



Children in Armed Conflict: Lessons from Iran on Cultural and Health-System Resilience

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Children constitute one of the most vulnerable groups in situations of armed conflict, yet the manifestations of this vulnerability are profoundly shaped by context. Global analyses of child well-being during war consistently describe recurring harms, including forced displacement, interruption of education and basic health care, deterioration in nutrition, increased vulnerability to vaccine-preventable diseases, and profound psychological trauma such as post-traumatic stress disorder, depression, and anxiety (1-3). These consequences arise not merely from exposure to violence but from the collapse of social, cultural, educational, and health-system protective structures. In this letter, the experience described in Iran's recent imposed war is used to reflect on how cultural, religious, family-centered, community-based, and health-system factors may have shaped children's health outcomes during conflict.

According to the narrative available, the imposed war began with the martyrdom of more than 160 school-aged children, and within one month the documented toll had increased to 216 children under 18 years and 17 children under 5 years, including newborns of 3 and 20 days of age. These tragedies emphasize that children were not shielded from lethal violence. Global findings demonstrate that exposure to life-threatening events, loss of caregivers, and sudden bereavement are major determinants of child morbidity in war zones (4,5). Despite these losses, the Iranian context described diverges from patterns commonly reported in other modern conflicts. Reports from the period indicate that Iran did not experience large-scale forced displacement, mass refugee flows, or widespread collapse of child health services. Rather, an absence of compulsory migration and even some instances of reverse migration, in which families returned to their home communities despite insecurity have been reported in Iran. This report, raise important questions about how families perceive risk, the cultural meaning of home, and the role of religious duty in decisions to stay or return. Comparative research suggests that large-scale forced

displacement is one of the primary mechanisms by which conflict magnifies harm to children (3). Refugee and internally displaced populations often face overcrowding, food insecurity, inadequate shelter, and deteriorating sanitation, elevating the risk of infectious diseases. Displacement also disrupts education and separates children from extended kin networks, increasing vulnerability to exploitation. In contexts where families remain embedded in their communities, protective structures, including extended kin support and local health facilities, are more likely to persist.

Family-centered and collectivist cultural norms constitute one potential protective factor. Middle Eastern family systems often emphasize strong intergenerational bonds, shared caregiving, and high parental investment in children's welfare (6). In conflict settings, such structures can buffer stress by distributing caregiving responsibilities and maintaining emotional continuity for children. Evidence from multiple war-affected regions demonstrates that supportive caregivers and stable family routines are among the strongest predictors of resilience in children exposed to trauma (7,8). The Iranian families have mobilized around their children during this imposed conflict, prioritizing access to care and drawing on cultural and religious interpretations to sustain meaning and hope.

Community-based structures, including mosque-centered associations and neighborhood networks, may also have contributed to resilience. In Iranian contexts, mosques often function as hubs for mutual aid, emergency coordination, and charitable activities. During natural disasters such as floods and earthquakes, mosque-based groups have repeatedly mobilized to provide shelter, distribute resources, and assist local authorities (9). Extrapolating from this evidence, similar mechanisms may have supported families during the conflict by preserving social cohesion and facilitating access to services.

Religious coping strategies provided another potential layer of psychological protection. Spiritual beliefs can help individuals make meaning of uncontrollable events and reinforce a sense of purpose. Positive religious coping has been associated with lower levels of depression and anxiety and with improved adjustment following traumatic experiences (10-12).

In Iran, cultural-religious narratives emphasizing endurance, solidarity, and spiritual framing of suffering may have supported children's emotional adaptation. A distinct element in the Iranian case was the continued functioning of components of the health system. Maternal and child health services, including immunization, primary care, and pediatric emergency care, reportedly remained accessible in many regions. Iran's long-established primary health-care system, including rural health houses and an extensive community health-worker network, has been shown to maintain resilience under sanctions and natural disasters (13,14). Such structures may have mitigated indirect mortality from preventable diseases, which typically rises during conflict.

An additional factor relevant to child mental health is the continuation of education despite physical school closures. While schools were closed for safety, forms of distance or virtual education continued. Global research following the COVID-19 pandemic and earlier conflict-adjacent disruptions demonstrates that maintaining structured educational engagement, even remotely, supports children's psychological stability by preserving routine, social connection, and cognitive stimulation (15-17). Although online or distance education cannot fully replace in-person schooling, studies consistently show that continuity of learning, teacher contact, and educational structure significantly reduce anxiety, behavioral deterioration, and feelings of isolation among children during crises. The maintenance of such continuity in Iran, has contributed to stabilizing child mental health.

The distinction between Iran's standing in the current imposed war and global patterns lies not in the absence of violence, children were clearly exposed to lethal conditions, but in the extent to which protective systems remained intact. In the Iranian case as described, certain cultural, familial, community, religious, and health-system buffers may have remained active and thereby mitigated secondary harms. Further interdisciplinary research is needed to explore how such mechanisms operate across diverse contexts.

In conclusion, armed conflict invariably harms children, yet the magnitude and pattern of that harm are shaped by context. The culturally grounded networks of family, community, religious institutions,

educational continuity, and a resilient health-care system may have moderated some consequences of the conflict for children in Iran. Understanding such protective mechanisms can guide the development of context-sensitive interventions to safeguard child well-being in conflict zones worldwide.

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