Upstream Local Actor and Community-Based Potential in Mass Atrocity Prevention

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Introduction

The concept of genocide and mass atrocity prevention is still relatively new. Research on genocide prevention would not begin until post 1995 following the genocides in Rwanda and the former Yugoslavia (Rosenberg & Zucker, 2015). Therefore, there is much left to be uncovered in the field (Rosenberg & Zucker, 2015), despite that genocides and mass atrocities have occurred for centuries prior to the coining of the term and continue to occur to this day (Bellamy, 2015).

The term genocide falls under atrocity crimes, an umbrella term that refers to genocide, crimes against humanity, war crimes, and occasionally ethnic cleansing (United Nations, 2014). It is worth considering that mass atrocities are complex and fluid social processes (Rosenberg, 2012) that can heighten according to the United Nations (1948). The legal definition requires that the perpetrators of a genocide have the intent to destroy a “national, ethnical, racial, or religious group” either in part or in totality by killing, inflicting conditions aimed to physically destroy, transferring children from, causing bodily or mental harm to, or imposing measures to prevent births of a target group. Notably, some historically targeted demographics are not included and there is a strong emphasis on the phrase “with intent” in the definition (Hinton, 2023). Due to the mentioned groups listed, the complicated lead-up to genocide, and the emphasis on proving the intent of the perpetrators, genocide is difficult to charge one with. This challenge, the limited categories of target groups in the legal definition of genocide, and the overlapping nature of atrocity crimes make way for “mass atrocity” as a popular term to describe the field. Deriving from atrocity crimes, mass atrocity is an act with no legal definition but is characterized as “large-scale systematic violence against civilian populations” as stated by Scott Strauss (2016).

Well acknowledged in the field is that all societies are at risk of mass atrocity (Waller, 2017). Therefore, although the circumstances of each atrocity are unique (Bellamy, 2015), there
is a widely used general framework of analysis to judge the risk of an atrocity crime being committed by any State put forth by the United Nations (UN). This Framework of Analysis for Atrocity Crimes recognizes eight risk factors common to all types of atrocity crimes and then cites two more risk factors for each individual type (United Nations, 2014). The model is intended to be used by large-scale actors, as the United Nations (2014) describes atrocity prevention to be “primarily the responsibility of individual States” as well as members of the international community and regional State alliances. More specifically, this refers to States that have adopted the UN’s 2005 Responsibility to Protect document, meaning they are compelled to assist in the de-escalation or prevention of atrocity crimes as they arise (United Nations, n.d.). As of 2007 the International Court of Justice has also considered genocide prevention a legal obligation upon States (Rosenberg, 2012), furthering a State’s obligation to evaluate the risk of atrocity and prevent it as needed. Important to note, the risk factors in this framework require dangerously worsening civilian safety conditions to prove the risk of atrocity being enacted and these risk factors largely describe situations in which civilians are in danger of being directly killed (United Nations, 2014).

Background

As mentioned above, the UN’s Framework of Analysis for Atrocity Crimes is designed towards evaluating atrocities that are done via direct civilian killing. However, this causes difficulty in assessing the risk of a key subcategory of atrocity crimes: Genocide by attrition. Genocide by attrition is done by stripping the human, political, civil, and/or economic rights from a target demographic. This subcategory recognizes that many victims of atrocity are not directly killed by militants or armed violence during a genocide. Instead, they may die from
variables such as disease or starvation related to other acts of persecution towards the targeted group, sometimes in the gradual lead up to, and during a “direct killing” mass atrocity. The intentional denial of rights can be used to destroy a targeted demographic, fitting this category easily into the definition of genocide. This atrocity type is not as rare as one may think, as it has numerous examples, such as the treatment of Jewish citizens in the Warsaw Ghetto (Poland) prior to the Holocaust, the Khmer Rouge’s (Cambodia) treatment of its citizens amidst its reign (Fein, 1997), and even persists to this day with examples such as the mass deaths from starvation and disease in the Darfur region of west Sudan (Reeves, 2005; The Genocide Education Project, n.d.). Even Black activists in the United States have petitioned the UN to charge the US with genocide for this type of atrocity (Civil Rights Congress, 1952). Yes, most atrocities occur during armed conflict. However, a significant amount can occur out of armed violence that justifies developing atrocity prevention measures separate from typical conflict resolution strategies (Verdeja, 2019).

