

**PEACE THROUGH HEALTH:
A CASE STUDY OF PHYSICIANS FOR HUMAN RIGHTS-ISRAEL**

By

**Judy Kitts
B.A., Queen's University, 2004**

**A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of**

MASTERS OF ARTS

**In Dispute Resolution, Faculty of Human and Social Development
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ABSTRACT

This thesis explores Peace through Health (PtH) in the context of an intractable conflict by examining the 10 PtH mechanisms within Physicians for Human Rights-Israel (PHR-I). In using a single qualitative instrumental case study of PHR-I, my research sought to answer the questions: *Is Peace through Health an appropriate peace-building response in the context of the Palestinian-Israeli conflict? How are the 10 mechanisms of Peace through Health reflected in the work of Physicians for Human Rights-Israel? And how can Peace through Health be evaluated in regions of intractability to provide evidence for this emerging field?*

Findings indicated that PtH is an appropriate response, if a) importance was placed on the political dimension and b) understood in the context of a multi-track approach. In terms of the 10 mechanisms of PtH, my research found that while some of the mechanisms were reflected in the work of PHR-I, the impact they could have on peace was limited by the political realities of the Israeli-Palestinian conflict. Finally, in terms of evaluation, my findings suggest that the contribution that health can make to peace-building, at present, is small and exceedingly difficult to measure as the question of ‘how’ continues to hinder the process of evaluation.

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ABBREVIATIONS

CISEPO	Canadian International Scientific Exchange Program
GSS	Israel Security Service (Shin Bet)
ICBL	International Campaign to Ban Landmines
ICESCR	International Covenant on Economic, Social, and Cultural Rights
IDP	Internally Displaced Persons
IMA	Israel Medical Association
MTD	Multi-Track Diplomacy
NGO	non-governmental organization
oPt	occupied Palestinian territory
OTP	Occupied Territories Project
PHR-I	Physicians for Human Rights-Israel
PtH	Peace through Health

GLOSSARY

Armed Conflict	Armed Conflict is defined by Project Ploughshares as a political conflict in which armed combat involves the armed forces of at least one state (or one or more armed factions seeking to gain control of all or part of the state), and in which at least 1,000 people have been killed by the fighting during the course of the conflict. Armed conflict is used here to distinguish itself from the term ‘conflict’ in general, which may be seen as perception of incompatible goals and potentially a stimulus for positive development and action.
Barrier, The	Announced by the Israeli government on 14 April 2002, the barrier being build by Israel in the oPt is referred to by Israelis as the “security fence,” “separation fence,” or “anti-terror fence,” and as the “expansion wall,” “annexation wall,” or “apartheid wall” by Palestinians. The United Nations commonly refers to it as the “barrier.”
Health	In 1948, in its Constitution, the World Health Organization defined health in holistic way - a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.
Intractable Conflict	According to Louis Kriesberg, an intractable conflict is a protracted conflict that persists for a long time. They are waged in ways that the adversaries or interested observers regard as destructive, and partisans and intermediaries attempt, but fail, to end or transform them (2003).
Multi-Track Diplomacy	The Institute for Multi-Track Diplomacy defines multi-track diplomacy (MTD) in a conceptual way to view the process of international peacemaking as a living system. It looks at the web of interconnected activities, individuals, institutions, and communities that operate together for a common goal: a world at peace. There are nine tracks to peace of MTD: government, professional conflict resolution, business, private citizens, research training and education, activism, religious, funding, and public opinion/communication.
occupied Palestinian territories	This term is used by the International Court of Justice and the United Nations. It refers to the areas occupied by Israel following the 1967 war, namely the West Bank,

Gaza, and East Jerusalem. These areas are controlled by Israel but are part of the pre-1967 borders as affirmed by the UN Security Council Resolution 242.

Peace

Peace, defined positively, refers to not only the absence of war, but the presence of social justice through equal opportunity, a fair distribution of power and resources, equal protection and impartial enforcement of law (Galtung 1990). The term ‘peace’ is used here in this broadest sense.

Peace through Health

This term refers to “any initiative that is intended to improve the health of a population and to simultaneously heighten that population’s level of peace and security” (MacQueen et al. 1997, 175).

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and to my parents for always being there.

CHAPTER ONE: INTRODUCTION

1.1 Background

In 2004, I was awarded the opportunity to work in Beirut, Lebanon for the International Campaign to Ban Landmines (ICBL). As an intern for a small non-governmental organization, the Landmine Resource Centre, I traveled throughout the country, witnessing the effects of these indiscriminate weapons. This experience served as my first glimpse of an initiative that attempted to bridge the link between peace and health.

In using health data to demonstrate that landmines have unacceptable and inhumane effects, the ICBL de-legitimised the use of landmines as an instrument of war by highlighting their indiscriminate effects on civilians. In redefining a seemingly military issue as a public health concern, health practitioners exerted their expertise and influenced international law.¹

On a personal level, this experience served to highlight the inextricable link between conflict and health as I worked closely with landmine victims who struggled to reintegrate into the community. The resilience of the victims and the unwavering support of the community were deeply moving and when I returned to Canada six months later, I found myself continually thinking about these victims and the irreversible impact of conflict on health.

In brief, this experience was the impetus behind my research presented here and has sparked a deep interest in exploring, on both a personal and academic level, the impact of conflict on health.

¹ ¹ The Mine Ban Treaty, an international agreement to ban landmines, was signed in Ottawa, Canada and came into force in 1999 (ICBL).

1.2 Statement of the Problem

Intractable conflicts are highly destructive, enduring, and particularly resistant to attempts to resolve them. Currently, about 40% of intra-state armed conflicts have persisted for 10 years or more, with 25% of wars lasting more than 25 years (Marshall and Gurr, 2005). Characterized by intransigence, longevity, complexity, and serious trauma for the disputants and often for bystanders as well, intractable conflicts erupt over a variety of issues, including high stakes distributional issues, value and identity-based problems and threats to health and human safety (Putnam & Wondelleck, 2003). Intractable conflicts have posed daunting challenges to the study of conflict resolution, and while the theoretical interest in intractability has increased, so has the number of conflicts that fall within this category.

The Second Intifada marked a new series of trauma in the midst of the intractable conflict between the state of Israel and the Palestinian movement for self-determination. As the second major wave of violence between Palestinians and Israelis continues, the death toll since September 2000, both military and civilian, is estimated to be over 5,400 Palestinians and over 650 Israelis (B'Tselem 2007).

The intractable conflict in Israel and the occupied Palestinian territories has highlighted the impact of conflict on health and “the role of health workers in preventing and mitigating destructiveness” (MacQueen and Santa Barbara 2000, 293). While the impact is indisputable, Peace through Health (PtH) explores “how health interventions may contribute to peace in actual and potential war zones and situations of conflict” (Arya 2004, 242). PtH recognizes that peace-building is a multi-sectoral approach, in which the health community has a powerful role to play in peace efforts around the

world. Nevertheless, PtH has been plagued with criticisms for its lack of evidence and its ideological goals. Furthermore, critics have cited Mary Anderson's *Do No Harm* as a warning that PtH, along with other types of aid, can potentially feed into, reinforce, and prolong conflict (1999, 37).

1.3 Study Purpose and Question

The purpose of exploring Peace through Health within Physicians for Human Rights-Israel (PHR-I) was to provide information concerning the appropriateness of PtH within the context of the intractable conflict in Israel and the occupied Palestinian territories. In particular, this study explored the 10 Peace through Health mechanisms within Physicians for Human Rights-Israel in an effort to examine “the opportunities and strengths of health workers in the promotion of peace” (Santa Barbara and MacQueen 2004, 384). Finally, this study explored the challenges of evaluating Peace through Health in the midst of an intractable conflict.

My research sought to answer the questions: *Is Peace through Health an appropriate peace-building response in the context of the Palestinian-Israeli conflict? How are the 10 mechanisms of Peace through Health reflected in the work of Physicians for Human Rights-Israel? And how can Peace through Health be evaluated in regions of intractability to provide evidence for this emerging field?* These questions were addressed using a case study of Physicians for Human Rights-Israel.

1.4 Relevance

This case study of Physicians for Human Rights-Israel explored Peace through Health in the context on an intractable conflict by examining the current PtH mechanisms

developed by Graeme MacQueen and Joanna Santa Barbara. The observations that were drawn from the thematic analysis of the data harvested from the Physicians for Human Rights-Israel provide insight on how health organizations can play a role in peace-building in the context of a seemingly intractable conflict. Finally, in working with PHR-I, I explored the challenges of evaluation in Peace through Health in regions of intractability.

CHAPTER TWO: LITERATURE REVIEW

2.1 The Impact of Armed Conflict on Health

While the number of armed conflicts worldwide continues to decline (See Figure 2.1.1), there is no cause for celebration (Project Ploughshares 2007). According to Project Ploughshares Monitor 2007, 29 countries are currently hosting armed conflict, leaving millions of people caught in the crossfire (Ibid) (See Figure 2.1.2). 35 people die every hour as a result of armed conflict (World Health Organization 2002a) and during the last decade, 90% of all deaths related to war were among civilians, many of them women and children (Levy 2002, 114).

Armed conflict has an irreversible impact on human lives, yet the direct violence accounts for a relatively small proportion of the suffering people in conflict-affected communities endure (Santa Barbara and MacQueen 2004, 384). In fact, the indirect consequences of armed conflict, including problems with access to services, fragmentation, damaged infrastructure, inadequate medical supplies and poorly trained and supported health workers (Panch et al. 2002, i) can be as, and potentially more, serious and widespread than the direct consequences.

The WHO's Collaborating Centre for Research on the Epidemiology of Disasters published a report in 2002 titled *Armed Conflict and Public Health*. The report highlights the impact of armed conflict on health in terms of four indirect consequences - mass population displacement, damage to agriculture, damage to healthcare infrastructure, and decreased health expenditure (Guha-Sapir and van Panhuis 2002) (See Figure 2.1.3).

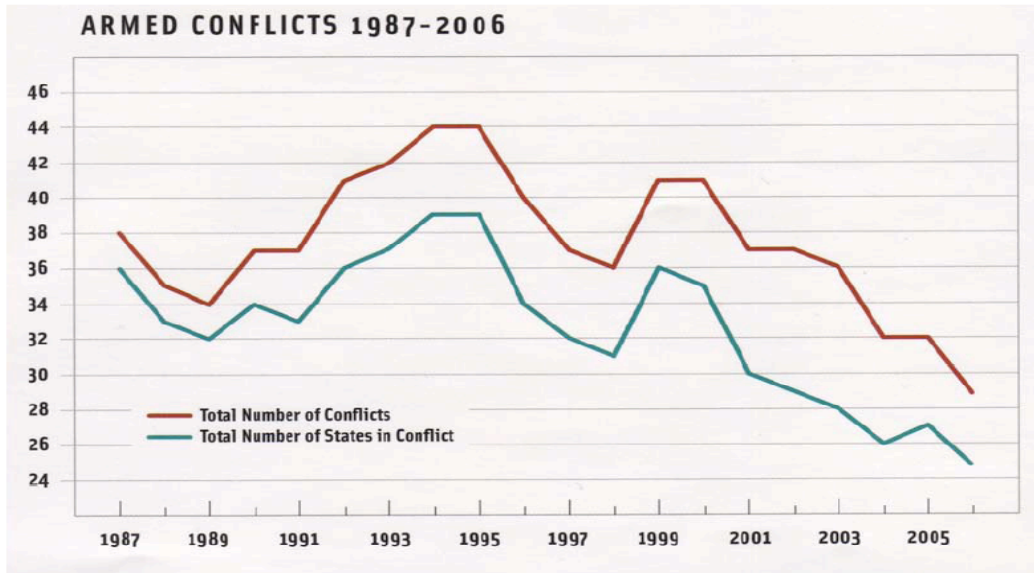


Figure 2.1.1: Armed Conflict in Decline

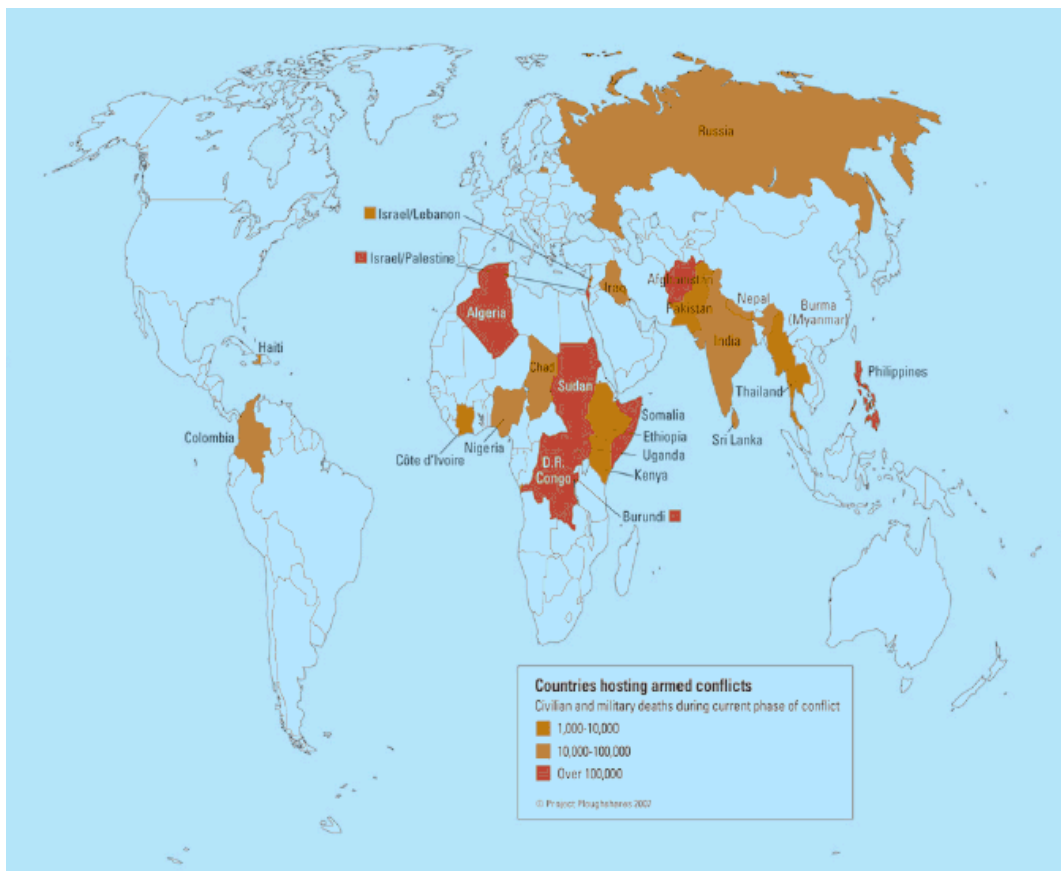


Figure 2.1.2: Armed Conflict in 2006

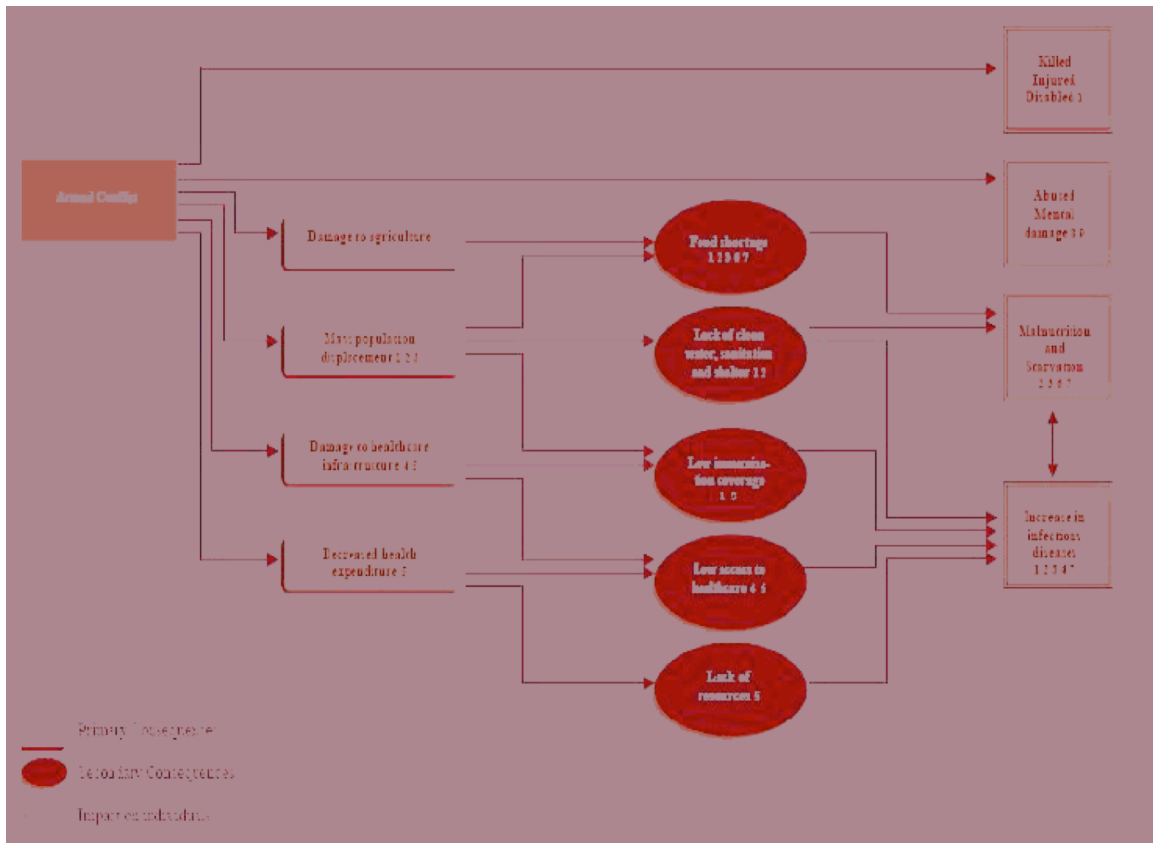


Figure 2.1.3: Impact of Armed Conflict on Health

According to the Internal Displacement Monitoring Centre, 4 million people were displaced in 2006 as a result of armed conflict, bringing the total number of internally displaced persons (IDP) to 25 million (Glusker 2007, 9). Lacking access to water, food, shelter, and health care, IDPs are more vulnerable to disease and malnutrition. In fact, the precarious living situations of IDPs are particularly evident in overcrowded camps, where despite the fact that national governments have the primary responsibility to ensure that the displaced are provided for, they depend almost entirely on international food aid and the services of international aid organizations (Ibid, 7).

