011 alone, 37 armed conflicts were recorded globally, mostly centered in the Middle East, Asia, and Africa with the number of armed conflicts distributed as follows respectively: 6, 13, 15 conflicts [4]. Although the number of armed conflicts has decreased in the last few centuries, very few countries were able to recover and reach stability and solidity following the conflict [3].

Armed conflicts may cause people to relocate within the country or flee to a nearby country, usually with low economic status. According to the Internal

Displacement Monitoring Center, there were 21.3 million internally displaced persons in 1990 and that number increased to 33.3 million in 2013. The remaining individuals continue to endure in the area affected by the conflict [5].

Violent conflicts always result in Human Rights violations that inflict tremendous harm on civilians in one way or another. These violations may include harm in different aspects including physical, mental, and social harm, as well as the destruction of the infrastructure. Loss of the infrastructure could affect the quality of life for people living in those areas [6] [7]. These changes can cause deprivation and shortage in life essentials including water, food, shelter, and electricity that in one way or another affects the health of the population making it difficult for them to survive during and after the conflict [8] [9].

The youth population is extensively affected by modern armed conflict and is actively involved [8] [10]. Of the billion children and adolescents living in areas of armed conflict, 18 million were internally or externally displaced [11]. Regardless of the type of armed conflict, children witness distress, threats, fear, and loss of loved ones that affect their physical, mental, social, and behavioral well-being [12].

Effect of arm conflict on children

Children are affected by the occupation in different ways. Loss, displacement, and abuse are the three interrelated experiences resulting from these violent contexts [13]. Checkpoints and barriers hinder access for hundreds of children to their schools and homes. The blockade on the Gaza Strip began in 2007 and has so far resulted in many losses of loved ones, caused numerous disabilities and injuries to children. The displacements and imprisonment of children contribute to the absence of a healthy and safe living environment for these younger generations. The interaction of all

these factors directly or indirectly impacts the psychological, physical, and overall well-being of children and adolescents. Many are experiencing post-traumatic stress disorders, depression, bedwetting, bullying, and several other behavioral and mental distresses. Some cases reach suicide as well [14] [15]. In general, the impact of this violence violates the child's rights and development. The sum of all this violence discussed earlier violates Palestinian youth's rights, affects their daily lives, and may impact the quality of their lives in the future.

In an ideal world, individuals are entitled to their basic human rights. Children and adolescents are an especially vulnerable group for rights violations. According to the 1996 Machel study, basic rights must be provided for a child to have the opportunity to live in a healthy environment to properly develop both mentally and physically [16]. Every child is entitled to have a loving and nurturing home, in which they feel safe, secure, and surrounded by family and friends in a stable community. The right to health and the development of a rounded personality without any negative interference are also crucial rights for the development of that child's personality and wellbeing [9].

Armed and political violence interferes with the welfare of whole communities. However, since children and adolescents are at an extremely fragile point in their lives, the effects of this violence on their physical and mental health are devastating. The outcome of armed violence and how it affects children can be both direct and indirect. Recruitment in armed forces, injury due to violence, and death are some of the consequences that directly interfere with the healthy courses of their lives [17]. Indirect effects caused by displacement, witnessing acts of violence, and loss of relatives and loved ones can easily affect the psychological state of the child and have overwhelming neurological changes [18].

The ongoing conflict in Palestine with Israel since 1948 meant that the Palestinians had to endure prolonged periods of wars, curfews, military checkpoints, and political arrests. These events along with witnessing violence and loss of loved ones affect the daily progress of the population, the overall attitude as well as the economic state of every household. These circumstances along with the ongoing displacement and violence have been directly affecting the physical wellbeing of children and adolescents in Palestine. The study has been conducted with Health Behavior in School-Aged Children (HBSC) to assess and evaluate the exact size of the physical issues and behaviors by witnessing violence and other traumatic events brought by conflict. A future goal is set to establish an intervention program that includes certain activities, which provides a solution for these negative effects on the youth of Palestine.

This study aims to investigate the relationship between exposure to armed conflict and children's physical health and behaviors in the West Bank.

