

## ICMJE DISCLOSURE FORM

**Date:** 3/18/2023

**Your Name:** Saroj Jayasinghe

**Manuscript Title:** The 12 Dimensions of Health Impacts of War (The 12-D Framework): A Novel Framework to Conceptualise Social and Environmental Determinants of Health and Public Health

**Manuscript Number (if known):** [Click or tap here to enter text.](#)

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6	Payment for expert testimony	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> </table>							
7	Support for attending meetings and/or travel	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> </table>							
8	Patents planned, issued or pending	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> </table>							
9	Participation on a Data Safety Monitoring Board or Advisory Board	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> </table>							
10	Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%;"></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> <tr><td style="height: 20px;"></td><td></td></tr> </table>							

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<b>12</b>	Receipt of equipment, materials, drugs, medical writing, gifts or other services	<input type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 15px;"></td><td style="width: 50%; height: 15px;"></td></tr> <tr><td style="height: 15px;"></td><td style="height: 15px;"></td></tr> <tr><td style="height: 15px;"></td><td style="height: 15px;"></td></tr> </table>							
<b>13</b>	Other financial or non-financial interests	<input checked="" type="checkbox"/> <b>None</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 15px;"></td><td style="width: 50%; height: 15px;"></td></tr> <tr><td style="height: 15px;"></td><td style="height: 15px;"></td></tr> <tr><td style="height: 15px;"></td><td style="height: 15px;"></td></tr> </table>							
<p><b>Please place an "X" next to the following statement to indicate your agreement:</b></p> <p><input checked="" type="checkbox"/> I certify that I have answered every question and have not altered the wording of any of the questions on this form.</p>									