Production within this sector is also drastically affected by the occurrence of conflict. In rural areas, production drops on average by 12.3% per year during periods of

violent conflict (Taeb 2004, 13). A 2003 study conducted under the International Food Policy Research Institute illustrates that conflict and post-conflict countries tend to be food insecure, with more than 20 percent of the population lacking access to adequate food (Messer and Cohen 2006, 9). Various factors contribute to food insecurity in conflict regions, including government spending. In conflict-affected countries, governments typically have higher military and defence budgets, yet the expenditures for agriculture, including health and nutrition programs, are considerably lower (Ibid, 13).

In addition, conflict directs scarce resources away from the protection and promotion of health, medical care, and other human services and destroys the infrastructure that supports health (Levy and Sidel 2008, 3). This disruption heightens the occurrence of ill-health. According to the 2005 Human Security Report, more women and children die from preventable diseases, malnutrition and childbirth complications in conflict zones than from actual violence or brutality (Human Security Centre 2005). Without adequate healthcare facilities, conflict-affected communities experience a decline in primary health care services, including the availability of treatment facilities, medications, and the number of appropriately trained health professionals. Furthermore, while conflict decimates the health infrastructure, the limited health services that are available are often inaccessible due to the disruption in other sectors. Roads may be blocked, mandatory curfews may be in place, or basic mobility rights may be restricted, thereby prohibiting the ability to access public health services.

Finally, in conflict-affected countries, government spending is directed largely to defence. In post-conflict countries, governments face multiple competing demands for

public expenditure, including reconstruction costs, environmental repair, and governmental reform. In fact, the United Nations Children's Fund reports that conflict-affected countries have “failed to make much improvement in child malnutrition and mortality rates, in part because of the destructive violence and in part because of underinvestment in health, education, and nutrition programs relative to military spending” (Messer and Cohen 2004, 3). One study finds that civil wars typically have a severe short-term negative impact on economic growth within the country and its neighbours (Murdoch and Sandler 2002, 106). Naturally, with a declining revenue and a contracting economy, governments tend to cutback on health expenditures, which often results in the depletion in the number of local health services and health practitioners available (Guha-Sapir and van Panhuis 2002, 19).

The WHO’s report *Armed Conflict and Public Health* highlights the impact of conflict in terms of mass population displacement, damage to agriculture, damage to healthcare infrastructure, and decreased health expenditure. Not surprisingly, these indirect consequences, along with others, can have lasting and profound effects on the physical, mental, social, and spiritual aspects of a community.

The impact of armed conflict on health is indisputable. In fact, conflicts are increasingly being incorporated as a central determinant into the discourse of public health. In fact, the Ottawa Charter of Health Promotion cites eight prerequisites for health: shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity, and peace (WHO 1986). In highlighting the social determinants of health, the Charter states that a healthy community requires a secure foundation in all

these basic prerequisites. It comes as no surprise then, that the Israeli-Palestinian conflict has deeply impacted the health of both the Israelis and Palestinians.

2.2 Health Crisis in the Occupied Palestinian Territories

According to Amnesty International's 2007 Report, increased violence between Israelis and Palestinians resulted in the death of 650 Palestinians and 27 Israelis in 2006 (2007, 147) while the Palestinian Red Crescent reports 1,809 injuries in the West Bank and Gaza alone (2007). In addition, military blockades and increased restrictions imposed by Israel on the movement of Palestinians caused a significant deterioration in living conditions for Palestinians, with poverty, food aid dependency, health problems and unemployment reaching crisis levels (Amnesty International 2007, 147). A recent study conducted by Physicians for Human Rights-Israel concluded that when the Rafah Crossing² was closed on June 6th 2007 and the Erez Crossing³ was closed just days later, the access of the sick and wounded to medical centres for treatment unavailable in Gaza was completely blocked. The study found that from June 14th to July 4th 2007, 44 people requested permission to enter Egypt for medical treatment, yet 16 of these requests were rejected (PHR-I 2007a, 1).

In November 2006, the UN High Commissioner for Human Rights, Louise Arbour, noted an "an alarming deprivation of human rights" that has resulted in the precarious impact on the health status of people in the occupied Palestinian territories and Israel (Manenti 2007, 3). The right to health⁴ including the availability, accessibility, and

² The Rafah Crossing is an international border crossing between Gaza and Egypt.

³ The Erez Crossing is a pedestrian/cargo terminal on Israeli Gaza Strip barrier.

⁴ The right to health is entrenched in Article 12 of International Covenant on Economic, Social and Cultural Rights (ICESCR). It states that parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. As of October 2007, there are 157 state

quality of health facilities, services and goods in the oPt is deteriorating, while tertiary health care is practically unavailable in the West Bank and Gaza, leaving patients desperate for treatment outside of the oPt (Ibid). However, since the disengagement in 2005, Israel now claims that the state bears no legal responsibility towards the inhabitants of Gaza, arguing that the passage of the sick and wounded will be enabled as a humanitarian gesture only (PHR-I 2007a, 1). In fact, PHR-I recently reported that military authorities are now making a distinction between danger to life and danger to ‘quality of life,’ meaning that patients in danger of losing a limb will not be considered to be in a condition that necessitates passage to medical centres in Israel (Ibid).

Furthermore, the system of closure, which includes more than 500 checkpoints, the separation wall, the random and frequent closure of the Rafah, Erez, and Karni crossings,⁵ as well as a strict permit system,⁶ are critical barriers to the right to health (Manenti 2007, 3). The adverse effects of this system include the faltering number of patients managing to reach East Jerusalem hospitals, the difficulty in getting permits for Palestinian personnel employed by East Jerusalem health care providers, and the financial suffocation of East Jerusalem hospitals by the lowered occupancy rates and the ensuing huge financial losses (PHR-I 2005, 5).

Furthermore, a recent survey conducted by the UN Office for the Coordination of Human Affairs found that 30 of the 57 communities located close to the West Bank separation barrier had no direct or regular access to their land (2006). In fact, “some 80

parties to the ICESCR, including 66 countries that have also signed the treaty, but not ratified it. In 1991, Israel ratified this covenant, but did not adopt it into internal legislation. (UNHRC 2004).

⁵ The Karni Crossing is a cargo terminal on the Israel Gaza strip border.

⁶ In 1991, Israel changed the policy it had implemented in 1967. The general exit permits of 1972, which enabled Palestinians from the oPt to enter Israel freely, were revoked. A new permit system was created that required any Palestinian wishing to enter Israel could do so only by means of an individual permit.

percent of the [barrier] is being built on Palestinian land inside the West Bank, in some places up to 20km east of the Green Line” (Amnesty International 2006, 20). As a result, currently the majority of Palestinian refugees live within 100km of the borders of Israel and the oPt, where their homes of origin are located (Badil Resource Center 2007, 50).

B’Tselem, the Israeli Information Centre for Human Rights, reports other health concerns. In 2005, over 200,000 residents in the West Bank were not connected to a running-water network, and 209 people were left homeless in 2007 after the houses that were built in the West Bank were demolished (B’Tselem 2007). B’Tselem also states that “more than 9,200 Palestinians are being held in Israel, with the vast majority in facilities of the Israel Prisons Service, and a small number in Israeli Defence Forces’ facilities” (Ibid).

Mental and psychological health problems are also a serious concern. The World Health Organization’s profile of the oPt cites that since 2000, there has been a significant increase in the number of patients seeking treatment at community mental health centres, while the availability of community mental health services is scarce, and access to them is difficult (World Health Organization 2006). In fact, there are currently 9 psychiatrists and at most 15 clinical psychologists in the West Bank, who serve 2.7 million people, and the only in-patient facility is the Bethlehem mental hospital. Not surprisingly, findings from the WHO state that about 70% of people who sought mental health care over a six-month period did not receive any (Ibid).

2.3 Intractable Conflict

The Israeli-Palestinian conflict is a classic example of an intractable conflict. “It has persisted – sometimes as an autonomous bilateral contest, sometimes linked to regional, interstate struggles involving Egypt, Jordan, Lebanon, and Syria – for almost five decades” (Crocker, Hampson and Aall 2005, 11). It underlies issues of religious and ethnic identity and historical claims to the ownership of land. It lies between countries that have tried to remain neutral and those that have facilitated and engaged in the ongoing conflict. Finally, the Israeli-Palestinian conflict has remained resistant to peace treaties and other peace-building efforts, including the most recent failure, the Annapolis Conference.

This intractability that has led to the direct and indirect health consequences that have plagued generations of Palestinians and Israelis. Peter Coleman argues that intractable conflicts can be distinguished from manageable conflicts by their issues, contexts, and type of escalation (2000). *Issues*, Coleman argues, tend to be related to resources, values, power, and basic human needs, while *context* refers to the fact that many intractable conflicts are embedded in long-standing differences and inequalities. Finally, the *type of escalation* tends to take conflicts out of the parties’ control and pushes them to act in increasingly extreme ways that they would not, under other circumstances, consider remotely acceptable.

Nevertheless, “there is nothing pre-ordained about the course or dynamics of a conflict. Some conflicts erupt and are settled peacefully within a short time; others simply defy any attempt at termination” (Bercovitch 2003). Naturally, the Israeli-Palestinian

conflict falls within the latter category and poses a great danger to the international community. In fact, conflict not only impacts the countries directly involved, but can also lead to instability around the world by stimulating refugee flows, locking countries into poverty, increasing the spread of diseases, and threatening international security. Finding ways to transform these conflicts is imperative, and solutions will only come from a multi-track approach that embraces a large network of organizations, institutions, disciplines, methodologies and individuals.

2.4 Multi-Track Diplomacy

According to the Institute for Multi-Track Diplomacy, multi-track diplomacy (MTD) is a conceptual way to view the process of peace-building as a living system (2007). It looks at the web of interconnected activities, individuals, institutions, and communities that work together in an effort to build peace (Ibid). The term multi-track diplomacy is based on the original distinction made by Joseph Montville in 1982 between track one (official, governmental action) and track two (unofficial, nongovernmental action) approaches to conflict resolution (McDonald 2003). In 1991, however, it became clear that the term ‘track two diplomacy’ did not adequately represent the wide range of unofficial interaction that can support the resolution of international conflicts. As a result, the original two-track approach was expanded to include a total of nine tracks. These tracks can be used as a framework for understanding the complex system of peace-building. They include: 1) government, 2) conflict resolution professionals, 3) business, 4) private citizens, 5) research, training and education, 6) activism, 7) religion 8) the funding or philanthropic community and 9) public opinion/media/communication (Multi-

Track Diplomacy 2007). These nine tracks, illustrated in Figure 2.4.1, are not ranked in a hierarchical order, but rather, as the diagram suggests, they are interconnected and “when functioning together, they can actually produce a synergy to approaching conflict” (McDonald 2003). In fact, peace-building cannot be carried out by diplomats and other explicitly political actors alone; rather each [track] has its distinctive profile, its own distinctive mode of peace work (World Health Organization 2002b, 20).

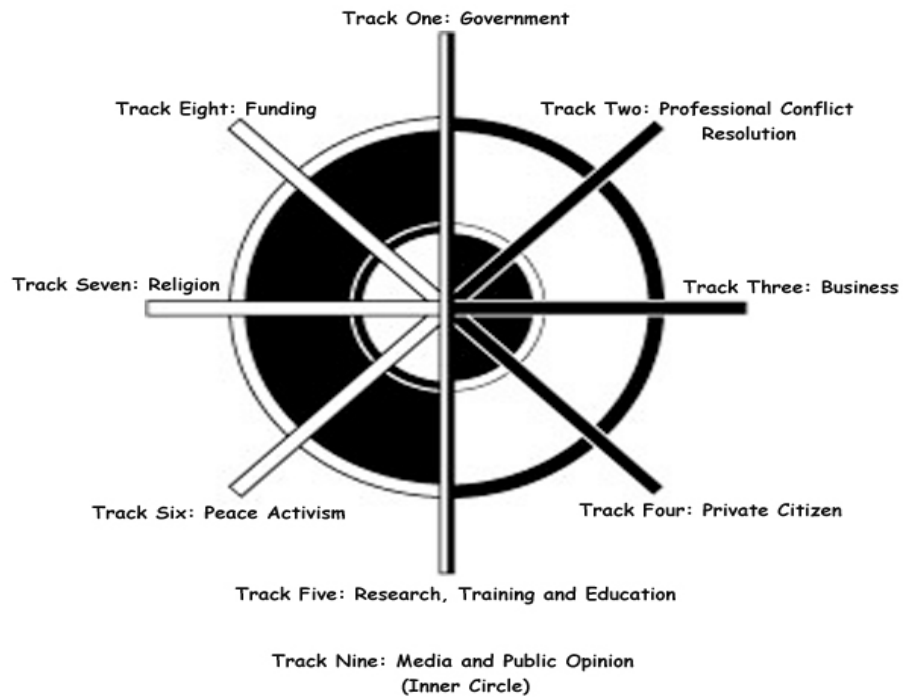


Table 2.4.1: The Nine Tracks of Multi-Track Diplomacy

The concept of a multi-track approach highlights the fact that the causes of peace are just as complex as the causes of war (Peters 1996, 7) and while health is not directly listed as one of MTD’s nine tracks, health can potentially play a key role in peace-building. As illustrated above, conflicts have an irreversible impact on the health of a

population, and the health sector has its own unique set of skills and knowledge that may contribute to the process of peace-building.

2.5 The Role of Health Organizations in Conflict-Affected Areas

Health organizations have an important role to play in conflict-affected areas. They support and facilitate the dissemination of knowledge, provide medical care, and advocate for equitable and accessible public health services. Health practitioners are often regarded as healthcare *protectors*, and when conflict threatens the health of a population, helping to reduce conflict and its consequences can be regarded as an objective of health organizations (Guha-Sapir and van Panhuis 2002, 37).

A number of characteristics highlight the unique position health organizations hold in conflict-affected regions. First, health is a universal human right and is highly valued in communities around the world regardless of ethnicity, culture, and creed. As a result, when conflict threatens the health of a population, communities welcome and rely on health organizations to alleviate the suffering and impacts of conflict.

Second, on the basis of the Hippocratic Oath, health practitioners are often seen as impartial, as they ethically cannot refuse medical assistance to anyone in need, and often operate across ethnic divisions and transcend national boundaries. Johan Galtung, a pioneer of peace research, suggests that the Hippocratic Oath serves as the Ethics of Conflict, saving and enhancing life across borders and fault-lines, including between enemies (Galtung 1997, 8). Health has the ability to transcend the interests of all parties to a conflict.

Finally, while the health infrastructure is often damaged in conflict-affected regions, it is also often the first public sector to be rebuilt. In fact, in post-conflict communities, the health infrastructure is often one of the few aided by international and NGO assistance. This can provide communication, transport, technology transfer and educational support that are otherwise unavailable (Peters 1996, 7).