2. Methodology

2.1. Survey design

A representative sample of Palestinian Arab students in grades 5-9 (ages 10-15) from 93 single-sex and 7co-ed schools in the West Bank and East Jerusalem, participated in the study which was administered by the Palestinian Authority or the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

The 100 schools were randomly selected and stratified by school authority (60 governmental, 40 UNRWA) and by region (proportional to population size). From each selected school, 60 students were randomly selected, stratified by grade (twelve

students from each grade level), yielding a gross sample of 5,981 students. Some of the selected schools had less than twelve students in one or more of the targeted grades. Twice as many girls' schools than boys' schools met the sampling requirements, hence girls were overrepresented in the student sample (4,004 girls and 1,957 boys). Data collection included: (1) in-class student questionnaires regarding bullying, political violence, home violence, self-disclosure to parents and friends, school satisfaction etc. and (2) a parental background questionnaire including their education level (paper and pencil – administered at home). Due to the nature of the sample and the data collection method (in-class group-administered surveys), participation rates were high. All student-reported instruments were higher than 95%, the parental questionnaire was 84%. After deleting cases with missing values, 5713 cases 95.5% of the original 5981 remained. Below we detail the measures used in the study.

2.2. Measures

Palestinian students' exposure to armed conflict was measured using a scale called Subjective Threat from Armed Conflict Events (STACE). STACE mainly addressed the intensity of the event as well as the physical consequences of the exposure to ACE. The students were first asked if they were exposed to an Armed Conflict Event (ACE) and using a "Guttman-Scale" approach examined the nature of the exposure. The questionnaire included 10 levels of questions to measure the intensity of the exposure as follows:

1. I witnessed the arrest of someone I know by the Israeli army.
2. I witnessed the injury of somebody I know by the Israeli army.
3. I witnessed the demolishment of the house of somebody I know.
4. I have been threatened with violence by the Israeli army.

5. I heard about the death of somebody I know by the Israeli army.
6. I have personally been arrested by the Israeli army.
7. My house has been raided at night or during the day by the Israeli army.
8. I have been hurt either physically or emotionally by the Israeli army.
9. I witnessed the demolishment of my own house by the Israeli army.
10. I witnessed the death of somebody I know by the Israeli army.

The previously mentioned levels are scaled according to the intensity of the event. The intensity increases from 1-10. Levels 1-3 are categorized as low-intensity exposure, 4-7 are considered as intermediate exposure, and finally, 8 through 10 are considered to be of high intensity.

To determine the negative effect of exposure to armed conflict, the questionnaire also includes questions regarding a range of issues including smoking, parental, school, and peer support, youth violence, and psychosomatic symptoms. Investigating psychosomatic symptoms included questions regarding the occurrence of a range of symptoms, including:

1. Headaches.
2. Back pains.
3. Mood swings.
4. Bad temper.
5. Sleeping issues.
6. Dizziness or loss of consciousness.

The support system of the students was also examined by asking a series of questions regarding the parents' support they might or might not receive as well as the peer support from friends and finally support from the school that comes directly

from the teachers and the school system itself. The questions concerning support range from mistreatment to bullying, to easiness of making conversations with parents, friends, and teachers.

2.3. Study Variables

The main purpose of the study is to use the STACE scale developed by Harel et al. 2010 [9] on the newly collected data set to form the HBSC study 2013 [19]. The first aim was to assess the social determinants of mental health of exposure to armed conflict events and its associated levels of subjective threat. The second aim was to investigate the anticipating relationship between the levels of STACE and two gatherings of psycho-behavioral results: (1) positive prosperity (positive life recognitions and life fulfillment), and (2) risk behaviors (smoking and association in youth violence. The third aim was to discover the role of parents and schools supports in reducing the impact of armed conflict on the psychological and behavioral outcomes across the Palestinian children.

2.4. Statistical analysis

Differences between demographic variables and in social support, school satisfaction, mental health, and exposure to armed conflict events were examined using χ^2 for categorical variables, one-way ANOVAs for continuous variables. Analyses were performed using SPSS version 20.0 for windows (IBM, 2011).

Sets of Hierarchical linear regression models were constructed for the study population for each of the six dependent variables: GSS (PTS), psychosomatic symptoms, life satisfaction, positive health, youth violence, and smoking. The independent variables were gender, age, exposure to armed conflict events as measured by STACE, and parental support

3. Results

Participant socio-demographic characteristics by age group and gender are presented in Table 1. Participants are distributed uniformly between different age groups and genders; the sample was stratified according to grade level and gender type in about 20 % of each grade. The respondents were distributed as 33% boys and 67% girls. Some of the selected schools had less than twelve students in one or more of the targeted grades. Twice as many girls' schools than boys' schools met the sampling requirements, hence girls were overrepresented in the student sample (3,813 girls and 1,902 boys).