Some noted prevention strategies for genocide by attrition not inherently linked to conflict resolution include developing atrocity early-warning and forecasting systems (Rosenberg, 2012; Verdeja, 2019) such as reporting on signs of worsening conditions by communication networks and compiling group and region-specific measures of public health and social conditions for continued international observation (Fein, 1997). “Secondary prevention” measures, or direct intervention practices, include providing food aid in cases of forced starvation, offering conditional development and resource incentives to perpetrators contingent on genocidal and discriminatory acts ceasing and human rights norms being followed, placing economic restrictions on human rights violators (Fein, 1997), and military intervention as needed (Verdeja, 2019). As noted in the common risk factors amongst atrocity crimes in the UN framework, human rights violations of varying degrees may overlap in factors leading to harm
(United Nations, 2014). Therefore, genocide prevention efforts do not need to be targeted towards genocide alone and can still be effective when intended as general human rights protection and atrocity prevention efforts (Verdeja, 2019). Also like the UN framework for atrocity crimes, most literature on atrocity prevention and human rights protection emphasizes state, regional, and international actors. These groups frequently will not intervene until there are dangerously worsening circumstances, often analyzed through the UN’s Framework of Analysis for Atrocity Crimes, as conditions would thereby invoke the Responsibility to Protect and justify potentially impeding state sovereignty of an atrocity perpetrator (United Nations, 2014).

Intervention must thereby occur at either “midstream” or “downstream” phases of prevention.

As described by Strauss (2016) and Waller (2016), atrocity prevention is broken into three time periods. First upstream prevention, which occurs prior to the atrocity and typically before there are clear victims. However, as noted above, atrocities such as genocide are complex gradual processes and may be preceded by other human rights violations, meaning victims may still be present in the upstream timeframe. The second time period is midstream prevention which occurs during the atrocity and there are clear victims (Strauss, 2016; Waller, 2016). The previously mentioned “secondary prevention” measures are frequently used here (Fein, 1997). Finally, downstream prevention occurs after the atrocity, thereby after there are clear victims, and is primarily composed of peacebuilding efforts to prevent the atrocity from occurring again (Strauss, 2016; Waller, 2016). Although fewer victims are present, it is less costly, and it is widely considered more effective to intervene at the upstream level (United Nations, 2014), the concerns of impeding state sovereignty make it difficult for the typically recognized actors to operate this early.

How does one address the potential of upstream action without impeding state sovereignty? Local actors may provide an avenue. This study shall define local actors as smaller-
scale organizations, meaning non-US state or country equivalent, federal, or international level organizations. This definition will include county governments, township governments, community-based human rights organizations, community-based service organizations and programs, and small-scale advocacy networks. Unlike foreign entities who may struggle from not fully understanding the deep historical and localized knowledge of a conflict (Verdeja, 2019), local actors are native to the area and may better understand local needs and community dynamics which, when appropriately targeted, can improve atrocity resiliency for a given area (Bellamy, 2015; Moix, 2016; Verdeja, 2019). Atrocity resiliency can be characterized by, but is not limited to, structural, economic, cultural, and societal changes that actively fight or discourage common characteristics in societies that are moving towards atrocity from occurring. These changes must not be able to be unraveled in a single generation to effectively hinder movements towards the reoccurrence of atrocity (Bellamy, 2015). Additionally, due to their domestic status, local actors would not need evidence of victims and direct-killing atrocity to mobilize aid.

Little research has been done on concrete local actor potential in upstream prevention aside from literature which suggests it is beneficial to consider. Moix (2016), however, notes the value of learning more regarding local and community-based approaches to atrocity prevention. Supplementally, Funk (2012) recognizes that prevention potential may vary based on the type and structure of each local actor, suggesting that studies done to measure this potential should use a diverse set of local actors. This study recognizes the often under-analyzed and gradual lead up to atrocities such as genocide by attrition and the difficulty in recognizing risk factors in one’s home region. It will analyze how a variety of local actors in the New York State Capital Region directly address the risk factors of genocide by attrition and do so also indirectly through the lens of general human rights protection and the offering of services and programming. This study
aims to provide preliminary highlights regarding the current potential for local actors and community-based atrocity prevention and considers methods of expanding this potential.