While these three characteristics highlight the unique position that health organizations may hold in conflict-affected areas, there is another important perspective to consider. Mary Anderson, author of *Do No Harm: How Aid Can Support Peace Or War*, argues that local and international aid organizations are not neutral in the midst of conflict. She also argues that how services are administered can actually cause harm in the midst of conflicted-affected communities (Anderson 1999). For example, initiatives designed to contribute to peace may unintentionally challenge traditional values or authority structures, raise the stakes of economic competition, or create ‘winners’ or ‘losers’ (Bush 1998, 5). In fact, the very nature of peace-building creates a new set of relationships. Peace-building introduces external actors and observers, and while it is “commonly assumed that peace-building reflects humanitarian, honourable intentions in seeking to stop the violence and human rights abuses that occur during conflicts, there is significant risk that external interventions can have unforeseen, negative consequences” (Boyce et al. 2002, 3).

2.6 Peace through Health

There are simple parallels between the concepts of peace and health. While health may be seen as the absence of disease and peace as the absence of war, in both areas we

are encouraged to aim for more (Santa Barbara 2005a, 478). We are encouraged to aim for a positive approach, whereby **health embraces the complete physical, mental, and social well-being** (WHO 1948), and **peace includes the presence of social justice through equal opportunity, a fair distribution of power and resources, equal protection and impartial enforcement of law** (Galtung 1990). When examining the terms peace and health through both positive and negative definitions, we can begin to see how inter-connected these two concepts are. We can begin to see how a peaceful society needs healthy individuals and communities, and how a healthy society that fairly distributes its power and resources can contribute to a peaceful environment.

This inextricable link between health and peace is the foundation for the emerging field of Peace through Health that “explores how health interventions may contribute to peace in actual and potential war zones and situations of conflict” (Arya 2004, 242). The McMaster University’s Centre for Peace Studies defines Peace through Health as “any initiative that is intended to improve the health of a population and to simultaneously heighten that population’s level of peace and security” (MacQueen et al. 1997, 175). While the primary function of health professionals is to deliver health services, Peace through Health argues that health professionals have a unique position in conflict-affected communities and can actively contribute to peace-building.

For example, in 1985, the people of El Salvador embarked on the first of three scheduled “days of tranquility” – a one-day ceasefire between rebel forces and government troops brokered by UNICEF and the Roman Catholic Church (Peters 1996, 13). The cease-fires took place one Sunday a month for three consecutive months, and enabled hundreds of thousands of children in El Salvador to be inoculated, while

arguably laying the foundation for peace talks in the region (MacQueen and Santa Barbara 2000, 294). Similarly, health professionals have also used their expertise and social standing to campaign against certain weapons on the basis of their horrific and indiscriminate effects. The International Physicians for the Prevention of Nuclear War became engaged in the issue of nuclear weapons, and directly influenced Gorbachev's thinking as he ended the Cold War (Gorbachev 1987), while the International Campaign to Ban Landmines led to the Mine Ban Treaty and de-legitimized the use of these indiscriminate weapons. Another example is the Butterfly Garden in Sri Lanka, an after-school and weekend program that provided creative play programming to over 600 schoolchildren from 20 communities representing local ethnic groups, Tamil and Muslim. The Butterfly Garden demonstrated a range of positive effects on the participating children, with more tentative indicators of success as a peace-building and reconciliation measure apparent at the aggregate level of individuals who have been touched directly by the Butterfly Garden (Chase and Bush 2002, 11).

The development of Peace through Health has been a collaborative endeavour between various institutions and individuals. However, it is important to note that although the term 'Peace through Health' is used in this thesis, similar ways of conceptualizing peace and health initiatives have been developed under the umbrella of 'Health as a Bridge for Peace' by the WHO and 'peace-health initiatives' by McMaster's University. For the purposes of consistency, I will refer to "any initiative that is intended to improve the health of a population and to simultaneously heighten that population's level of peace and security" (MacQueen & Santa Barbara 2000, 293) as Peace through Health.

Furthermore, the area in which health and peace initiatives are working also vary from organization to organization. The McMaster University's Peace Studies group has restricted its activities to tertiary prevention, working to promote rehabilitation after disease has been established (Arya 2004, 252), while other organizations focus on primary prevention whereby initiatives include the reduction of risk factors and the promotion of protective factors (Klaus 2004, 29). Physicians for Human Rights-Israel, the focus of this case study, is working in secondary prevention, which refers to the situation where armed conflict has already broken out (the disease has manifested itself) and methods of peace are sought (peacemaking) (Arya 2004, 246). In this stage, health workers are attempting to mitigate or halt the violence on the basis of easily predictable population health effects (Santa Barbara and MacQueen 2004, 386).

Finally, the objectives, the design, and the actors of Peace through Health initiatives also differ. These differences make it difficult to compare the outcomes of projects and contribute to the confusion with regards to the usefulness of Peace through Health (Buhmann 2005, 301). Furthermore, the evaluation of PtH is in its infancy and has, up to today, taken place almost exclusively retrospectively. In response, the community of PtH has begun to construct 'working values' of Peace through Health that may help to create some consistency within the field. Graeme MacQueen and Joanna Santa Barbara of McMaster University have developed a list of mechanisms that highlight how peace work can take place within the health sector. For the purpose of this study, I will use the 10 mechanisms developed by Santa Barbara and MacQueen; however, it is important to note that as the authors suggest, the list of mechanisms "does

not yet constitute a theory, but represents a step toward the creation of one” (2000, 384).

A brief description of the 10 mechanisms is provided here:⁷

i) Use of health-related superordinate goals: Superordinate goals are those that transcend the separate goals and immediate interests of parties to a conflict. They are goals that are valued in the long term by both parties, transcend the immediate interests of both parties, and thus have the capacity to bring the parties into a more peaceful relationship. These goals can only be achieved with the cooperation of both conflicting groups.

ii) Evocation and extension of altruism: Health care is an institutionalised expression of human altruism. Altruism tends to shrink (i.e. to be severely limited to compatriots) during an armed conflict. When health care is extended to opposition groups, whether through an insistence on treating enemy wounded with the same compassion and professionalism as one’s own wounded or through a variety of other means, a major inroad is made against the dehumanisation and demonisation that accompany war, and that are essential to its long-term pursuance. Health practitioners can extend the concept of altruism by “treating victims impartially in a war zone” and personalize the enemy, when conflicting parties seek to diminish, depersonalize, and dehumanize the ‘enemy.’

iii) Healing of trauma: Psycho-social trauma is commonly the most widespread effect of armed conflict. Trauma that is specifically psychological may contribute to demoralization and lack of initiative, as well as to rigid patterns of thinking that perpetuate war and make it chronic. Health-care professionals are familiar with this healing capacity and could be especially effective if they can use methods of healing and rehabilitation that are linked to social processes of reconciliation and peace building.

iv) Contribution to civic identity: When societies have been divided by identity conflicts, people who have an adequate and equitable health-care system are strengthened in their sense of belonging to the society or the state that has provided it for them. They are less apt to join groups with competing claims on their identity.

v) Contribution to human security: An adequate and equitable health-care system, which addresses people’s basic needs, gives them an essential form of security. Without it, they might resort to violence or war to achieve it, by joining insurgencies or breakaway states to assure their own security or that of their children.

vi) Discovery and dissemination of facts: Propaganda is essential to the long-term waging of war. It can be countered effectively only through the discovery and dissemination of accurate information. Health-care personnel are often in the best position to provide such information. In addition to challenging misinformation that may be used to fuel or prolong a conflict, health-care workers could alert the international community to war crimes, crimes against humanity and genocide, and they might be in a position to describe the health consequences of particular forms of weapons.

⁷ Adapted from Santa Barbara and MacQueen (2004) and Arya (2004),

vii) Redefinition of the situation: The meaning of war is not obvious. Its meaning for a population is established by particular groups—social classes, military elites, media, and so on. War can be presented as a game, a test of manhood, a competition of civilisations, or a religious contest of good and evil. Health workers can refuse to accept these understandings and definitions and can promote different ones. They can promote the understanding of war as a population health disaster or as a complex emergency. They can present war as an institution that is neither inevitable nor conducive to the long-term welfare of humanity.

viii) Diplomacy, mediation, and conflict transformation: Health workers are not unique in developing skills in diplomacy, mediation, and conflict resolution, but they will sometimes have unique opportunities to use them. They might be able to bring groups together around superordinate goals associated with health, and to work with groups struggling to assure their security in a devastated environment.

ix) Solidarity and Support: Many peace-through-health mechanisms involve solidarity and support for victims of war. In listing this as a separate mechanism we are drawing attention to actions in which these dynamics are explicit. This includes the direct accompaniment of victims or potential victims by health workers, as well as direct advocacy on their behalf. Solidarity and support is especially relevant when there are great differences of power between the conflicting parties

x) Dissent and non-cooperation: When health workers are called on to collaborate in unjust wars or preparations for such wars, or in the development of inhumane weapons or war policies, they can refuse to do so. This might involve refusing to cooperate with civil defence measures, refusing to aid in the design of particular weapons and strategies, or refusing to lend their professional legitimacy to institutions or persons that promote war. Health workers can criticise government policies they see as conducive to war.

These 10 mechanisms are the framework for Peace through Health, constituting a unique “track” to peace-building. As argued above, peace requires a multi-track approach, and while this list may not be exhaustive, it lies under the rubric of PtH and embraces the web of interconnected forces that must work together in an effort to build peace.

To complement the 10 mechanisms, I will also consider the model offered to us by the discipline of Public Health, where armed conflict is seen as a disease with risk factors that can be approached from primordial, primary, secondary, and tertiary

prevention (Yusuf et al. 1998, 1669). While health practitioners have an important role to play at each stage, this model allows us to recognize that not all mechanisms listed above may be present during a PtH initiative. In fact, a project's objectives and goals may vary depending on whether it focuses on preventing a war from breaking out or on promoting community reconciliation in a post-conflict setting. Considering the various stages of a conflict is especially important when conducting research in Israel and the occupied Palestinian territories as "there is little evidence that Peace through Health initiatives have been successful during acute conflict" (Buhmann 2005, 309).⁸

Thus, it is critical that we do not approach Peace through Health and its mechanisms as a tool that can be systematically applied across all contexts, but rather as a set of mechanisms that can serve as a theoretical framework in which to view "the opportunities and strengths of health workers in the promotion of peace" (Santa Barbara and MacQueen 2004, 384).

⁸ This may very well be the result of the focus of PtH initiatives in prevention and post-conflict stages.

CHAPTER THREE: METHDOLOGY

3.1 Research Design and Rationale

The approach most consistent with my research question is a single qualitative instrumental case study.

Qualitative research takes place in natural settings and allows for the study of “real-world situations as they unfold naturally” (Patton 2002, 40). This approach allows for the important dimensions to emerge from the analysis of a study without presupposing in advance what those important dimensions will be (1980, 44). In fact, qualitative research recognizes that there is no predetermined course established by or for the researcher, rather the goal is to understand naturally occurring phenomena in their naturally occurring states (Ibid, 41). Therefore, a qualitative research study is well-suited for my research as it not only provides “depth and detail” through various research methods, but also allows for changes and refinements to the research question at hand, while the researcher learns what to ask and to whom it should be asked (Creswell 2003, 180).

The qualitative research presented here takes the form of a case study, where the main unit of analysis is Physicians for Human Rights-Israel. The smallest source of data was the individual, and several intermediary initiatives were also important (the individual projects, namely the Occupied Territory Project).

Robert Stake, author of *The Art of Case Study Research*, identifies two types of case studies: intrinsic, in which the importance of the case is emphasized, and instrumental, in which the importance of the issues is emphasized (1995, 3). In my research, the case is Physicians for Human Rights-Israel, but Peace through Health is the framework for the issues under study. In my research, the “case study is *instrumental* to accomplishing

something other than an understanding of the organization” (Ibid); it is instrumental in exploring whether or not Peace through Health is an appropriate peace-building response in the context of the Israeli-Palestinian conflict. .

A single qualitative instrumental case study is the approach most consistent with my research question, as it highlights context as infinitely complex, and phenomena as fluid and elusive (Ibid, 33). This is especially pertinent when conducting research in areas of intractable conflict, where the intent is not necessarily to generalize to other situations, but rather to understand the context and specifics of a particular situation. “Particularization is an important aim” and qualitative researchers treat the uniqueness of individual cases and contexts as important to reaching a deeper understanding (Ibid, 39).

3.2 Selecting the Case for Study

Physicians for Human Rights-Israel is a non-partisan, non-profit, independent, voluntary organization that was established in 1988 at the height of the First Intifada by a group of Israeli and Palestinian physicians who realized that the issue of human rights and medical care are integral parts of the same struggle. According to its website, PHR-I has “expanded their activities to include topics centering on health in the broadest sense, while calling for social solidarity both within and outside the borders of Israel.” As a human rights organization that focuses on health in particular, PHR-I’s activities touches all people, from the Palestinians in the oPt to the Bedouin-Arabs in the unrecognized villages of the Negev. PHR-I believes that every human being has the right to health and that “the medical community has a clear obligation to struggle and advocate for the

realization of every person's universal right to health, medical treatment and proper living conditions" (PHR-I 2007c).

According to its website, PHR-I has more than 1,150 members - both health care providers and human rights workers, and runs five main projects: the Occupied Territories Project, the Prisoners and Detainees Project, the Migrant Workers and Refugees Project, the Project for the Unrecognized Villages of the Negev, and the Residents of Israel Project. In addition, the organization runs a mobile clinic in the oPt, and an open clinic in Tel Aviv that provides services for all people within Israel who have no legal status and therefore no health insurance. The organization is comprised of almost entirely of volunteers, with the exception of approximately a dozen staff, an elected board of directors, and a few civil services workers. PHR-I's office is located in Tel Aviv, Israel.

3.3 Bounding the Case

The research took place in Tel Aviv, Israel, as well as, in Na'Alin, West Bank. Data collection began on November 12th and was concluded on December 5th 2007. The case is Physician Human Rights-Israel with a particular emphasis on the Occupied Territories Project (OTP). A partnership between PHR-I and me was created with the help of psychiatrist, peace activist and academic, Dr. Joanna Santa Barbara. All correspondence prior to the data collection took place over email.

3.4 Data Collection

Case study research relies on the collection of multiple sources of evidence. For the purposes of my research, I relied on five sources of data: document analysis,

information interviews, direct observation, semi-structured interviews, and a focus group.

Table 3.3 identifies the methods of data collection, highlighting the reasons for inclusion and the units of analysis.

Table 3.3 Data Collection Methods⁹		
Method	Unit of Analysis	Reason for Inclusion
Document Analysis	28	26 documents, including annual reports, publications, newspaper articles, and policy papers - published between 1999 and 2007.
Information Interviews	7	5 staff members and 2 civil service workers - chosen from a total of 18 employees of PHR-I, one delegate from each of the five projects (two from the Migrant, Refugees, and Asylum Seekers Project) and the Patient and Volunteer Coordinator.
Direct Observation	2	2 field site visits - Mobile Health Clinic in Na'Alin, West Bank and Free Open Health Clinic in Tel Aviv, Israel.
Semi-structured Interviews	6	6 participants, including the President and Founder, the chairperson, a board member, the Executive Director, the OTP Director and the OTP Intervention Coordinator – chosen with help from the Executive Director.
Focus Group	5	5 participants, including 2 civil service workers – chosen based on availability.

Document Analysis

Document analysis includes studying excerpts, quotations, or entire passages from organizational, clinical or program records; memoranda and correspondence; official publications and reports; personal diaries; and open-ended written responses to questionnaires and surveys. Document analysis “can serve a dual purpose as they are not only a basic source of information about an organization’s activities and processes, but

⁹ Some participants took part in more than one method. In total, there were 14 participants.

they can also give the researcher ideas about important questions to pursue through more direct observations and interviewing (Patton 1980, 152). In brief, a document analysis can provide a behind-the-scenes look at an organization that may not be directly observable to the researcher (Ibid, 153), thereby offering valuable information and increasing the researcher's knowledge and understanding.

Almost immediately upon arriving at PHR-I, I began collecting resources from the office, with permission from the Executive Director. These resources complemented the material I had previously found on PHR-I's website. I also asked all research participants for help in accumulating resources. Documents reviewed included annual reports, publications, newspaper articles, and policy papers. In all, 28 documents were reviewed. These documents were in English, though many were also published in Hebrew and Arabic.

Information Interviews

An information interview is a research tool designed to find out more about the daily activities and occurrence of a person's occupation. While this is a common method in career planning, it proved to be a particularly useful method in discovering first-hand information concerning PHR-I's activities. The organization's website had provided me with the basic understanding of the five projects, but in order to get a comprehensive understanding of the activities, I sought to speak to the coordinators of each program.