Table 1. Study participants distributed by grade and gender

	Boys		**Girls**		**Total**
Grade	**N**	**%**	**N**	**%**	**N**
5	386	20.3	761	20.0	1147
6	377	19.8	770	20.2	1147
7	380	20.0	769	20.2	1149
8	389	20.5	760	19.9	1149
9	370	19.5	753	19.7	1123
Total	1902		3813		5715

The exposure intensity level, Positive Health, tobacco use, experience violence, Psychosomatic symptoms, and life satisfaction distribution by gender are presented in table 2. The girls have more exposure intensity levels than boys (55.8%, 28.1%) respectively. Girls double exposed to posttraumatic stress symptoms than boys (42.2%, 21.4%) respectively.

Table 2. Study variables distribution by gender

	Boys		Girls	
	N	**%**	**N**	**%**
exposure intensity level	1573	28.1	3121	55.8
Positive Health	435	7.9	822	14.9
Tobacco use	171	3.1	402	7.4
Violence	1086	19.6	2077	37.5
Psychosomatic symptoms	748	15.1	1411	28.4
Life satisfactions	466	9.7	939	19.5

A chi-square test of independence was performed to examine the relation between the subjective threat from armed conflict events (STACE) and the study variables. Table 3 shows that the relations between these variables were strongly significant in all study variables except life satisfaction. Results in Table 3 show that girls most likely to show higher significance than boys mainly in perceiving peer support, $X^2 = 11.8$, 10.4 girls boys respectively.

Table 3. Chi-Square analysis for STACE study variables and gender

	Boys	**Girls**	**Total**
Positive health	17.9***	47.3***	62.4***
Tobacco risk	74.6***	127.6***	199.8***
Violence	22.1***	37***	58.8***
Life satisfaction	2.1	3.5	1.3
Parent support group	16***	42.5***	58***
Family support group	21***	55.3***	74.7***
peer support group	10.4**	11.8***	22.1***

Grade	22.1**	38.3***	54.4***
Authority	1.7	2.1	0.5

* P<0.05, **<0.001, ***<0.0001

Study Variable Inferential Analysis:

A logistic regression analysis was conducted to predict the level of positive health using STACE, age, and gender as predictors for UNRWA Schools as shown in table 4. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi-square = 72.4, p < .000 with df = 2). The Wald criterion demonstrated that STACE, age, peer support, family support, parent support, and gender were had no significant predictors. EXP(B) value indicates that when STACE is raised by one unit the odds ratio is 7.8 times as large and therefore children are 7.8 more times likely to the experience level of positive health. Likewise, EXP(B) value indicates that when age is decreased by one unit (one year) the odds ratio 1.3 times as large, and therefore children are 1.3 more times likely to experience a level of positive health. Furthermore, Likewise EXP(B) value indicates that when children have no peer support the odd ratio is 1.2 times as large and therefore children are 1.2 more times likely to the experience level of positive health.

Table 4. Linear Regression Models Predicting the Level of Positive Health By study variables

	Public				**UNRWA**			
	B	**S.E.**	**P Value**	**β**	**B**	**S.E.**	**P Value**	**β**
Subjective threat from armed conflict events (STACE)	.404	0.38	.288	1.497	2.050	1.04	.049	7.768
Gender (Female(1=Yes))	-.016	0.106	.879	.984	-.169	0.118	.151	.844
Age1(Grade 5-6)	.357	0.137	.009	1.428	.233	0.162	.149	1.263
Age2 (Grade 7-8)	.102	0.138	.459	1.108	.049	0.164	.764	1.050
Parent Support	-.163	0.137	.235	.849	-.119	0.165	.471	.888
Family Support	-.065	0.134	.630	.937	-.147	0.162	.363	.863
Peer Support	.170	0.101	.095	1.185	.205	0.122	.094	1.228

Table 5 shows a logistic regression analysis that was conducted to predict the level of tobacco risk using STACE, age, and gender as predictors for Public Schools. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi-square = 156.5, $p < .000$ with df = 2). The Wald criterion

demonstrated that peer support (p=0.036) made a significant contribution to prediction. STACE, gender, age, parent support, and family support were not significant predictors. EXP(B) value indicates that the male odds ratio is 1.4 times as large and therefore children males are 1.4 more times likely to experience the level of tobacco risk.