Data and Methods

This study systematically reviews the mission statements and publicly available information on initiatives and educational goals of the local actors in question before diving into newspaper and other media coverage on the organization or its initiatives for further context. From there, annual reports published by these local actors are investigated, both recent and from their archives, to understand the organization’s community reach, noted limitations, and growth. The stated sources are reviewed using a coding protocol to interpret the meaning behind rhetoric and language used within the sources and the actions taken by the local actors such as through educational campaigns or events held. This information is analyzed if it fits at least one of five categories: (1) Encouraging human rights or language surrounding human dignity; (2) goals or methods aimed at fighting disparity, a lack of or restricted access to rights or services, or willful negligence related to disparity; (3) goals, methods, or language encouraging resiliency; (4) methods or language centered around providing community-specific needs; and (5) goals, explanations, or other language fighting social fragmentation, alienation, or othering in relation to the target demographics.

Human rights or human dignity language is included as a category because, as mentioned previously, genocide prevention efforts are still effective when intended as general human rights protection and/or atrocity prevention efforts (Verdeja, 2019). Therefore, this factor is used to assess a local actor’s potential through implied intentions. The disparity category is included as Fein (1997) uses this type of neglect or restriction of a target group to describe “genocide by
attrition”, the type of atrocity studied in this paper. Therefore, this category shows direct and indirect efforts and intentions to prevent this specific type of atrocity. The resiliency category is designed to highlight both efforts against atrocity and local actors’ potential as Bellamy (2015) explains that to prevent the reoccurrence of atrocity or the appearance of atrocity in the future, societies must be focused on encouraging resilience by constructing societal changes (for preventing social fragmentation, for preventing disparity, etc.) that cannot be unraveled in a single generation. The provision of community-specific needs category is included to touch on the sentiments of Bellamy (2015), Moix (2016), and Verdeja (2019) that local actors who are native to the area they serve can better understand community dynamics and local needs than a large-scale organization. This category is also used to understand the current and future potential of the selected actors in localized atrocity prevention. Finally, the social fragmentation and othering category is included as the UN Framework of Analysis for Atrocity Crimes includes this category as a risk factor specific to genocide (United Nations, 2014).

**Selected Local Actors**

The selected local actors are those who aim to assist in select rights areas frequently targeted as a form of genocide by attrition, especially in areas that tend to disproportionately affect minority groups both mentioned and not mentioned in the legal definition of genocide. Due to the expansive and numerous natures of atrocities relating to disparity, this study focuses specifically on the access to and disparities in healthcare. This sector of disparity was chosen given the NYS Capital Region’s history with healthcare access in relation to certain groups which continues to show its effects to this day. This includes the region’s ongoing history with the opioid crisis which overwhelmingly affects black and brown individuals (Healthy Capital
District Initiative: Population Health Improvement Program, 2019), how the AIDS epidemic affects access to care for the queer community in the area, especially for queer people of color (Nelson, 2023), and overall mental healthcare which tends to be more pronounced for various minority groups (Equinox, 2021). The seven local actors selected for the study are listed with further details in Table 1 and are primarily local not-for-profit organizations or local hospital systems that provide services and/or education in more than one healthcare disparity. In addition, a few county-level government programs on the relevant disparities are included due to the roles of local government and region-wide initiatives in fighting community epidemics. None of the local actors chosen were branches of non-local organizations, however, some were members of local organizational alliances focused on sharing information and resources between local actors. Focusing on healthcare access and a select number of local actors also serves to make the study logistically feasible for its current purposes.