My research began with seven information interviews, each lasting approximately thirty minutes. The information interviews were undertaken with delegates from each of PHR-I's five projects. I interviewed the Project Director of the *Unrecognized Negev*

Villages Project, the Project Director of the *Residents of Israel Project*, the Project Director and the Intervention Coordinator of the *Migrant Workers, Refugees and Asylum Seekers Project*, the Intervention Coordinator of the *Prisoners and Detainees Project*, and the Intervention Coordinator of the *Occupied Territories Project*. I also conducted an information interview with PHR-I's Patient and Volunteer Coordinator. The purpose for the information interviews was to give me an opportunity to meet the staff and learn more about PHR-I's five projects. It also led me to define the limits of my research to one project – the Occupied Territories Project.

Direct Observation

Observation is grounded in direct experience and enables the researcher to perceive interaction in real time. “To understand fully the complexities of the situation, direct participation in and observation of the phenomenon of interest may be the best research method” (Patton 2002, 21). Through direct observation, the researcher is better able to understand and capture the context within which people interact. Direct observation, however, is different from other forms of observation, as the researcher does not try to become a participant. Rather, the researcher is solely an observer, who strives to be as unobtrusive as possible.

I was invited to Na'Alin in the West Bank to observe a women-only mobile health clinic operated by PHR-I. I recorded notes and later received from the Patient and Volunteer Coordinator a report summarizing the day's activities (i.e. the number of patients seen, the number of health services in the village, etc.). I also observed PHR-I's open health clinic, which was located in the same building as PHR-I's office.

Semi-Structured Interviews

Semi-structured interviews involve the implementation of a number of predetermined questions that are typically asked to each interviewee in a systematic and consistent order (Berg 1998, 61). The researcher is allowed freedom to digress, and permitted to probe far beyond the answers to the prepared and standardized questions (Ibid).

There were six semi-structured interviews, each lasting approximately one hour. I interviewed the President and Founder, the chairperson, a board member, the Executive Director, the OTP Co-Director and the OTP Intervention Coordinator. During each interview, I posed questions that focused on Peace through Health and the 10 mechanisms (See Appendix I: Semi-Structured Interview Design). Participants were asked for their perspectives on whether and how they saw the mechanisms reflected in their work.

Participants were chosen with guidance from PHR-I's Executive Director. Of the six participants, three are physicians and three identify themselves as human rights activists. Interviews were audio-taped and later transcribed. Notes were also taken during the interviews.

Focus Group

A focus group is particularly useful for exploring people's knowledge and experiences, as it relies almost exclusively on the active participation of participants and encourages an iterative process. The idea behind a focus group is that group processes can

help people to explore and clarify their views in ways that would be less easily accessible in a one-on-one interview (Kitzinger 1995, 299). Capitalizing on the communication between research participants in order to generate data, participants are encouraged to talk to one another: asking questions, exchanging anecdotes and commenting on each others' experiences and points of view (Ibid).

A two-hour focus group was held with staff members in the boardroom at PHR-I. The discussion was intended to reach out to more members of PHR-I, but because of scheduling conflicts only five participants were present. The discussion took the same form as the semi-structured interviews (See Appendix II: Focus Group Design). The focus group was audio-taped and later transcribed.

3.5 Data Analysis

The organization of data began with data preparation, whereby the transcribed recordings of the semi-structured interviews and focus group were sent to the participants for verification. Data was also checked for accuracy, and the names of people and organizations mentioned in the recordings were verified.

The data collected from the semi-structured interviews and the focus group was entered into a database, and data was manually coded based on the 10 mechanisms of PtH. The first level coding highlighted the appearance of these mechanisms in the activities and values of PHR-I, as expressed by the participants in the focus group and interviews. A separate database was created to deal exclusively with the document analysis, whereby all reviewed documents were coded in the same manner. Finally, a third database was created for direct observation.

During the second level of coding, themes were developed. For example, references to working with other organizations and creating partnerships were grouped under “collaboration,” while references to evaluating results and the success or failure of PHR-I’s projects were inputted as “evidence”.

Brief notes were used to highlight any important contextual factors, such as current events, and non-verbal communication.

3.6 Establishing Trustworthiness

Lincoln and Guba proposed four constructs for measuring the soundness of qualitative research design: credibility, transferability, dependability, and confirmability (1985, 43).

Credibility, an indicator of how well the subject of the study was accurately identified and described by the inquiry of the research, was tested by member checking. I gave all participants the opportunity to review the transcripts for verification. This process allowed the participants to review the material for accuracy and palatability. In all cases, the transcribed documents were sent back seemingly untouched, except for a few spelling changes and clarifications.

Transferability, the applicability of one set of findings to another setting, cannot provide external validity of an inquiry, but can only provide the thick description to reach a conclusion about whether transfer can be contemplated as a possibility (Ibid, 316). I provided an in-depth description of the case study at hand and have kept detailed field notes. I also created comprehensive databases that will help to enhance transferability.

Dependability, the measure of the researcher's ability to account for changes in the phenomena under study and to adapt the design of the inquiry (Ibid, 299), was achieved

through triangulation of data by the use of multiple informants (14 participants took part in my research and 28 documents were reviewed) and multiple data collection methods (document review, information interviews, direct observation, semi-structured interviews, and a focus group).

Confirmability, a measure of the researcher's objectivity, was reinforced through triangulation as detailed above and my reflective field notes. A record of the research process, including a detailed timeline, as well as copies of all transcribed interviews and the focus group, has been maintained.

3.7 Ethics

In *Do No Harm: How Aid Can Support Peace – or War*, Anderson states that “aid delivers a message” (1999, 55). I worked under the principle that research also delivers a message and that the content, style, and modes of communication a researcher takes can reinforce, prolong, and exacerbate conflict. As such, it was important that I was well-informed about the history of the conflict as well as up-to-date with current events.

Before departing, I was in contact with the President and Founder of PHR-I, and the Executive Director. I also announced my arrival to all the staff through email and sent a copy of my research proposal for their interest. During my stay in Israel, the political situation was relatively stable, but the Hamas takeover of Gaza in June 2007 had created a period of hostility, whereby PHR-I's activities in the Gaza have been challenged by the increased restrictions on movement. It was important that as a researcher I was aware of the context in which I found myself, as the tension in the office was often high. Expressing sensitivity was important, and I had to be extremely flexible in arranging the

interviews and focus group and remind all participants that I was happy to arrange interviews at their convenience.

Informed consent to participate in the research was obtained from all participants through written consent forms (See Appendix III: Participant Consent Form). Participants had to give consent at each stage of the research (i.e. information interviews, semi-structured interviews, and the focus group). No one refused to be interviewed. Data was collected and stored in confidentiality. All audiotapes and field notes were transcribed directly onto my computer and secured with passwords. The recordings have since been deleted. Ethics approval was received from the University of Victoria's Office of Research Services.

3.8 Challenges and Limitations

A qualitative instrumental case study design was appropriate for my research, but at times I felt that the amount of time I had in Tel Aviv with the organization was too limited. While case studies need not take a long time (Yin 2003, 11), I often thought that a more comprehensive understanding of the activities and programs of PHR-I could have been achieved had I spent more time in the field. The constraints of both my time and the responsibilities of the members of PHR-I meant that I was not able to interview everyone at PHR-I. It must, therefore, be noted that the views reflected in my research are not the views of *all* the members, but rather a number of perspectives of how some members view the workings of PHR-I.

In addition, the very nature of a single case study limited my research findings. Physicians for Human Rights-Israel was the main unit of analysis, and while this study is a detailed examination of one case, it created a challenge in trying to make

generalizations about the role of health organization in regions of intractability. In fact, I began to understand that while case studies may attempt to generalize, the real art of case studies is their ability to particularize. This limitation was particularly challenging in the process of analyzing my research findings and drawing conclusions. It presented me with the challenge of determining what PHR-I can say about the role of health organizations in general and what it can say about its role in particular.

Another challenge that presented itself was language. While I had been expecting to deal with a language barrier, all the participants spoke English. However, language did create a barrier during staff meetings, office lunches, and other formal and informal meetings. I missed a few opportunities to gather more data because the meetings were in conducted in Hebrew. For example, I was invited to attend a meeting with the staff and board members, but I decided not to attend as it was held in Hebrew and I did not have access to a translator.

From a different angle, I also struggled with the language of my research, especially in terms of the word ‘peace.’ During the focus group, I presented the participants with both positive and negative definitions, and while most participants were comfortable using these definitions, some thought that the term ‘peace’ was overused and often misused:

“Everyone is cynical about the word peace.”

“It is not clear what peace means – the peace process or a negotiation or actions on the ground or words or no war like with Egypt.”

One participant, in particular, felt that the term ‘peace’ had been “hijacked by the Zionist left” whose desire for peace with the Palestinians is often criticized for “originating from a wish for to separate from Palestinians rather than from any concern to

redress an historical injustice” (Pappe 1997, 38). This created a challenge, as I began to understand that “words may mean quite different things depending on the context and may not be appropriate to your local situation” (Bunde-Birouste et al. 2006, 6). Peace is commonly understood as the absence of violence – its negative definition – and while I continually cited Galtung’s positive definition of peace, many participants struggled to work within this definition as it was unfamiliar and arguably outside their individual perception of the term ‘peace.’

3.9 Reflections on my Role as a Researcher

The staff at PHR-I were often working on critical issues of pressing concern, and frequent meetings arose whereby the matter was truly one of life or death. This created a challenge as I had to put my work as a researcher in perspective with the work of PHR-I. I had to be humble, realize that my research was not critical, and not take offence when interviews were re-scheduled.

It was also important that I acknowledge the participants as the experts. The members of PHR-I are authorities in the field of human rights and have far more knowledge about the situation in Israel and the oPt than I, as an outsider, do. Not only do they publish reports on the current situation, they also live through these very events and are witnesses to them; therefore, it is important that I acknowledge my role as, in many respects, the student. Consequently, I took a position with PHR-I as a co-learner and facilitator, and when presenting participants with the subject of Peace through Health, I explored along with them how health organizations can contribute to peace-building in regions of intractability.

CHAPTER FOUR: FINDINGS AND RESULTS

In this chapter, I will explore the research question: *How are the 10 mechanisms of Peace through Health reflected in the work of Physicians for Human Rights-Israel?*

The other two research questions will be explored in the following chapter.

The first part of the chapter begins with a brief description of PHR-I's Occupied Territory Project, while the second part is devoted to exploring the 10 mechanisms of Peace through Health. For each one, there is a brief description of how the mechanism is reflected in the activities and values of PHR-I. Data for the following analysis was obtained from a document analysis, information interviews, direct observation, semi-structured interviews, and a focus group.

4.1 PHR-I: The Occupied Territories Project

PHR-I's Occupied Territories Project is one of the organization's five main projects. It is staffed by two Co-Directors and one Interventions Coordinator, and supported by a number of volunteer physicians and human rights activists. According to their website, the Occupied Territories Project works to combat the systematic harm inflicted on the lives of Palestinians by improving accessibility to health services. PHR-I receives dozens of appeals from patients and medical teams who face difficulties in traveling to various medical centres. They work opposite the civil administration, the Israeli Army, and Department of Defence in order to ensure that patients and medical personnel can receive and provide care. In cases where such efforts fail, PHR-I appeals to Israel's High Court of Justice in the name of individuals whose rights have been violated.

These appeals are brought forth in hopes that they will bring about a debate concerning the impact of the state policies on the right to health.

In addition, PHR-I's Occupied Territories Project appeals to the medical community in Israel to protest the repeated ethical violations resulting from Israel's policies, and to assist in all aspects of guaranteeing the right to health for the Palestinian population. They also run a mobile health clinic that operates in the oPt each Saturday. Furthermore, professional meetings are conducted between Palestinian doctors and Israeli colleagues to encourage professional cooperation and to protest the destruction and seclusion of the Palestinian health care system by Israel.

Finally, the Occupied Territories Project speaks out against all state policies that infringe upon Palestinians' right to health. PHR-I firmly believes that it is "the obligation of the state to fulfill this right and to refrain from placing obstacles in its way – whether they are concrete walls of separation or economic and social barriers" (PHR-I 2007c). PHR-I is more than a health organization; it is committed to human rights and to ending the occupation in the Palestinian territories.

4.2 The 10 Mechanisms of Peace through Health

Use of Health-Related Superordinate Goals

Superordinate goals are those that transcend the separate goals and immediate interests of parties to a conflict. They are goals that are valued in the long term by both parties, transcend the immediate interests of both parties, and thus have the capacity to bring the parties into a more peaceful relationship. They can only be achieved with the cooperation of both conflicting groups.

While "certain goals in population health may make it desirable to seek cooperation between contending parties in a region affected by war" (MacQueen and Santa Barbara 2000, 294), in the context of the Israeli-Palestinian conflict, cooperation

may not be realistic or even welcomed. In fact, the Executive Director of PHR-I was extremely hesitant when discussing this particular mechanism. She emphasized that while health is important to all Israelis and Palestinians, “it is usually governments who take this position.” The concern is that joint Israeli and Palestinian health initiatives are often approached under the umbrella of superordinate goals, when, in fact, it is the interest of the more powerful group that dominates. For example, the state of Israel is presently concerned with the spread of the Avian Flu. In January 2008, the Israeli Ministry of Agriculture confirmed that the potentially deadly H5N1 virus was found in dead birds at a local zoo in Binyamina (Integrated Regional Information Network 2008). Joint initiatives with the Palestinian Authority are in discussion,¹⁰ and while projects that seek to stop the spread of the Avian Flu are undeniably important, many Palestinians have other health concerns. “The Israeli government wants to cooperate with the Palestinian Authority because it is of interest to them, because they don’t want the flu to come in from the occupied Palestinian territories. This is *their* concern.” She continued to explain that PHR-I does not speak about superordinate goals because it is often met with scepticism from the Palestinians, who are highly suspicious of joint initiatives that are presented under this mechanism. The problem with many of these joint initiatives stems from their conception; who is introducing these superordinate goals? In El Salvador, UNICEF initiated an immunization ceasefire that was later endorsed by both parties of the conflict. The success of the “Days of Tranquility” could be attributed to the fact that the initiative was launched by a third party that was able to “transcend the immediate goals sought by the parties of the conflict” and highlight their “capacity to bring a more forth a more peaceful and cooperative relationship” (Peters 1996, 77).

¹⁰ See Leventhal et al. (2006).

PHR-I, however, is an Israeli organization. It is not outside the conflict, and its members realize that they are in a position of power. This power, however, can create genuine concerns when trying to implement initiatives under the mechanism of superordinate goals. “There are much more difficult problems with joint projects towards superordinate goals when there is an oppressor-oppressed relationship of severe power inequality across the conflict divide” (Santa Barbara 2005c, 154). In fact, in the context of the Israeli-Palestinian conflict, joint health initiatives are often met with criticism from Palestinians and Palestinian NGOs.

Recently, in June 2005, 20 Palestinian organizations called for a boycott against cooperation with Israeli institutions and NGOs that were complicit with the occupation (Union of Health Workers et al. 2005). The call put forth the argument that it wasn’t enough for Israeli organizations to promote dialogue and collaboration between Palestinians and Israelis, rather they “may want to consider becoming actively involved in Israeli or joint Israeli-Palestinian activities aimed at ending Israeli military occupation of Palestinian land, the removal of closures, checkpoints, siege and the Apartheid Wall, among other manifestations of the root cause of ill health: the occupation” (Ibid). In fact, the Canada International Scientific Exchange Program (CISEPO), which develops and implements health sector cooperative activities in the Middle East between Arabs and Israelis, has been criticized for focusing solely on individual relations and failing to recognize the social and political realities of the conflict (Jabbour 2005). From a Peace through Health perspective, CISEPO, and other like-minded initiatives, may help to create and enhance opportunities for cooperation, but their failure to address the systemic

realities limits the success of the initiative to individuals and peace, “is much more than individual relations” (Ibid, 1211).

PHR-I recognizes the realities of the conflict and the power imbalance that ensues. One participant stated: “I think that one of PHR-I’s strengths as an organization is that it is willing to give up power,” while another argued that “if you want to speak about peace and compromise, then you can’t keep all the power and cards in your own hands.” Joanna Santa Barbara suggests that for those espousing superordinate goals across conflict divides, the minimal conditions for such work should be: 1) The goals are generated or, at least, strongly endorsed by the “inside parties” in the conflict; 2) The collaborative relationship involves acknowledgement of the harm done by each group to the other; and 3) Where there is ongoing harm being done, the partnership attempts to address and alleviate it (2005c, 155). PHR-I fulfills these three conditions, but still it remains hesitant to initiate projects under this mechanism. Past initiatives that have failed to successfully transcend the interests of both parties, the undeniable imbalance of power, and the suspicion that often arises when superordinate goals are put forth have constrained PHR-I from working within this mechanism.