A logistic regression analysis was conducted to predict the level of tobacco risk using STACE, age, and gender as predictors for UNRWA Schools as shown in table 5. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi-square = 172.6, $p < .000$ with df = 2). The Wald criterion demonstrated that peer support (p=0.036) made a significant contribution to prediction. STACE, gender, age, parent support, and family support were not significant predictors. EXP(B) value indicates that the male odds ratio is 1.1 times as large and therefore children male are 1.1 more times likely to experience the level of tobacco risk.

Likewise, EXP(B) value indicates that when age is raised by one unit (one year) the odds ratio is 1.2 times as large, and therefore children are 1.2 more times likely to experience the level of tobacco risk.

Table 5. Linear Regression Models Predicting the Level of Tobacco Risk By study variables

	Public				**UNRWA**			
	B	**S.E.**	**P Value**	**β**	**B**	**S.E.**	**P Value**	**β**
Subjective threat from armed conflict events (STACE)	-.495	0.409	.227	.610	-.673	0.624	.281	.510

Gender (Female(1=Yes))	.317	0.163	.052	1.373	.074	0.172	.668	1.077
Age1(Grade 5-6)	-.306	0.195	.116	.736	-.216	0.237	.360	.805
Age2 (Grade 7-8)	-.032	0.185	.865	.969	.218	0.226	.334	1.243
Parent Support	-.050	0.202	.806	.951	-.225	0.25	.369	.799
Family Support	.022	0.198	.910	1.023	-.263	0.238	.269	.769
Peer Support	-.323	0.153	.036	.724	-.468	0.192	.015	.626

Table 6 shows a logistic regression analysis that was conducted to predict the level of violence using STACE, age, and gender as predictors for Public Schools. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi-square = 60.5, $p < .000$ with df = 2). The Wald criterion demonstrated that age (p=0.007), parent support (p=.019), and peer support (p=.007) made a significant contribution to prediction. STACE, gender, and family support were not significant predictors. EXP(B) value indicates that when age is raised by one unit the odds ratio is 1.3times as large and therefore children are 1.3 more times likely to experience the level of violence. Likewise, EXP(B) value indicates that when children have no parent support the odds ratio is 1.3 times as large, and therefore children are 1.3 more times likely to experience the level of violence.

A logistic regression analysis was conducted to predict the level of violence using STACE, age, and gender as predictors for UNRWA Schools as shown in table 6. A test of the full model against a constant only model was statistically significant,

indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi-square = 62.7, $p < .000$ with df = 2). The Wald criterion demonstrated that STACE, age, peer support, family support, parent support, and gender were had no significant predictor. EXP(B) value indicates that when children have no family support the odds ratio is 1.2 times as large and therefore children are 1.2 more times likely to experience the level of violence.

Table 6. Linear Regression Models Predicting the Level of Violence By study variables

	Public				**UNRWA**			
	B	**S.E.**	**P Value**	**β**	**B**	**S.E.**	**P Value**	**β**
Subjective threat from armed conflict events (STACE)	-.443	0.423	.295	.642	-.689	0.663	.299	.502
Gender (Female(1=Yes))	-.067	0.089	.456	.936	-.136	0.101	.177	.873
Age1(Grade 5-6)	.049	0.112	.661	1.050	.037	0.135	.783	1.038
Age2 (Grade 7-8)	.295	0.11	.007	1.343	-.054	0.135	.688	.947
Parent Support	.271	0.116	.019	1.311	-.221	0.14	.113	.802
Family Support	-.176	0.115	.125	.839	.187	0.139	.178	1.205
Peer Support	-.228	0.085	.007	.796	-.300	0.104	.004	.741

Table 7 shows a logistic regression analysis was conducted to predict the level of psychosomatic symptom using STACE, age, and gender as predictors for Public Schools. A test of the full model against a constant only model was statistically

significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi-square = 62.3, $p < .000$ with df = 2). The Wald criterion demonstrated that gender (p=0.02) and peer support (p=.005) made a significant contribution to prediction. Gender was not a significant predictor. EXP(B) value indicates that when STACE is raised by one unit the odds ratio is 1.2times as large and therefore children are 1.2 more times likely to the experience level of psychosomatic symptom. Likewise, EXP(B) value indicates that when children have no parent support the odds ratio is 1.1 times as large, and therefore children are 1.1 more times likely to the experience level of psychosomatic symptom.