**Table 1: Local Actors Selected**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Healthcare Disparities Reviewed</th>
<th>Type of organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany County</td>
<td>Mental Health (Department of Mental Health)</td>
<td>Local Government</td>
</tr>
<tr>
<td></td>
<td>Opioids (Department of Health Opioid Task Force)</td>
<td></td>
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<tr>
<td>Albany Damien Center</td>
<td>HIV/AIDS</td>
<td>Not-for-profit Organization</td>
</tr>
<tr>
<td>Albany Med Health System</td>
<td>Mental Health</td>
<td>Hospital System</td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>Alliance for Positive Health</td>
<td>HIV/AIDS</td>
<td>Not-for-profit Organization</td>
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<tr>
<td></td>
<td>Opioids</td>
<td></td>
</tr>
</tbody>
</table>
Findings

The overarching findings across organizations found in this study relate to the categories of resiliency, social othering, and local needs. The lack of notable patterns relating to the categories of human rights language or regarding disparity speaks to how the local actors in this study portray themselves and their initiatives. Many actors are coded for at least one of these two categories based on their publicly available information; however, most organizations seem to avoid explicitly stating that situations in the communities they worked in constituted as unmet rights or inequities. Instead, they imply these potentially “controversial” messages and focus instead on more “positive” rhetoric of what they provided for the community. It remains to be seen if this style of messaging is a product of the culture of the area where the local actors work, the norm in healthcare and health disparities, or another factor. If this is a specific rhetorical choice made by the local actors, further investigation should be done to determine if this rhetorical choice is the most effective option for the organization to achieve its goals and mitigate atrocity risk.

**Finding 1: Resiliency at the Individual Level Prioritized**

The findings show many organizations encouraging resiliency through rhetoric used or services and programming offered. This resiliency can be categorized further, as shown in Figure 1. The first category of resiliency building targets individuals directly affected by the condition

<table>
<thead>
<tr>
<th>Equinox</th>
<th>Mental Health</th>
<th>Not-for-profit Organization</th>
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<tbody>
<tr>
<td>Healthy Capital District (Only reviewed HDC’s published reports)</td>
<td>Opioids</td>
<td>Regional Alliance</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>St. Peter’s Addiction Recovery Center</td>
<td>Opioids</td>
<td>Hospital System</td>
</tr>
</tbody>
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and their friends and families who may be indirectly affected, which will be referred to as the “community of those affected” or CoTA. Techniques specifically targeting this community are common amongst all local actors and some techniques include therapy access, support and social groups, aid in understanding the condition, treatment to prevent growth or community resurgence of the condition, and skills development for those directly affected by the condition to encourage social and financial independence. For example, Saint Peter’s Recover Center offers individualized counseling sessions and a recovery program based on Narcotics Anonymous for drug users under the organization's care (St. Peter’s Health Partners, n.d.).

While these techniques serve to build up the CoTA, solely targeting resilience in this community remains risky as it reduces the visibility of the condition, the local actor, and the strength of the cultivated community in the eyes of the larger public of the region. Lack of engagement with the general community could limit the general community’s understanding and knowledge regarding the condition and those affected by it.

Figure 1: Resiliency Findings
Finding 2: Resiliency at the Local Community and/or Regional Level

A second category of resiliency building encouraged by some organizations is resiliency for the general local community or region. All local actors employing this category of community resiliency building also employ techniques in the first category. Notably, this category is observed to be less common and done primarily through providing services and programming also to the target communities that were disproportionately affected by the condition in question. For example, the Albany Damien Center’s “MPower!” program provides health and human services to members of the LGBTQIA+ community in addition to being primarily an HIV and AIDS resource center (Albany Damien Center, n.d.). This method expands past the CoTA, however as explained above, minority demographics are disproportionately affected by the conditions and disparities selected for this study. Therefore, the local actor’s reach may still not allow for widespread visibility and engagement to avoid the outcome described in the paragraph above. In this resiliency category, some local actors also provide detailed information through their websites and newsletters to inform the general local public on
the condition and reduce stigma towards individuals directly affected by said condition. The Alliance for Positive Health is a good example of this as an entire section of its website provides information on the various conditions it provides services for. In the HIV and AIDS portion of this section, the website assures the reader that the condition is treatable and spread of the condition can be restricted (these are common misconceptions about the condition in modern day) while also using person-first language wherever possible (“people with HIV”) to focus on those with the condition being seen as people (Alliance For Positive Health, n.d.). This is a promising step towards engaging the larger local community and mitigating a risk factor of atrocity.