Evocation and Extension of Altruism

Health care is an institutionalised expression of human altruism. Altruism tends to shrink—ie, to be severely limited to compatriots—during an armed conflict. When health care can be extended to opposition groups, whether through an insistence on treating enemy wounded with the same compassion and professionalism as one’s own wounded or through a variety of other means, a major inroad is made against the dehumanisation and demonisation that accompany war, and that are essential to its long-term pursuance. Health practitioners can extend the concept of altruism by “treating victims impartially in a war zone” and personalize the enemy, when conflicting parties seek to diminish, depersonalize, and dehumanize the ‘enemy.’

Altruism refers to treating victims impartially in a conflict zone, when military and other civilian personnel are being propagandised into believing that people on the

opposite side of a conflict have and deserve fewer rights (Arya 2004, 245). PHR-I's activities demonstrate the organization's commitment to extending altruism to "out groups" as they push "beyond traditional in-group identities, challenging and extending the boundaries of health care" (MacQueen and Santa Barbara 2000, 294). The compassion of PHR-I's staff and volunteers is exemplified in all of its activities, but specifically in its efforts to personalize the other. In providing health services and advocating for the right to health without making a distinction between "in-groups" and "out-groups," PHR-I exemplifies how the health sector can be one of society's main ways of nurturing and caring for others.

Health, however, is such a powerful tool that it can sometimes be used to damage rather than to mend. In fact, the medical community is often characterized by conformity, as physicians have often participated in torture and some physicians have, historically, turned a blind eye to violations that they find within their very own medical institutions. In response, PHR-I reaches out to medical schools in an effort to teach medical students that human rights are inseparable from their profession. In focusing on medical ethics, PHR-I upholds the Hippocratic Oath and works to deepen the medical community's obligation to human rights, as an intrinsic part of their profession. Nevertheless, the problem of 'dual loyalties,' where a physician's obligations towards their patients contradicts an obligation towards a third party (employer, insurance companies, the State), continues to present a challenge to the medical community. The President and Founder of PHR-I echoed this concern:

What you can see is that doctors *are* partial. They are nationalistic. They are blind, willingly blind, to many things and they act in service of the regime wherever and whenever the regime is working - the Soviet Union, South America, Germany, Europe, and Israel...You cannot trust doctors to be a

bridge between the two nations. You cannot trust doctors to be a kind of engine to bring people together. Individual people might do it and some people think PHR-I does it, but the medical institution has failed.

The cynicism that is reflected here is not based a theoretical proposition, but rather a personal experience in which the participant publicized the unethical role that Israeli doctors were playing in detention centres by labelling seriously mentally ill Palestinian detainees as ‘malingerers,’ and denying them treatment (Siegel-Itzkovich 1997, 539). In response, the Israeli Medical Association (IMA), a professional association of doctors within Israel, charged the President and Founder of PHR-I with slander and failed to investigate the allegations (Ibid).

The IMA has been accused of violating the World Medical Association’s Declaration of Tokyo, which forbids the involvement or collusion of doctors with torture or other cruel, inhuman, and degrading procedures (Summerfield 2003, 561). Not surprisingly, the IMA has been subject to much debate within PHR-I as staff, volunteers, and board members all hold varying opinions on how, or if, PHR-I should work with the IMA. My research findings suggest that health care may not actually be an “institutionalized expression of human altruism” (Santa Barbara and MacQueen 2004, 384), rather it may quite simply involve some altruistic individuals whose impulse to care about others extends beyond ‘us’ and ‘them.’ Nevertheless, in the words of one participant, “We should not be cynical about the physicians and activists who reach PHR-I. There is a lot of good will in the Israeli medical community.”

PHR-I operates within the field of human rights, upholding the Covenant on Economic, Social, and Cultural Rights as its crux. While altruism is embodied within the

organization, it works under the premise of health as a human right, whereby all human beings are entitled to basic rights and freedoms.

Healing of Trauma

Psycho-social trauma is commonly the most widespread effect of armed conflict. Trauma that is specifically psychological may contribute to demoralization and lack of initiative, as well as to rigid patterns of thinking that perpetuate war and make it chronic. Health-care professionals are familiar with this healing capacity and could be especially effective if they can use methods of healing and rehabilitation that are linked to social processes of reconciliation and peace building.

All participants felt that the healing of psycho-social trauma could not be directly addressed by Israeli organizations or PHR-I in particular. In fact, participants stressed that the only way to help in the healing of trauma is to put an end to the occupation itself: “How can the occupiers possibly heal the occupied during the occupation.” The President and Founder firmly stated that the healing of trauma by Israelis was a not a viable solution to the suffering of Palestinians:

It is impossible for us because no matter how much we are against the war and the occupation, we are Israeli. Our language is Hebrew. Our extended families are soldiers, so while one of our family members is shooting at Palestinians, the other is demolishing the houses of these people, and then we say ‘let me help you heal?’ I don’t believe this is possible.

One participant also stated that the healing of trauma should be reserved for those either within the community itself (i.e. Palestinian organizations) or for external international organizations (i.e. Médecins Sans Frontières). The participant asserted that it should not be a goal of any Israeli organization to heal trauma because it is not within its capacity as there are “cultural and ideological barriers that limit the amount of work an Israeli health organization can do in this respect.”

While PHR-I may question its role in the healing of trauma, its mobile health clinic occasionally includes a volunteer psychologist or counsellor. Participants, however,

were hesitant to believe that these professionals have any real impact on the healing of trauma, but it was suggested that it was more of a demonstration of solidarity and support than an effort to heal the trauma of Palestinians.

PHR-I also collaborates with Palestinian NGOs, in particular with mental health organizations, to help empower these groups that work towards the healing of trauma. In June/July 2006, 14 Palestinian medical health professionals¹¹ from medical centres in the West Bank attended lectures and workshops on the theory and treatment of psychological trauma – cognitive, neurological, and psychodynamic issues; diagnosis and treatment of eating disorders; coping with loss; use of art in therapy; and coping with intercultural issues in treatment (PHR-I 2006b, 8).

PHR-I is also continually raising awareness about the trauma experienced by Palestinians through its publications. Reports on the effect of sonic booms and house demolitions have been published, but one participant stated that “this isn’t the healing of trauma; this is only highlighting the problem and trying to bring attention to it.”

In brief, while health organizations may be familiar with the methods of recovery and rehabilitation, the healing of trauma can not be sufficiently addressed by PHR-I since the conflict is ongoing and the members of PHR-I also happen to belong to the dominant group that is, in part, the perpetrator of the conflict. It is critical to note that while a health organization may have the knowledge and tools to address this need, they must first consider the context in which they find themselves. Conflict-sensitivity is paramount in reducing societal tensions and an organization that finds itself in a position like that of PHR-I is limited by the very political and social context that calls for the healing of

¹¹ An additional 6 psychiatrists and one lecturer from the Gaza Community Mental Health Program were not permitted to enter Israel for the training.

trauma, namely the occupation. In fact, as an Israeli organization, PHR-I may be more qualified to help heal the suffering of Israeli citizens who have been impacted by the conflict.

Contribution to Civic Identity

When societies have been divided by identity conflicts, people who have an adequate and equitable health-care system are strengthened in their sense of belonging to the society or the state that has provided it for them. They are less apt to join groups with competing claims on their identity.

PHR-I actively contributes to civic identity within Israel. For example, the Unrecognized Villages Project focuses on actualizing the right to health care in the unrecognized villages and supports the struggle of the Arab Bedouins to have their villages recognized by the state, while the Migrant Workers and Refugees Project offers health treatment to migrants, by representing migrant workers in claims against private insurance companies, and by supporting seekers of political asylum.

In contributing to a health care system that is equally accessible to all members of society – refugees, migrant workers, Arab Bedouins, immigrants, etc. - PHR-I is promoting “a feeling of belonging to a broader and more inclusive group which respects and meets their common needs” (MacQueen, McCutcheon, and Santa Barbara 1997, 187). This sense of belonging increases people’s interest in the society as a whole and creates a greater sense of civic identity.

Within the Occupied Territories Project however, PHR-I respondents did not feel that this mechanism was reflected in their work. “This mechanism is far more relevant inside of Israel. In the oPt, the Israeli state is not even considering providing health services and there is no wish to bring the Palestinian health care system into ours,” one participant explained. Since 1994, under the Oslo Accords, Israel transferred

responsibility in the oPt to the Palestinian Authority, leaving the Palestinian people living under a complex mix of Israeli occupation and Palestinian autonomy. With a health system that is “decentralized, highly dependent on services provided by private non-governmental organizations and structurally incapable of meeting the health needs of the Palestinian population” (PHR-I 2006a, 1), the Palestinian health care system is on the brink of collapse; yet Israel continues to deny any responsibility despite its physical and economic control over the oPt. In searching for a solution to the ongoing conflict with both one-state and two-state proposals, it is critical that all organizations working within occupied Palestinian territories recognize the current realities of the conflict, where working for civic identity is not only a challenge, but also unwelcome. In fact, while PHR-I advocates for the right to health for Palestinian patients in the oPt, it is not under the mechanism of promoting civic identity. One participant explained, “We don’t fight on behalf of Palestinians for the access to health care in order to strengthen feelings of civic identity. We do it because they are human beings and entitled to right to health.”

Contribution to Human Security

An adequate and equitable health-care system, which addresses people’s basic needs, gives them an essential form of security. Without it, they might resort to violence or war to achieve it, by joining insurgencies or breakaway states to assure their own security or that of their children.

According to Human Security International’s website, “a commitment to human rights and humanitarian law is the foundation for building human security.” It is advanced by protecting and promoting human rights, the rule of law, democratic governance and democratic structures, a culture of peace and the peaceful resolution of conflicts. PHR-I aims to increase the human security of people within Israel and the oPt by promoting the right to health: “This is something we demand – that all people have

access to a decent health care system.” As a human rights organization, there is a need to consider objectives within a framework of human security and the broader political, social, and economic realms. One participant explained:

One facet of the problem in Palestine is poverty. People are very poor and can't afford medication, so there is very little security. There is no medical insurance and only limited access to health care. We meet people who have diabetes and cancer, but no medical treatment. This is a lack of human security that can only be achieved with an increase in the economies of the West Bank and Gaza – only then will health be improved in the region.

PHR-I contributes to human security in the sense that they are struggling for the right to health in Israel and the oPt; however, participants felt that their work should not be seen as supplementing the responsibilities of the state. PHR-I's website states: “There is no replacement for a regional, advanced, and financially secure medical system run by the local authorities.”

Finally, the mechanism of human security also states that without an adequate and proper health system, people might resort to violence in order to achieve it. Participants were hesitant to agree, but argued that, while this may be the case, this is not their motivation for advocating for health rights: “We don't think that there is not going to be conflict if people are healthy. We are quite simply saying that it is their right, as human beings, to be healthy.” One participant however stressed there was a strong link between the health of a community and its response to the conflict:

No one would disagree that if there were smaller disparities in terms of education and employment, that there would also be a link between how these people would affect their government or how motivated they would be regarding the conflict. For example, what about the people who live in Soderot and everyday are met with katyushots [rockets]; well, we realize that there is a link between the welfare of the person and how they see the conflict.

One of the Co-Directors of the Occupied Territories Project continued, “There is no real separation between the political issues of the occupation and the issues of social justice. They are linked and one affects the other. It is one struggle.”

Discovery and Dissemination of Facts

Propaganda is essential to the long-term waging of war. It can be countered effectively only through the discovery and dissemination of accurate information. Health-care personnel are often in the best position to provide such information. In addition to challenging misinformation that may be used to fuel or prolong a conflict, health-care workers could alert the international community to war crimes, crimes against humanity and genocide, and they might be in a position to describe the health consequences of particular forms of weapons.

On September 1st and 2nd of 2006, a delegation of physicians from PHR-I visited the Gaza Strip. “This undertaking was finally permitted, after the Israeli government had prohibited the entry of PHR-I’s Jewish members for the last six years. The purpose of the visit was to assess the critical medical and economic situation reported by various sources from the Gaza Strip and abroad” (PHR-I 2006c, 3). One participant noted that since the situation in Gaza is one of “total isolation and the information that goes out is very much marketed by the people outside of Gaza,” it was imperative that PHR-I was able to enter Gaza to discover the realities of the occupation. Another participant echoed this sentiment: “Israel for the last year has tried to create a very big prison called ‘the Gaza Strip. There is no media or journalists allowed in Gaza. There is no movement in or out and no supplies. They are making things very tight and pressured.”

After returning from the Gaza, PHR-I published a report entitled *The Gaza Strip: State of Disaster*, in which it demanded that Israel “open the borders of the Gaza Strip immediately; allow without delay the entry of goods, especially medications; and

facilitate provision of civilian services that the Palestinian Authority is unable to provide due to the economic crisis, which is caused among other factors by the freezing of tax revenues” (2006, 13). This report is just one among many that serves to reveal the organization’s findings from its field work. However, participants reported that while they have had access to the Gaza on an ongoing basis since the inception of PHR-I through phone calls, emails, or direct entry, the current situation is more challenging than ever. The Interventions Coordinator of the Occupied Territories Project reported:

“For many years we used to get all our patient cases from one organization that cooperated with us, but now because of the political situation inside Gaza, we don’t get those patients anymore. Now, we are fighting for information because it not only helps patients, but it also helps to bring us information to build a case of principle. Everyday we know what is going on in Gaza – 24/7 – we have contact with people from Gaza. Now the system changed and we don’t know what is going on. We are fighting for information. I guess we have been blacklisted, but I am not sure.”

Each month PHR-I’s Occupied Territory Project receives approximately 70 to 80 appeals from patients and medical teams who face difficulties in traveling to various medical centers. The Interventions Coordinator reports that these appeals come most frequently from the Gaza Strip and while their efforts often fail, “just the fact that the patients can call out means that information about the situation in Gaza is revealed.” In fact, it is from these very appeals that PHR-I is able to collect evidence and individual narratives for its policy papers that provide the basis for its political lobbying efforts.

According to PHR-I’s website, in November 2007, PHR-I petitioned the Israel High Court of Justice to grant 11 patients permission to leave the Gaza Strip for treatment in Jordan, the West Bank, East Jerusalem or Israel. While five of the patients previously defined as ‘security threats’ were authorized to exit Gaza for medical treatment, the Court

refused five additional patients and one patient died on November 17th in Gaza. The story reached the Jerusalem Post, Haaretz, and ABC News, among others, and raised awareness concerning the Israeli policy at Erez Crossing, which has increasingly denied access to care to hundreds of patients in need of treatment unavailable in the Gaza Strip

Once PHR-I has discovered facts, its main task is to raise public awareness concerning the violations of the right to health. Members are continually writing updates, research reports, and policy papers in efforts to disseminate the facts. In fact, PHR-I published annual activity reports from 1989 to 2000, and in 2000, it switched to writing far more detailed publications where they focus on critical issues, such as the collapse of the Palestinian health care system, house demolitions, and medical ethics. All publications appear in English, Hebrew and Arabic and are accessible from their website (<http://www.phr.org.il/phr>).

Disseminating facts is a goal of PHR-I, but the organization is not overly optimistic in terms of what it thinks their work can do. As one participant explained, “The situation in Gaza is more visible today than it was even last week, but this is not only because of us. It is mostly because it is a sensation.”

Similarly, many participants felt that while they may discover new facts and raise awareness, what they often find “is not really something unknown. It is something undiscussed” and what their work really does is spark a public debate: “Most of the time we only get an argument, but that is important too - the fact that there is an argument.”

PHR-I has access to the infrastructure, skills, and resources that can help to uncover accurate information about the effects of conflict; however, despite the fact it continually raises awareness about health and human rights violations, most participants felt that it

did not create any real change in the Israeli public's perception of the 'other.' In fact, PHR-I's other projects are reportedly met with more understanding and a greater public response than the Occupied Territories Project.¹² One participant noted: "It depends what population you're talking about. When it comes to the Palestinians, the general public is not ready." In fact, the small changes that may have resulted from PHR-I's other projects is arguably, as one participant states, "because the facts were discovered and disseminated at the right time and gave power to a public mood that was already there." While PHR-I continues to raise awareness about the situation in the occupied Palestinian territories, the overall response from the participants was that the environment in Israel was not conducive to creating public change. One participant explained that despite the organization's efforts to disseminate information, there has been little movement: "This is part of why the peace process is stuck. The Israeli public is indifferent."

Redefinition of the Situation

The meaning of war is not obvious. Its meaning for a population is established by particular groups—social classes, military elites, media, and so on. War can be presented as a game, a test of manhood, a competition of civilisations, or a religious contest of good and evil. Health workers can refuse to accept these understandings and definitions and can promote different ones. They can promote the understanding of war as a population health disaster or as a complex emergency. They can present war as an institution that is neither inevitable nor conducive to the long-term welfare of humanity.