A logistic regression analysis was conducted to predict the level of psychosomatic symptoms using STACE, age, and gender as predictors for UNRWA Schools as shown in table 7. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi-square = 66.4, $p < .000$ with df = 2). The Wald criterion demonstrated that STACE, age, peer support, family support, parent support, and gender were had no significant predictor. EXP(B) value indicates that when STACE is raised by one unit the odds ratio is 2.6 times as large and therefore children are 2.6 more times likely to the experience level of psychosomatic symptom.

Table 7. Linear Regression Models Predicting the Level of Psychosomatic symptom by study variables

	Public				**UNRWA**			
	B	**S.E.**	**P Value**	**β**	**B**	**S.E.**	**P Value**	**β**
Subjective threat from armed conflict events (STACE)	.165	0.35	.637	1.180	.944	0.526	.073	2.571
Gender (Female(1=Yes))	-.206	0.089	.020	.814	.023	0.1	.817	1.024
Age1(Grade 5-6)	-.147	0.113	.194	.864	-.013	0.134	.921	.987
Age2 (Grade 7-8)	-.045	0.11	.681	.956	-.140	0.134	.298	.870
Parent Support	.086	0.115	.458	1.089	-.067	0.138	.627	.935
Family Support	-.040	0.114	.726	.961	.001	0.136	.993	1.001
Peer Support	-.241	0.085	.005	.786	-.070	0.104	.499	.932

Table 8 shows a logistic regression analysis that was conducted to predict the level of life satisfaction using STACE, age, and gender as predictors for Public Schools. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi-square = 1.3, $p < .000$ with df = 2). The Wald criterion demonstrated that age (p=0.006), parent support (p=.023), and peer support (p=.042) made a significant contribution to prediction. STACE, gender, and family support were not a significant predictor. EXP(B) value indicates that when STACE is raised by one unit the odds ratio is 1.4 times as large and therefore children are 1.4 more times likely to experience the level of life satisfaction. Likewise, EXP(B) value

indicates that when age is decreased by one unit (one year) the odds ratio is 1.4 times as large, and therefore children are 1.4 more times likely to experience the level of life satisfaction. Furthermore, EXP(B) value indicates that when children have low family support the odd ratio is 1.1 times as large and

therefore, children are 1.1 more times likely to experience the level of life satisfaction.

A logistic regression analysis was conducted to predict the level of life satisfaction using STACE, age, and gender as predictors for UNRWA Schools as shown in table 8. A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between those with and without symptoms (chi-square = 22.8, $p < .000$ with $df = 2$). The Wald criterion demonstrated that STACE, age, peer support, family support, parent support, and gender were had no significant predictor. EXP(B) value indicates that when age is raised by one unit the odds ratio is 1.2 times as large and therefore children are 1.2 more times likely to experience the level of life satisfaction. Likewise, EXP(B) value indicates that when peer support is low the odds ratio is 1.2 times as large and therefore children are 1.2 more times likely to experience the level of life satisfaction.

Table 8. Linear Regression Models Predicting the Level of life satisfaction by study variables

	Public			**UNRWA**				
	B	**S.E.**	**P Value**	**B**	**B**	**S.E.**	**P Value**	**β**
Subjective threat from armed conflict events (STACE)	.352	0.45	.435	1.421	-.880	1.094	.421	.415

Gender (Female(1=Yes))	.009	0.102	.926	1.010	-.052	0.117	.657	.950
Age1(Grade 5-6)	.352	0.128	.006	1.422	.187	0.156	.230	1.206
Age2 (Grade 7-8)	.067	0.122	.582	1.069	-.073	0.153	.634	.930
Parent Support	-.304	0.134	.023	.738	-.239	0.16	.137	.788
Family Support	.199	0.135	.141	1.220	-.023	0.161	.885	.977
Peer Support	-.197	0.097	.042	.821	.182	0.121	.133	1.199