**Finding 3: Responding to Social Fragmentation and Othering**

Social fragmentation and othering findings show that efforts are primarily focused on fighting stigmas surrounding conditions. However, some organizations do bring attention to social fragmentation and othering aimed at target groups or communities. This was done by explaining which groups are disproportionately affected by the condition in question and using inclusive and welcoming rhetoric to educate others on the phenomenon and fight stigma surrounding members of these target groups who may also experience one or more of these conditions. For instance, Equinox’s most recently posted newsletter recognizes “the profound mental health-related challenges faced by Black, indigenous and other people of color, and LGBTQ+ individuals” and includes poetry describing the emotional hardship mental health stigmatization can cause an individual while in the poem relating different manners in which one who struggles with mental health problems is no different than an individual without mental health problems (Equinox, n.d.). The Albany County Department of Mental Health also is an example of these efforts as it includes on its website that a goal of its Suicide Prevention Education Committee is to “end stigma, shame and blame by supporting worth, dignity and
inspiring hope” regarding the stigmatization around those who struggle with mental health or suicide (Albany County Department of Mental Health, n.d.). Sources such as the local actor's website, newsletters, or even by providing information in person in the building in which the local actor holds their operations are used to communicate this fight against stigma.

Finding 4: Preventing Atrocity through the Provision of Local Services

The final category of findings is on the provision of local needs. Most local actors in this study focus on condition-specific needs but lack the provision of local community-specific needs. For example, the Albany Med Health System Mental Health Department offers education on the conditions served, psychiatric evaluations, and treatment to the CoTA, but lacks additional programming to address this healthcare disparity or its roots in the larger community (Albany Med Health System, n.d.-b). This example is also not specific to this organization being part of a hospital system, as the HIV and AIDS department of this organization did offer a small number of local-specific needs such as an educational program about caring for older HIV patients given Albany’s large aging population (Albany Med Health System, n.d.-a). Despite the overall lack of local needs offered, the local government departments examined and their regional governmental healthcare alliance have very thorough documentation of local community needs which intersected with the conditions in this study and had set goals around addressing these needs. Healthy Capital District for example highlighted the sizable percentage of those struggling with mental health in the Capital Region who were also living in lower incomes or poverty (Jobin-Davis et al., 2022). Albany County has detailed explanations of its progress and regressions in each goal over time and even ranks various local needs by priority to address needs such as transportation for individuals receiving outpatient mental healthcare (Giordano et al., 2019). This governmental ranking of local needs is apparent in the work of other local actors in the area as well. For example, reducing stigma is not listed as a priority goal for Albany County, yet offering
opioid-related programs and services was (Giordano et al., 2019), and this can be seen with the number of programs in the community centered around opioid services as opposed to the weaker presence of initiatives fighting the stigma surrounding the conditions in question for the region studied. This may suggest a level of government-agenda setting for non-governmental local actors. Additionally, New York State supports the funding and contract work of various local organizations to provide services for conditions such as opioid addiction (New York State Office of Addiction Services and Supports, n.d.), which may also contribute to the governmental influence in agenda-setting for non-governmental local actors. This agenda-setting can help guide other local organizations, but agendas should not be exclusively set through these government entities and alliances as they may not always be an accurate measure of community needs. For example, in the Health Capital District report, there is a health assessment of community needs listed and part of the assessment utilizes polling measures of the region’s residents to understand the public's perspective on which the most critical health topics are to be addressed (Jobin-Davis et al., 2022). However, the majority public’s polling perception of what are important disparities to address may not be reflective of disparities that disproportionately affect various minority groups. As a result, while the governmental agencies may feel compelled to prioritize health disparities impacting larger demographics of their constituents, non-governmental local actors may need to fill in these gaps by also including initiatives that are less popular public-wide to ensure that local needs especially affecting minorities are being met.