In September 2007, the Israeli government declared the Gaza Strip a "hostile entity" and began cutting electricity and fuel to the Hamas-led territory in response to continued rocket attacks into Israel (BBC News 2007). PHR-I immediately spoke out

¹² The Migrant Workers and Refugee Project, according to the focus group participants, has had some success in changing public perception. The MWRF Interventions Coordinator notes: "For trafficked women, they were seen as prostitutes, but if you ask the Israeli public now, there is a greater understanding. They understand that they are victims. In terms of refugees, the idea of refugees is becoming clearer. People understand now the difference between a refugee and a migrant worker."

against this new classification of the Gaza Strip and the decision to impose collective punishment on 1.5 million Palestinians in the area. In response, in October of 2007, 10 organizations, including PHR-I, petitioned the Israel High Court of Justice and demanded an injunction against disrupting the supply of electricity and fuel to the Gaza Strip.¹³ The decision to impose collective punishment on the Palestinians endangered the functioning of hospitals, sewage pipes, and water pumps, while classifying Gaza as a “hostile entity” has decreased the number of permits available. As a result, the success of PHR-I’s Occupied Territories Project has declined. The Intervention Coordinator explained: “We used to have an 80% success rate for the cases in which we appealed to the High Court for a permit, but now we are standing at 30%. Since Israel defined Gaza as a hostile entity, it is even harder to help Palestinian patients access health services.”

Health organizations can not only refuse to support certain views of a conflict, but they can also “help to redefine a conflict in other terms by presenting it as a health disaster or complex emergency” (Santa Barbara and MacQueen 2004, 384). One way in which PHR-I reframes the conflict is in highlighting the individual suffering of Palestinians through the use of narratives. One participant explained, “I think one thing all of us try to do with data is to bring forth personal stories instead of numbers.” Similarly, one participant thought that focusing on individual suffering like the blocking of a cancer patient in Gaza from chemotherapy was in a way a frame for the conflict; a frame in which “people can relate to and empathize with.” PHR-I’s publications also take a similar approach. A recent publication written by PHR-I in 2006 entitled *Gaza: State of Disaster* contains personal narratives and graphic images, in hopes that it will “contribute towards producing a wave of opposition to the current policy” (2006, 2). In using the

¹³ See <http://www.phr.org.il/phr/article.asp?articleid=496&catid=73&pcat=73&lang=ENG>

frame of individual suffering, PHR-I portrays the conflict as a critical threat to the health of Palestinians. It allows the organization to highlight the impact of Israeli policies on individuals. One participant explained: “Health is our avenue. It is part of the crisis. It is part of politics. If one tries to separate the two, they are wilfully blind. In Gaza, the health situation is so poor because it is part of the political condition. It does not stand by itself.”

PHR-I is also active in trying to redefine the conflict itself. In fact, the conflict in Israel and the occupied Palestinian territories has long been seen as one of occupation, and PHR-I is beginning to examine the use of the term ‘annexation’ to define the ongoing conflict. Occupation is, according to international law, a temporary status, yet as one participant stated, “Israeli forces have been occupying Palestinian land for over 40 years.” In fact, the U.N. Resolution 242 of 1967, which calls for Israeli withdrawal from territories occupied during the 1967 June War, is based on the principle of the “inadmissibility of the acquisition of territory by war” (United Nations 1967). “Occupation under international law,” explained one participant, “is usually seen as something temporary and something military, but what is happening in the West Bank doesn’t look so temporary or even so military any more.” This process of redefining the conflict as one of annexation, whereby the state of Israel is trying to incorporate Palestinian territory into its geo-political borders, allows PHR-I to re-examine its demands from this new perspective. One participant stated that PHR-I was meeting with their partners in Ramallah later that week to discuss the issue of annexation. Later when I met one of PHR-I’s Palestinian project partners, she explained:

There is annexed land because of the war. There is annexed land because of the settlements. There is annexed land because of bypassed roads. Whether or not this is a creeping annexation that will eventually annex all of the West Bank is another question, but there is a strong trend in Israel that

suggests that Israel is from the river to the sea and there is a strong trend in Israel that suggests that Palestinians can have their homeland in Jordan.

Although the movement to redefine the occupation as annexation is more political than framing it as a health crisis, it is important to recognize that PHR-I is an organization made up of health practitioners and human rights workers. It does not see itself solely as a health organization, but as a human rights organization that is committed to ending the occupation. It believes that in redefining the occupation as annexation, it can more adequately explain the adverse effects of the separation barrier, the bypass roads, the settlements, and the restrictions on the movement of Palestinians.

PHR-I is continually trying to redefine the conflict and change the focus to keep the organization relevant and innovative: “We write our annual reports and publications and are constantly reframing, reframing, reframing.” It is imperative to PHR-I that the conflict is defined “not only in the eyes of the politics of peace talks or control or occupation, but also in terms of needs created by the crisis.” Nevertheless, the President and Founder of PHR-I argues that reframing is never an easy task, and often even when a conflict is reframed in such a way that elucidates new understandings, it is not enough: “It is not that people are not seeing things. It is an active act. One puts effort in not knowing. We don’t have to overcome the lack of knowledge, but the lack of will – the psychological defensive mechanism of denial.”

Diplomacy, Mediation, and Conflict Transformation

Health workers are not unique in developing skills in diplomacy, mediation, and conflict resolution, but they will sometimes have unique opportunities to use them. They might be able to bring groups together around superordinate goals associated with health, and to work with groups struggling to assure their security in a devastated environment.

The eighth mechanism of Peace through Health states that skills in diplomacy, mediation and conflict transformation are “important in situations where health workers might be able to bring seemingly diverse groups together around super-ordinate health-related goals.” Yet, as noted in the first mechanism, some participants of PHR-I believe that the power imbalance that stems from the Israeli-Palestinian conflict presents a unique challenge to initiating projects around superordinate goals. Furthermore, while PtH stresses the importance of skills training to effectively fulfill this mechanism, Peace through Health has been criticized for trying to create mediators out of health practitioners. In fact, without proper training, health practitioners can potentially exacerbate the conflict and increase societal tensions.

Mediation, a form of alternative dispute resolution, aims to assist two or more parties in reaching an agreement. This process typically involves a neutral third party. However, if the third party consistently puts forth proposals that favour one party over the other, the parties may not only fail to reach a resolution, but the third party may actually exacerbate the conflict. PHR-I is not a neutral third party: “We are not neutral in two senses. First, we are Israelis and we see ourselves as Israeli patriots. We are convinced that our work is in the interest of the Israeli society. Second, we are opposed to many of the state policies and the government does not consider us to be neutral. This particular mechanism is not a task for PHR-I.”

In fact, neutrality in such a highly politicized environment is rare and many organizations working in the region have put a greater emphasis on advocacy (International Development Committee 2004, 64), including PHR-I.

Our task is not to mediate. It is true that sometimes we apply to the Israeli Security Service on behalf of patients from the Gaza, but that is not

mediation; that is advocacy. We do not try to reach a compromise. We are advocating for the right to health care for the Palestinians in the Occupied Territories. We are not mediating between the Israeli Security System and the Palestinian Authority. That is not our task and not our mandate. There is a real difference between mediation and advocacy. We are not trying to reach a compromise.

PHR-I, like other organizations working in the region, is experiencing tension between advocacy and neutrality. “The long-term, lack of political settlement, and human rights situation have promoted some [organizations] to... take on more of an advocacy stance” (Fast 2006, 9). As one participant highlighted, “This is not a conflict between two equal parties. It is a situation of exploitation and to try and phase out the conflict, we think, serves the occupation. Therefore, we don’t want to mediate. We want to represent the voice of the Palestinians before the government.” While health organizations may risk losing both access and effectiveness if they are perceived as taking sides in a conflict, PHR-I is more than a health organization. While it provides health care impartially, it sees itself as a human rights organization that recognizes the inextricable link between health and politics.

While neutrality is a requirement for mediators, in the field of health taking a neutral stance can do great harm to the health of the population. In the oPt, neutrality is equated to silence, and silence is equated to acceptance (Fast 2006, 12). While the Executive Director of PHR-I suggested that the organization may be able to play a role as a health mediator, she insisted that PHR-I would never take a neutral third-party position, but will continue to advocate for the rights of Palestinians.

Solidarity and Support

Many peace-through-health mechanisms involve solidarity and support for victims of war. In listing this as a separate mechanism we are drawing attention to actions in which these dynamics are explicit. This includes the direct accompaniment of victims or potential victims by health

workers, as well as direct advocacy on their behalf. This mechanism is especially relevant when there are great differences of power between the conflicting parties.

Since its inception in 1989, PHR-I has run a mobile health clinic in the occupied Palestinian territories. According to its website, these medical days are held every Saturday in Palestinian villages throughout the West Bank and are staffed by Israeli physicians and human rights workers, both Jewish and Arab, along with Palestinian doctors from organizations such as the Palestinian Medical Relief Services, the Palestinian Red Crescent Society, and the Patients Friends Society. In 2007, PHR-I operated 75 medical days, including 12 paediatric clinics, 9 diabetes clinics, 9 gynaecology clinics, and 10 Women's Health and Human Rights clinics. During this period, 642 medical staff members treated 10,676 patients, of which 2,591 were children (Helfer, Adi, email to Judy Kitts, 20 January 2007). These statistics highlight the impact that the mobile health clinics have had on alleviating suffering, yet according to its website, PHR-I states that one of the "most valuable aspects of the clinic has been its ability to convey solidarity with Palestinian patients and specialists, through cooperation and professional information exchange." One participant explained that, from a medical point of view, the clinic's contribution is still relatively minimal and that the clinics are "more of an act of solidarity and support than providing actual medical treatment." Furthermore, while it may not provide extensive aid, it actually provides PHR-I with the information it needs concerning the current shortages in the Palestinian health care system to further advocate for the rights of the Palestinians.

PHR-I also provides representation before the state authorities for individuals whose right to health have been violated. In fact, approximately 1,900 men and women are assisted and represented yearly by PHR-I (PHR-I 2007c). The organization takes

action in order to help individuals receive the medical treatment they both need and deserve, but as the OTP Interventions Coordinator argued, “The appeals that PHR-I receives has less to do with actually helping Palestinians access health services because the help we can provide is very basic and the appeals are not always successful, but it is more about letting Palestinians know that you are there and that you are aware of the problems they face.” The appeals PHR-I receives come mainly from the Gaza Strip and while, at first, the patients are cautious, one participant explained that often they open up:

I can feel the solidarity, especially when I speak with Hamas people on the phone. From the beginning they are very suspicious and they talk very carefully. After a few conversations, I can feel that they are speaking freely. I am not a psychologist, so I can not measure the impact, but I can feel it.

PHR-I also conducts a number of workshops and seminars, “in which Israeli and Palestinian doctors work side by side in pursuit of professional dialogue and sharing of vital medical experience” (PHR-I 2006b, 7). During these professional days, Palestinian physicians are either invited to Israel for medical training, or Israeli doctors go to the occupied Palestinian Territories to lead seminars or workshops. In 2006, one-day training seminars took place with a focus on orthopaedics and another on diabetes, and three-day training seminars took place with a focus on trauma victims, breast cancer, and mental health (Ibid, 7-9). There is some discussion within PHR-I however, about whether or not this should be a focus of its activities: “We are not sure that this is something that we should be doing – giving this humanitarian help – as it is more the responsibility of the Palestinian Authority or the state of Israel, but it is helpful in terms of knowing what is going on.” In encouraging joint Palestinian-Israeli initiatives, PHR-I highlights that as an organization, it has learned “learned from experience that cooperation in the health field

which is based on the values of human rights, presents a positive alternative to the violence, and provides a bridge to achieve a genuine and just peace” (PHR-I website).

As previously mentioned, in June of 2005, 20 Palestinian organizations called for a boycott against cooperation with Israeli institutions and NGOs that are complicit with the occupation. Since its inception, PHR-I has been outspoken against the policies of the Israeli government and has actively lobbied the Israeli High Court of Justice on behalf of the Palestinians. This continual public demonstration of support for the Palestinian community is a critical component of the organization’s act of solidarity. A board member of PHR-I suggests that the fact it was not included in the boycott as other organizations were, is an indication “that to the Palestinian public, PHR-I is accepted as a valuable organization that can be trusted.” PHR-I not only focuses on medical treatment in the field, but combines its work with active political participation. “An intervention designed to protest against a war might be a success if it demonstrates solidarity with victims” (Arya 2004, 255).

The mechanism of solidarity and support is “especially relevant when there are great differences of power between the conflicting parties” (Santa Barbara and MacQueen 2004, 385). However, a number of participants felt that because of this very imbalance of power, their work is often asymmetric. In the mobile clinics, it is the Israelis who come with medical supplies and professionals to provide relief to the Palestinians who are suffering from poor health. A more symmetrical example of solidarity, according to one participant, was PHR-I’s work with Palestinian human rights organizations to end the mobility restrictions in the Gaza Strip. It was argued that this type of work may have a greater effect in demonstrating support for the Palestinians. Another participant thought

that the support provided could often be seen as paternalistic because of the imbalance of power: “There are inequalities even in the provision of health care as we are the people with the power and when we provide health care, we highlight this power, but if there was something that tried to provide power or give up power than that would be true solidarity.”

Dissent and Non-Cooperation

When health workers are called on to collaborate in unjust wars or preparations for such wars, or in the development of inhumane weapons or war policies, they can refuse to do so. This might involve refusing to cooperate with civil defence measures, refusing to aid in the design of particular weapons and strategies, or refusing to lend their professional legitimacy to institutions or persons that promote war. Health workers can criticise government policies they see as conducive to war.

One of the defining attributes of PHR-I that separates the organization from others is its willingness to speak out against the policies of the Israeli government. In fact, participants of the focus group asked that we begin the discussion with this very mechanism. Later in a one-on-one interview with the President and Founder, she also reiterated this point: “The mechanism of *Dissent and Non-Cooperation* is the most important mechanism. There is no limit to how politicized we should be.”

In terms of legal advocacy on the matters of principle, PHR-I initiated numerous petitions to the high court. These include, among others, an injunction against the fuel and electricity cuts in Gaza,¹⁴ a petition filed on behalf of 11 patients in the Gaza who needed medical care that was unavailable in Gaza,¹⁵ and a petition on the access of Palestinian ambulances to medical centres in East Jerusalem.¹⁶ There have been a few successes that stem from PHR-I’s legal advocacy work, including a bed for every

¹⁴ <http://www.phr.org.il/phr/article.asp?articleid=496&catid=73&pcat=73&lang=ENG>

¹⁵ <http://www.phr.org.il/phr/article.asp?articleid=502&catid=73&pcat=73&lang=ENG>

¹⁶ <http://www.phr.org.il/phr/article.asp?articleid=486&catid=73&pcat=73&lang=ENG>

prisoner and the ‘temporary’ increase in the amount of diesel supplied to Gaza’s power station. Yet, as one participant explained, this success has come at a cost, “the GSS [Israel Security Service] now tries to obstruct information from us. Sometimes if you are too good, you get the door shut on your face and you then have to climb through the window... You always have to find new ways... and it becomes harder and harder each time”

The fact that PHR-I is outspoken against Israeli policies and is not apolitical is something that the organization holds up in high regard: “The fact that we are active in the field gives us a certain degree of authority to demand policy changes because we are not just in our offices. We bring back testimony from the field from actual contacts so when we approach the High Court, it is not just theoretical.”

While PHR-I may continuously condemn the policies of the Israeli government, a number of participants stressed that they continually found themselves balancing on the edge: “I don’t think we always demonstrate dissent and refuse to cooperate. We do cooperate,” one participant explained. In fact, petitioning the Israeli High Court of Justice can be problematic because the organization is requesting assistance from the perpetrator of human rights violations - the state - and in this way reinforcing its legitimacy (PHR-I 2007b, 5). The Executive Director of PHR-I explained: “If you want to get results, you have to know how to play the game according to the rules, yet if we want to really challenge the administration, we need to go outside of the rules of game, but never too far because then you become irrelevant.”

Aside from condemning the policies of the Israeli government, PHR-I also works continuously in the field of medical ethics by putting pressure on physicians who

cooperate and participate in the unethical treatment of patients. For example, in June 2007, the state made a pseudo-medical distinction between danger to life and danger to “quality of life” (PHR-I 2007a, 1). In practice, this requires the cooperation of physicians with military authorities in order to classify patients according to this system. In response, PHR-I issued a *Medical Ethics Paper* stating that a physician working on behalf of the military authorities or the civil administration is not permitted to conduct or cooperate with triage performed by the military, since s/he knows that those not afforded a high priority will remain in Gaza, which lacks appropriate care, and that the reason for this is not a shortage of resources but external considerations which have nothing to do with the medical profession (Ibid, 4). In appealing to the medical community to protest against the repeated ethical violations resulting from Israel’s policies, PHR-I believes that Israeli physicians must take a decisive stance against these violations (PHR-I website).