4. Conclusion

Armed conflict is a socially neglected determinant of children's health, and the acute and chronic effects of armed conflict on children's health and well-being are among the greatest violations of children's rights today. The devastating effects of the conflict include all the serious and psychological violations of children's rights studied in this study, as well as a wide range of direct and indirect effects that follow children throughout their lives and into adulthood. Despite the huge number of children living in conflict-affected areas, our understanding of the magnitude of the effects of the conflict on children and the nuances of these effects and ways of mitigating and treating them are still limited. Although there are some differences in the magnitude of these transgender effects, exposure to armed conflict events has strong and consistent negative effects on most outcomes except youth violence, smoking, and psychosomatic symptoms of both sexes.

Pediatricians, allied child health care providers, public health professionals, researchers, and policymakers need to address the impact of armed conflict on children as a critical and priority issue.

5. References

1. Inchley, J. and D. Currie, *Growing up unequal: gender and socioeconomic differences in young people's health and well-being. Health Behaviour in School-aged Children (HBSC) study: international report from the 2013/2014 survey*. 2016: World Health Organization.

2. Currie, C., *Inequalities in young people's health: HBSC international report from the 2005/2006 Survey*. 2008: World Health Organization.

3. Justino, P. *Resilience in protracted crises: exploring coping mechanisms and resilience of households, communities and local institutions*. in *High-Level Expert Forum on Food Security in Protracted Crises, Rome, September*. 2012.

4. Themnér, L. and P. Wallensteen, *Armed Conflicts, 1946–2011.* Journal of peace research, 2012. **49**(4): p. 565-575.

5. Albuja, S., *Global Overview 2014: People internally displaced by conflict and violence*. 2014: Internal Displacement Monitoring Centre, Norwegian Refugee Council.

6. Veronese, G., et al., *Living in the shadow of occupation: Life satisfaction and positive emotion as protective factors in a group of Palestinian schoolchildren.* Children and Youth Services Review, 2012. **34**(1): p. 225-233.

7. Veronese, G., et al., *Agency via life satisfaction as a protective factor from cumulative trauma and emotional distress among Bedouin children in Palestine.* Frontiers in psychology, 2019. **10**.

8. Reinert, E. and A. Daastøl, *Production Capitalism vs. Financial Capitalism—Symbiosis and Parasitism. An Evolutionary Perspective and Bibliography.* The Other Canon Foundation and Tallinn University of Technology Working Papers in Technology Governance and Economic Dynamics No, 2011. **36**.

9. Harel-Fisch, Y., et al., *Psychosocial outcomes related to subjective threat from armed conflict events (STACE): Findings from the Israeli-Palestinian cross-cultural HBSC study.* Child abuse & neglect, 2010. **34**(9): p. 623-638.

10. Nanchen, M., *Q&A: The ICRC's Engagement on Children in Armed Conflict and Other Situations of Violence.* Int'l Rev. Red Cross, 2019. **101**: p. 653.

11. UNICEF., U.N.O.o.t.S.R.o.t.S.-G.f. Children, and A. Conflict, *Machel study 10-year strategic review: Children and conflict in a changing world*. 2009: UNICEF.

12. Tol, W., et al., *Module 1: Impact of Armed Conflict on Children Module 1: Impact of Armed Conflict on Children.* 2008.

13. Foran, M.P., et al., *Identification of current priorities for research in humanitarian action: proceedings of the First Annual UN OCHA Policy and Research Conference.* Prehospital and disaster medicine, 2012. **27**(3): p. 260.

14. Habibullah, W., et al., *Commonwealth Human Rights Initiative.* 2017.

15. Fortin, K., *The accountability of armed groups under human rights law*. 2017: Oxford University Press.

16. Machel, G., *Impact of armed conflict on children*. 1996: UN New York.

17. Tamashiro, T., *Impact of Conflict on Children's Health and Disability.".* Paper commissioned for the Education for All Global Monitoring Report-EFA Global Monitoring Report, 2011: p. 1-14.

18. Wagner, G., et al., *Exposure to violence and its relationship to mental health in Palestinian youth.* East Mediterr Health J, 2019. **25**.

19. Inchley, J., et al., *Health behaviour in school-aged children (HBSC) study: International Report from the 2013/2014 survey.* Health policy for children and adolescents, 2016. **7**: p. 1-277.