Lessons Learned and Recommendations

As mentioned in the findings, there are few uses of human rights language or acknowledgment of disparities by the local actors studied. Instead, more positively oriented language is used when discussing organizational initiatives. Resiliency building is primarily targeted at the CoTA, however, some initiatives to educate others through newsletters or websites
and providing services to communities the most at risk were also noted above. Efforts to fight social fragmentation are primarily focused on reducing stigma related to the specific conditions serviced, however, some local actors extend these initiatives into fighting the stigmatization and othering of the minority communities disproportionately affected by these health conditions as well. Finally, although most local actors do not provide many local need-based services, the local needs of the community are well documented through government and intergovernmental alliance reports. These findings go beyond the acts of the local actors studied, however. They also have larger implications for the Capital Region’s current level of resiliency against the slow creep of atrocity.

The review of organizational documents shows that there is limited information targeted to the general public to increase public knowledge of, or reduce stigmatization towards, the groups that are disproportionately impacted by the healthcare disparities studied. Additionally, as stated in the findings, most of the information or anti-stigmatization initiatives provided by the organizations in the study are found on the organization’s website or newsletter/other report. Thus, members of the larger community who may read the websites or newsletters of these local actors, especially in the case of service-oriented not-for-profit organizations, likely have a reason for engaging with these sources. For members of the community who do not have a reason to engage with these sources, further techniques will be necessary for the local actor to reach these individuals such as holding and being involved in events targeted to the entire local community or educating in community centers. Currently there is a lack of community events or other documented techniques to reach additional audiences oriented at fighting stigma or educating the community on who is the most at risk, despite these being part of the listed missions of organizations such as the Albany County Department of Mental Health or the Albany Damien Center (Albany County Department of Mental Health, n.d.; Albany Damien Center, n.d.).
case of Albany County specifically, it mentions encouraging collaborations with “community-based organizations” on its website when discussing anti-stigma initiatives (Albany County Department of Mental Health, n.d.), however further investigation will be needed to confirm if this local actor and others are in collaboration with organizations such as doctors' offices to spread anti-stigma messaging to individuals they would otherwise not reach in the local community. Additionally, further investigation must be done regarding the effectiveness of the currently used rhetoric on the local community.

The lack of publicly available information or anti-stigma initiatives that can reach the general public where they are can lead to the general public having little knowledge about the disproportionately affected groups in question. This can result in the spread of misinformation regarding the condition or group as the public may not have the knowledge to recognize the misinformation and it may encourage the estrangement of the target group from the larger community, further othering the group and making the larger local community less aware or interested in the challenges facing these individuals. Prevalent stigmatization toward a target group in a local community may also encourage an increased spread of hateful messages against said target group which is a risk factor of atrocity (United Nations, 2014). Believing in hateful propaganda or the social estrangement of the target group from the community can lead to the general public not being aware of atrocity as it attacks the target group and may even encourage the general public of the local area to be complacent in or partake in community destruction of those affected individuals or disproportionately affected target groups (United Nations, 2014). Therefore, these efforts to fight stigma and social othering are deeply important to mitigating this risk of atrocity and supporting resiliency-building techniques for the CoTA, and these efforts can become more effective at protecting target demographics and encouraging this community resiliency when coupled with general public-wide visibility and interaction.
An example of the potential to prevent atrocity behind these current and suggested methods can be the potential to hinder the progress of atrocities in an indirect manner. More specifically, fighting stigmas of a condition in the larger local community while also fighting disparities related to, and the treating of, the condition in question for the CoTA and overrepresented groups even if it is not deemed as important for the general public could also provide an interesting avenue in removing these conditions and their related disparities from being used as tools of genocide by attrition. If the conditions are not as stigmatized, then it may be more socially acceptable for governments and other forms of local organizations to provide services to the CoTA in dealing with and treating these conditions. With a more expansive provision of services, members of the CoTA could more easily access their rights to medical treatment and care. This could reduce the influence of these healthcare disparities upon the disproportionately affected minority communities. As a result of this, the specific disparities that were reduced in impact may no longer play a notable role in attiring a target group in the event of atrocity. In fact, similar goals are already being described by New York State in its intentions for state and local health departments to manage the opioid crisis by addressing stigma through “removing barriers to culturally competent care” (New York State Department of Health, Office of Drug User Health, 2020).