Dissent and non-cooperation is truly the focus of PHR-I’s activities. “This is all we do,” stated one participant. In fact, the President and Founder could not overestimate the importance of this mechanism:

I think that everyone, including doctors, need to be politicized. Otherwise, it is a kind of mild, blind, non-affective activity. Even though a person can come home at night and tell himself how wonderful he was today, it is not very helpful to the dynamics of the whole thing. The organization, and each and everyone in the organization, must be out of the consensus, which is not an easy place to be.

CHAPTER FIVE: DISCUSSION

5.1 Discussion of Findings

In an effort to discover if Peace through Health is an appropriate peace-building response in the context of the Palestinian-Israeli conflict, I explored PtH within the confines of a single qualitative instrumental case study. Findings from PHR-I highlighted that while the mechanisms identified by Santa Barbara and MacQueen are, to some degree, reflected in their activities as indicated in Chapter Four, its contribution to peace is limited by the very context in which the organization operates. Participants overwhelmingly questioned whether or not these 10 mechanisms could contribute, in any capacity, to peace-building when faced with such a politicized environment. In this chapter, I will explore the following two research questions: *Is Peace through Health an appropriate peace-building response in the context of the Palestinian-Israeli conflict? And how can Peace through Health be evaluated in regions of intractability to provide evidence for this emerging field?*

I will first discuss how PHR-I has taken a political stance against the occupation and how neutrality¹⁷ in the context of the Israeli-Palestinian conflict is often seen as normalization. I will then discuss that while the role of PHR-I, and other health organizations in peace-building, is unique, it is part of a dynamic system that is both supported and challenged by the other sectors that surround it. The importance of recognizing Peace through Health within a multi-track approach should not be underestimated. Thirdly, I will explore the limitations of a single working framework and present the most recent model developed by Neil Arya, the *Peace through Health*

¹⁷ Neutrality is used in this context to refer to taking no position on the conflict, remaining neutral in terms of the merits of each side. Impartiality refers to caring equally for all those concerned, based on the principle that all lives are of equal value (Santa Barbara 2005, 1008).

Working Model, which acknowledges that different PtH mechanisms may be appropriate at different stages of a conflict. Finally, the chapter will conclude with a discussion of the evaluation of Peace through Health in regions of intractability.

PHR-I – Taking a Political Stance

Organizations operating under the rubric of Peace through Health cannot be complacent. They cannot highlight the ethical obligations that physicians have as practitioners under the Hippocratic Oath¹⁸ and then refuse to acknowledge the very political environment that contributes to the pain and suffering of both Israelis and Palestinians. The very uniqueness of this field is that it bridges a genuine link between health and peace, and when organizations fail to recognize the systemic policies that violate the right to health, the entire opportunity that has been created by this transcendence disappears. Health organizations and health practitioners are often seen as legitimate and their credibility can work to their advantage; however, they must condemn policies and practices that violate the right to health or they will only serve to normalize the very actions that serve to oppress the population.

Neutrality and impartiality are core principles in humanitarian action, and while much of PHR-I's activities may be deemed humanitarian work (i.e. the mobile health clinics), it does not identify itself as a humanitarian organization; rather it sees itself as an organization that struggles for human rights in general, and the right to health in particular, in both Israel and the occupied Palestinian territories.

There is a unique relationship within PHR-I however, between the principles of humanitarian action and human rights. One participant explained: "The issue of policy is

¹⁸ "I will keep them from harm and injustice" – The Hippocratic Oath.

dealt with on a different level than the issue of health. On one hand, you are trying to provide some kind of aid and on the other, you are trying to solve for the long term and that is more political.” Another participant continued, “Every project deals with individuals and policies. That’s what makes us a human rights organization and not a humanitarian organization, like the Red Cross.” In fact, the very foundation of PHR-I is that it does not separate its activities from its political stance. It spells out clearly that it is against the occupation. Larissa Fast author of *Aid in a Pressure Cooker: Humanitarian Action in the oPt* states that “the political sensitivity of the Israeli-Palestinian conflict around the world (regardless of which side one favours) and the political and military power imbalances between these two sides both present serious ethical and logistical dilemmas to maintaining neutrality” (2006, 31). PHR-I is an exemplary organization in this respect as it understands that taking an apolitical stance can actually exacerbate the conflict, as this can be seen as failing to acknowledge the blatant violations that take place within the oPt and Israel. In fact, neutrality that is silent on abuses can be seen as pacification (Anderson and Olson 2003, 32).

Bernard Mayer, author of *Beyond Neutrality*, argues that people often don’t trust neutrality (2004, 17). They are suspicious of the concept and question its very meaning. In fact, neutrality is often not what conflicting parties are even looking for. They want “assistance, advocacy, advice, power, resources, connections, or wisdom” (Ibid). While Mayer’s argument is formulated for the profession of conflict resolution, there may be value in examining his position in terms of Peace through Health. For example, health practitioners often see neutrality, as an essential part of their identity in the medical field as it can grant them access to both parties of the conflict, yet neutrality may actually

hinder the success of PtH initiatives. In fact, while neutrality may help to create a safe, flexible, informal, and creative forum for interchange, it does not offer sufficient opportunities for voice, justice, vindication, validation or impact (Ibid, 29). Mayer continues, stating that the acceptance of neutrality means to presume certain aspects of moral, legal, and political equality (Ibid, 30). Naturally, the power relations within the Israeli-Palestinian conflict are far from equal, and neutrality could potentially hinder the success of any initiative in the region. As frustration grows with a continued political stalemate, Palestinians are linking humanitarian action with political agendas (Fast 2006, 31) and organizations that fail to address the systemic political realities may isolate the Palestinian community and thereby hinder the success of the initiative.

Not surprisingly, academics have repeatedly questioned: “*Can peace-through-health initiatives really afford to ignore politics?*” (Jabbour 2005, 1211). “*Is it possible to be an impartial practitioner of health or peace, believing in the equal value of all lives, and to take a position on the conflict?*” (Santa Barbara 2005b, 1008). My findings suggest that PtH *cannot* afford to ignore politics, and health and peace practitioners *can*, in fact, take a position on the conflict. In fact, PHR-I prides itself in the very fact that it does not hesitate to tackle political issues and of all the 10 mechanisms, it was the tenth that resonated with the organization the loudest. In areas of intractable conflict, the hallmark of PtH may very well be *dissent and non-cooperation* as everything and everyone within the conflict is part of the political environment that constitutes the very existence of the conflict. No one, especially those trying to work for peace, can ignore the reality in which they find themselves.

This is especially important to PHR-I. As an Israeli organization, PHR-I is part of the dominant power group. Members of PHR-I recognize that they are in a position of power within the conflict, yet as one participant noted, one of the strengths of the organization is that it is willing to give up power: “If you want to speak about peace and compromise, then you can’t keep all the power and cards in your own hands.” PHR-I continually stresses the importance of advocacy and its members understand the importance of transforming “the relationships from silence to awareness and from awareness to balancing power” (Lederach 1989, 13). This is imperative as “initiatives that are blind to – and passive in the face of – the power imbalances, competing interests, and political interests... are doomed to fail, or worse, to reinforce corrosive impacts” (Bush 2005, 4). In fact, “some peace efforts are conducted in ways that reinforce the asymmetries of power behind the conflict or legitimize a status quo that systematically disadvantages some people or groups relative to others” (Anderson and Olson 2003, 23)

The importance then of speaking out against the occupation as an Israeli organization can not be underestimated because of its position as a dominant power. “In the context of the military, economic, and political imbalances that exist between Israelis and Palestinians, Palestinians perceive activities that attempt to create normal relationships with Israelis or a normal situation without addressing root causes and inequalities as suspect at best and destructive at worst” (Fast 2006, 14). For example, the call for boycotting Palestinian-Israeli cooperation in the health sector as mentioned in Chapter Four highlights the importance of speaking out against the occupation. In fact, PHR-I was excluded from the boycott specifically because it openly rejected and fought the occupation for years (Giacaman 2005).

PHR-I has taken a political position as an Israeli organization and suggests that for local organizations in general, it may be more difficult to separate their activities from the political environment as the effects of the conflict are felt on a day to day basis. One participant explained:

The question of whether the medical international community should intervene in a specific conflict would require some kind of thinking and some proof of whether or not it would be useful or damaging. But those who are doing it from their own community, their own society, I think there are other kind of considerations.

The distinction that PHR-I makes between international and local organizations suggests that it may be easier for an international organization to act as neutral third-party than for those working from inside the conflict, as local organizations are made up of members that directly experience the cost of the conflict and so their neutrality is compromised. In fact, some participants highlighted the fact that because they are ‘insiders,’ they feel compelled to act out against the injustices they witness. This is not to suggest that international organizations are somehow removed from the conflict and that they don’t also bring their own views and biases; rather, this argument suggests that local organizations are possibly too intimately connected to separate these biases from their actions.

For PHR-I, to discount the importance of taking a political stand would be incredibly short-sighted. Its position as a local Israeli organization is central to how and why it has formed a political stance against the occupation. In the context of the Israeli-Palestinian conflict, neutrality is viewed as a form of normalization, and initiatives that neglect issues at the political level are not likely to be effective in expanding peace (Anderson and Olson 2003, 55). For example, how could a PtH initiative build

professional collaborative health partnerships while failing to recognize that many Israeli and Palestinian citizens only ever see the ‘soldier’ or the ‘terrorist’?

This is not to suggest that collaborative partnerships and joint initiatives are of no value. In fact, a board member of PHR-I argued in response to the *Call for Boycotting Palestinian-Israeli Cooperation in the Health Sector* that such activities are so important that they “cannot be overemphasized. Through them, professional and personal bridges are indeed built between Israelis and Palestinians” (2005). Nevertheless, joint initiatives are met with various challenges. In fact, in launching joint initiatives, organizations often assume “that both sides have something to gain through working together” (Anderson and Olson 2003, 86). In conflicts marked by deep power asymmetries, the “normalization of relationships across lines of conflict is often seen as cooptation by the less powerful side” (Ibid). With an imbalance of power, cooperation can continue to fuel inequities and the interest of the less powerful side can be overshadowed or even dismissed by the more powerful party.

My findings suggest that health and peace organizations can create as many professional training seminars and workshops as they please; they can work on super-ordinate goals and stop the spread of the Avian Flu, but until the root cause of the conflict is addressed, until more organizations and individuals - Palestinian, Israeli, and internationals alike - take a position against the occupation, all this work will be lost in the systemic realities that create these conditions of oppression. They will not change the public sentiment. They will not change state policies. And they will *not* contribute to peace-building. We need to consider, once again, what is Peace through Health and how can these mechanisms contribute to peace? In the case of PHR-I, many of PtH’s 10

mechanisms were present. Yet, the question that continually surfaced was why do we think these 10 mechanisms will contribute to peace? Overall, there was a genuine discord between these mechanisms and their impact - a genuine disbelief that simply because PHR-I was demonstrating solidarity, disseminating facts, and contributing to human security it was, in effect, contributing to peace-building. In many ways, the response to this very idea – that PtH can contribute to peace in this context – was disbelief. All participants stressed that despite the presence of some of these mechanisms, the political environment was not conducive to peace:

Peace won't be achieved without political change... We are trying to change state policies using the tool of health. Our vision is to end the occupation... It won't help even if we bring 500 people out of Gaza for medical treatment in Israeli hospitals. It won't help them afterward. It is just a band-aid. The system in Gaza will remain the same.

The reality is that the conflict is ongoing and PtH does not have the same impact in the context of the Israeli-Palestinian conflict as it would in a post-conflict situation. The situation in Israel and the occupied Palestinian territories, at the present, is not ripe for peace. Violence is ongoing and peace, defined negatively, is not on the horizon. Even a positive interpretation of peace is challenged by the current political realities. The public is indifferent and fatigued and governments on both sides continue to hinder the peace process. The contribution, then, that health organizations can make to peace-building within the Israeli-Palestinian conflict is severely limited unless they acknowledge the very realities that exist within the current state of the conflict.

Naturally, the next question is *“how would consideration of political realities reshape... peace-making efforts?”* (Jabbour 2005, 1211). Here I would suggest that in taking a political stance against the occupation, health organizations, in the very least,

would not be complacent to the violations of health rights that are taking place on both sides of the conflict, and in the utmost, they would be working towards the conception of both positive health and positive peace - the complete physical, mental, and social well-being *and* the presence of social justice through equal opportunity, a fair distribution of power and resources, equal protection and impartial enforcement of law (Galtung 1990). In considering the opportunities in light of the positive analogies, PtH could creatively link peace and health to develop initiatives that would acknowledge and address the root causes of the existing conflict. For example, rather than designing a workshop around post-traumatic stress disorder in the midst of the ongoing conflict, PtH would focus on the political realm when shaping their health initiatives. For example, PHR-I intervenes directly in individual cases and lobbies for systemic change by presenting these cases to the Israeli Court of Justice. It uses information the organization receives from the applicants to put together its own independent research that enables PHR-I to effect changes in state policies. These efforts can potentially contribute to reducing trauma by effectively changing the very policies that create this system of oppression. In fact, PHR-I has been cited by various academics in PtH as an exemplary model for its efforts in emphasizing the political dimension (Jabbour 2005, Arya 2004, Santa Barbara 2005c).

Systemic problems are often the main cause of intractable conflicts, and any initiative that hopes to impact peace must involve systemic change that helps to create and sustain a new social reality. An integral part of minimizing armed conflict is transforming those structures and dynamics that govern social and political relations as well as access to power and resources (Ardon 1999, 10).

The challenge for health organizations would then be to try to strike a balance between political work, where PtH initiatives would advocate and lobby against policies that are conducive to conflict, and humanitarian work, where they would treat and address the immediate health concerns of those suffering from ill health. As PHR-I indicates, there is a genuine trade-off when working in such a dynamic:

Most of the time, the individual takes the more urgent work because we can't put aside an ill person who needs cancer treatment or emergency heart surgery, while writing a letter about state policy or going to high court can always wait. It is always important to consider our priorities. It is not a pattern I can tell you. We don't even know and we don't know if we are doing it right. All the time, we are assessing.

There is no denying that urgent medical attention will always take precedence over long-term systemic issues, yet my findings suggest that if Peace through Health is to be an appropriate peace-building response in the context of the Israeli-Palestinian conflict, it must provide more than humanitarian aid. It must recognize the importance of exploring the political factors beneath the surface and, at a programmatic level, "this commitment translates to... ensuring that issues of justice and human rights are on the agenda" (Anderson and Olson 2003, 32).

The Role of Health organizations in a Multi-Track Approach

In intractable conflicts, politics cannot be left off the agenda, yet peace is part of an organic system; whereby "no one activity and no one level will be able to deliver and sustain peace on its own" (Lederach 1999, 30). In fact, the political arena is made up of more than just official government actions. Track Two diplomacy highlights that unofficial efforts by non-governmental organizations can also contribute to the process of peace-building and influence the political process.

PHR-I and other health organizations can play a significant role in Track Two diplomacy if we consider *health* as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1948). Montville identified three objectives of Track Two diplomacy: 1) to reduce or resolve conflict between groups or nations by improving communication, understanding, and relationships; 2) to decrease tension, anger, fear, or misunderstanding by humanizing the face of the enemy and giving people direct personal experience of one another; and 3) to affect the thinking and action of Track One by addressing root causes, feelings, and needs and by exploring diplomatic options without prejudice, thereby laying the groundwork for more formal negotiations or for reframing policies (Diamond and McDonald 1996, 2).

My findings suggest that PHR-I fulfills all three objectives of Track Two diplomacy. In terms of the first two objectives, PHR-I regularly publishes reports and papers to disseminate information and increase the understanding on both sides of the conflict. It also facilitates communication between parties and gives people direct experience of one another through health training seminars and weekly health clinics in the West Bank. The third objective, in particular, is central to PHR-I’s activities, as it continually struggles to affect the thinking and action of Track One by addressing the root causes of the conflict. In fact, every year, PHR-I submits approximately 60 legal appeals as well as a number of proposals for legislation and represents over 1,900 men and women yearly before state authorities (PHR-I 2007c). In challenging governmental officials on issues where the organization is convinced that state policies are infringing on the right to health, PHR-I pushes the boundaries in hopes to affect the actions of diplomats, high-ranking officials, and heads of state.