The findings in this study were not limited to the categories coded for. In general, local governments and regional government alliances seem to have more engagement with the general public and thus bring messaging and services to a wider range of individuals in the local community compared to their non-governmental counterparts. This may be due to the local government’s central presence in the area. Therefore, while non-governmental local actors can conduct their own collaborations between each other, non-governmental local actors may also benefit from collaborations with local governments to share resources and have access to a more
central community presence along with the currently implied initiative sharing. This may be
done in the form of creating organizational alliances, task forces, or a more informal measure to
ensure agenda-setting measures are not solely dictated by the expectations placed on the local
governments of the area. In a similar vein, collaborations with larger-scale organizations such as
state governments where local actors provide certain services to the community in exchange for
additional resources such as is seen in the New York State contracting model could continue to
show potential (New York State Office of Addiction Services and Supports, n.d.). This said, to
expand the current potential of local organizations, these collaborations with larger entities will
need to be balanced with working to provide local-specific and culturally-specific needs that
intersect with the conditions they focus on since these local actors are the ones who would know
what the additional needs of the communities they serve are.

Conclusion

Local actors have large potential to provide local-specific needs and services to the
communities they reside in, and non-governmental organizations may especially be able to aid
less heard minority groups who are not as often serviced in the disparities that disproportionately
affect their communities. In the case of healthcare-related organizations, methods of expanding
this local actor potential may include holding educational and community-building events to
reduce stigmas surrounding the CoTA and the conditions the local actors provide services for and
encouraging community resiliency in protecting the CoTA and the marginalized groups that are
disproportionately affected by the condition. If this fight against stigmatization expands into also
fighting stigmas against the marginalized communities disproportionately affected, this can work
to reduce the alienation and othering of this demographic from the larger community. This can
result in making the general community less vulnerable to hateful propaganda and other risk
factors of atrocity and may allow communities that are especially affected by a particular health disparity to seek care more easily.

To have true community resiliency against atrocity, cultural and social changes must develop in the community that cannot be undone in a single generation. To do so, these organizations must have visibility in the larger community to reach individuals who would otherwise have no reason to interact with the local actors in question. Collaborating with local governments and regional alliances may provide the centralized community presence and resources necessary for these resiliency efforts to be effective, but a balance should still be struck between agenda-setting initiatives done by governmental and non-governmental actors. Additionally, providing intersectional local community needs when approached through the lens of providing human rights can also help improve a community’s resilience against genocide by attrition given that creating structures that ensure access to human needs and rights can hinder the spread of attrition aimed at stripping those rights.

This study is not without limitations. The author recognizes that access to information on local actor potential in atrocity prevention was limited to only English and Spanish. The study was also restricted to select local actors and one sector of disparity for logistical purposes. The few events held by the selected local actors could not be attended nor did the methods include interviews with representatives from the local organizations, also due to logistical issues and out of consideration for the busy workloads of employees and volunteers working in these local organizations. Connected to the busyness of these local actors, preliminary methods of expanding local actor potential listed in this paper must be implemented on a timeline that suits the local actors, but are still important to incorporate in the community nonetheless. Local actors must often balance competing demands, limited resources, and overwork amongst other factors when conducting their initiatives, and so any additional or changed methods they take must be
chosen with care to not disrupt the current functions of the organizations. Further research should be done into how to best incentivize local actors to adopt these practices and how to provide them with the resources to do so. As these proposed methods become more frequently adopted in communities, the longer term social and cultural effects they have on their local communities should also be studied to further understand the limitations or unforeseen side effects of these methods.

Additionally, further research should be done to understand how these methods of expanding potential relate to other types of healthcare disparities, such as access to reproductive healthcare, and even healthcare disparities that even more clearly and disproportionately impact select target groups such as gender-affirming healthcare or disability services. This study should also be expanded to other sectors of attrition such as civil rights and food security and recreating this study in other communities of various backgrounds, structures, and demographics across the United States and other early pre-atrocity countries may provide new insights into methods of expanding local actor potential in atrocity prevention as well as their limits.
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