As part of a multi-track approach, health organizations may contribute to peace-building, but it is imperative that organizations are realistic in setting their objectives and goals. Realism is important in attempting to incorporate a peace-building perspective into health initiatives in conflict-affected societies (Bunde-Birouste 2004, 16). In fact, the health sector cannot act in isolation as it is part of a larger system of elements that only together can influence the political environment. “It is only through a collaborative effort among all social societal sectors and power structures that real change is possible (Notter and McDonald 1996).

Intractability and the Peace through Health Working Model

Health initiatives, like PHR-I’s, that try to address the root causes that underlie the conflict and change the patterns of interaction of the involved parties may potentially increase the health and security of a population, yet it is critical that all sectors trying to contribute to peace-building assess the current stage of a conflict when creating and implementing any initiative. In fact, since intractable conflicts are typically non-linear and move through various stages often unpredictably, the components of a conflict often change and therefore, so too should the objectives, methods, and actions of each sector within a multi-track approach.

In the article *Can Medicine Prevent War*, the authors suggest that we “start thinking of war as a complex disease, whereby interventions during pre-conflict, active conflict and post-conflict stages allow for preventive manoeuvres at the primordial, primary, secondary, and tertiary stages (Yusuf et al. 1998, 1669). Primordial interventions look for root causes and ways to prevent them from escalating. Primary

interventions refer to preventing a war from breaking out when a situation of conflict is already in existence. Secondary interventions refer to situations where conflict has broken out and we are searching for methods of making peace, while tertiary interventions seek to promote rehabilitation after disease has been established (Ibid)

Neil Arya of McMaster University enlisted the help of the Public Health Model to support and enhance the Peace through Health framework and its 10 mechanisms. Arya’s *Peace through Health Working Model* (See Figure 5.1.2) suggests that the mechanisms, “while highly descriptive and reflective on a broad scope of activity, do not take into account how different mechanisms might be appropriate at succeeding stages of a conflict, and how this might facilitate goal setting” (Arya 2004, 246).

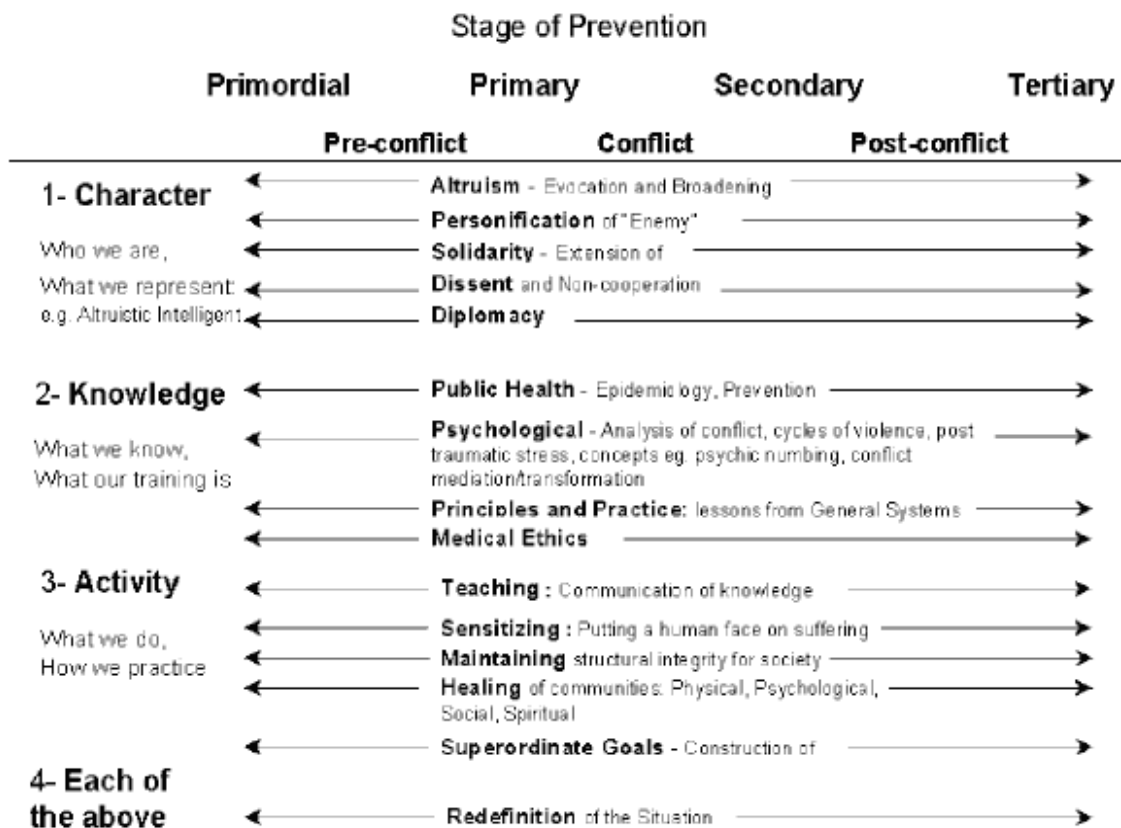


Figure 5.1.1: Peace through Health Working Model

This model highlights the 10 mechanisms, but puts them on a continuum, suggesting that while some mechanisms may be particularly relevant during the pre-conflict stage, others may have little relevance during the conflict or post-conflict stages. If we situate the Israeli-Palestinian conflict in secondary prevention as identified in the *Peace through Health Working Model* above or more particularly in a stalemate as demonstrated in Figure 5.1.3, it may help to explain why some mechanisms are present within PHR-I while others are not. Stalemate refers to the point where “neither party can or will escalate the conflict further, though neither is yet able or willing to take the actions that will eventually generate an agreement” (Pruitt and Rubin 1986, 127).

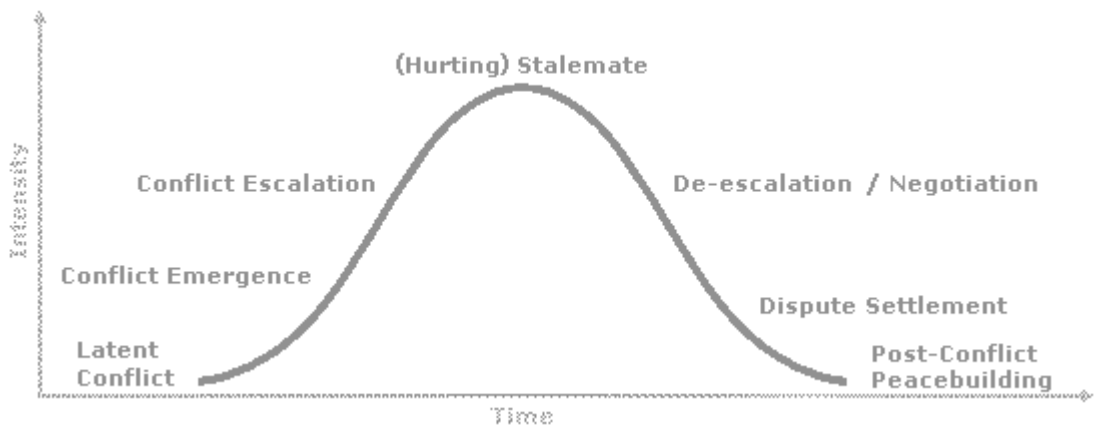


Figure 5.1.2: Stages of a Conflict

In fact, in terms of joint health initiatives, it may help to explain why collaboration is often viewed with scepticism from members of the Palestinian community who deem these projects as “delusional, deceptive, and quite harmful” (Santa Barbara 2005, 155). These initiatives are often viewed as inauthentic and leave the less powerful party feeling manipulated into working together to normalize relations, while tensions continue to build. Similarly, it may also help to explain why the healing of trauma is not a viable objective of Peace through Health in the context of an ongoing

conflict as the deadlock can be painful to both parties and health initiatives cannot provide a permanent solution to the suffering of trauma victims.

On the other hand, this model can also help to illustrate why certain mechanisms *are* in place. In a stalemate, it is often difficult for parties to transform the nature of the conflict because of deeply engrained perceptions. In long-term conflicts, “individuals have been socialized to the polarized view of self and other” (Brahm 2003) and the extension of solidarity and support can help to humanize the ‘other’ and challenge these negative perceptions. In fact, PHR-I’s mobile health clinics, training seminars and workshops, and direct advocacy on behalf of Palestinians, increase the opportunity for dialogue and communication and can give both parties better understanding of their respective interests and positions. In addition, dissent and non-cooperation are also central to PHR-I’s activities, and its political stance against the occupation may serve as a shared narrative with Palestinians and challenge the existing stalemate. In fact, challenging the asymmetrical power relations may be one way in which the stalemate can be broken.

While similar models have linked conflict stages with various actions,¹⁹ this model highlights the capacities of medical professionals to act uniquely for peace, under the categories of Character (who we are), Knowledge (what we know) and Activity (what we do). Applying this framework to PHR-I can help to exemplify how the contextual factors of a given conflict and the capacities of the organization at hand can influence the success of a Peace through Health initiative. For example, as previously mentioned, PHR-I characterizes itself as more than just a health organization, but also as a human

¹⁹ CERTI identified five stages of conflict and different Health as a Bridge for Peace actions that were appropriate for each stage (See Rodriguez et al 2001).

rights organization that is committed to ending the occupation. Furthermore, while it may indirectly work for peace, PHR-I does not characterize itself as a peace organization. In fact, it has distinguished itself from the language of peace arguably because the term ‘peace’ has been misused in Israel and the oPt. As such, it is equally important that PHR-I can also define itself by ‘who they are not,’ by detaching itself from Israeli organizations that do not take a political stand against the occupation. In terms of knowledge, PHR-I is an expert on the right to health, and is made up of both physicians and human rights workers. The combination of PHR-I’s character and knowledge allows the organization to provide immediate health care and advocate against policies that create these inequities. As such, it is the combination of character and knowledge that can help in understanding which particular activities and mechanisms PHR-I can and cannot be fulfilled as illustrated in Chapter Four.

This model is particularly relevant for an organization working in regions of intractable conflict, as it is imperative that PtH initiatives “recognize [their] role in terms of the stage of the conflict, the limitations of knowledge, training, and group and individual characteristics” in effort to develop realistic goals (Arya 2004, 250). Arya suggests that this particular model may be relevant to organizations, like PHR-I, that often decide whether or not to work on particular issues solely on the basis of ‘gut feeling’ as this categorisation may help these organizations understand what their limitations and capacities are (Ibid).

It is important to acknowledge however, that while the *Peace through Health Working Model* is a more comprehensive approach to exploring the role of health organizations in regions of conflict, it still represents *one* framework, and there will likely

never be just one. Rather, because of the contextual considerations and the variations across conflict regions, a single tool will never be able to sufficiently provide a complete and comprehensive understanding of an organization's peace-building impact. As such, when I approached PHR-I with the 10 mechanisms of PtH, I presented them quite simply as a general guideline in which to explore Peace through Health. I was genuinely open to see all or none of the mechanisms reflected in their work. In response, PHR-I approached the framework with caution, and later a Palestinian partner suggested that "the difference between PHR-I and other organizations is that it is not about items on a list." This is particularly relevant, as this study did not seek to find a single framework for understanding the inter-connectedness of health and peace. It was not my intention to generalize. In fact, truth lies in particulars, and the case study was instrumental in exploring Peace through Health in the *context* of the Israeli-Palestinian conflict and *within* Physicians for Human Rights-Israel.

A framework, if one is to use one at all, must be adapted to the local situation. Many organizations may have developed their own mechanisms and benchmarks or may be resistant to using a Western approach. In fact, "the uniqueness of each project and the fluidity of their environments conspire to frustrate attempts to impose a rigidly uniform framework" (Bush 1998, 1).

It was important, then, that when introducing the framework of Peace through Health to PHR-I, I allowed each participant to reflect on their work in relation to each mechanism, exploring how it did *or* did not manifest in their work. They were invited to explore other mechanisms, or speak directly to any links between health and peace as well. Overall, the mechanisms proved to be a good tool to explore Peace through Health

within the organization. Participants considered the relevancy of each mechanism and questioned those that conflicted with their objectives.

Aside from the 10 mechanisms identified and explored in the previous chapter, however, PHR-I continually highlighted the importance of justice. As one participant explained: “Peace above all is making justice, so in that sense, I think PHR-I can contribute to peace. We have a lot to say about creating a more just society and maybe that is how we contribute to the process of peace.” Another participant thought that looking at justice through the prism of health was a very focusing element, as it introduced critical topics of oppression and victimhood. This particular argument was presented whole-heartedly by one of PHR-I’s Palestinian partners who firmly believes that justice precedes peace.

You can not have peace without justice. These mechanisms contribute to *justice* and to hide the issue of justice under peace is problematic. Peace may be sexier, but justice takes you to the root of the problem. When the occupation ends, then, it may be worthwhile to talking about peace.

Justice and peace then, are not necessarily synonymous. When I talk about peace, *my* definition includes the very aspects of justice – equal opportunity, shared power, a fair distribution of resources – but this is not about me. As Edward Said wrote: “Now that Oslo has clearly been proven the deeply flawed and unworkable ‘peace’ process that it really was from the outset... ‘Peace’ is now a discredited and fraudulent word... Can one continue to use the word ‘peace’ without hesitation? It is impossible” (Said 1998). In fact, PHR-I highlighted that while some of the mechanisms were relevant to their work, the language of Peace through Health was often polarizing. In the article *Alice Through the Looking Glass*, Bush draws from a passage in the film *Alice in Wonderland* to highlight the power of language (2005, 1):

“When *I* use a word,” Humpty Dumpty said, in a rather scornful tone, “it means what I choose it to mean. Neither more nor less.”

“The question is,” said Alice, “whether you *can* make words mean so many different things.”

“The questions is,” said Humpty Dumpty, “who is to be master. That is all.”

Language is divisive and in conflict settings, we are encouraged to pick and choose our words carefully. Often however, it is those who are in the dominant positions of power that choose the discourse. In fact, in some situations, the terms ‘peace’ or ‘peace-building’ may not be appropriate; rather, talking about ‘building unity’ or ‘building harmony’ may be more acceptable (Bunde-Birouste et al. 2006, 6). When approaching communities with Peace through Health, it is important not to get caught up in the word ‘peace.’ It is important that we remember that there may be a well-developed language of peace that may not even include that very word.

Peace through Health and Evaluation

One of the major shortcomings of Peace through Health stems from the challenges of evaluation. As an emerging field, PtH does not enjoy the benefits of a wealth of literature and a plethora of knowledge within its field; rather it is still evolving, creating its own unique direction, while also drawing from other disciplines, like Public Health, to complement its work. One of its main challenges is that Peace through Health aims to simultaneously improve the outcomes of peace *and* health, thereby requiring an evaluation tool that addresses the impact of an organization’s work on both of these areas. And while the evaluation of health interventions is a well-developed area, the evaluation of peace outcomes is still novel. There are multiple factors that can simultaneously affect a conflict situation, from civil society movements to the influx of

international aid. These factors, among others, can create confusion for organizations that are trying to evaluate the impact of their work in a conflict setting. PHR-I echoes this sentiment: “In terms of our objectives that are beyond the scope of the individual – ending the occupation, changing the immigration policy of the state of Israel, equality inside the state of Israel – we are only a small part of a bigger puzzle. We are part of civil society... It is a whole social process.”

Nevertheless, Peace through Health continues to be challenged by academics and field practitioners for being a laudable, but unrealistic concept that requires much more than ideology; Peace through Health needs evidence (Vass 2001, 1020). In response, many academics within the field have answered this call with systematic evaluation tools that can assess the impact of health and development initiatives have on conflict-affected regions,²⁰ yet recent research by a student at McMaster University found that the solution to the challenges of evaluation “are unlikely to be found in existing literature on evaluation of peace outcomes from peacebuilding and conflict resolution practice” (Farrell 2005, 80).

Furthermore, many members of PHR-I questioned the approach of evidence-based evaluations in general: “I am not sure an evidence-based approach is the best method for this kind of work. We do this work because we can’t do otherwise and not because there is an evidence base. I think that we must try and change and seek how can

²⁰ The Peace and Conflict Impact Assessment is a framework for understanding the impact that development projects that take place in conflict-prone regions have on the "peace and conflict environment" (Bush 1998, 6). The Health and Peacebuilding Filter is designed to provide rapid assessment of peacebuilding and conflict prevention components of health initiatives in conflict-affected societies (Bunde-Birouste et al 2006, 1).

we do better, but I wouldn't approach the question of peace, the way we approach a physician about the question of treatment. It is much more complicated than that.”

This is not to say that evaluation should be ignored, and many participants agreed that it is a critical component of program management:

As an organization, we are trying to evaluate our successes and failures, but this is challenging. Did we fail because the objective conditions are impossible or did we fail because we are not doing adequate work? We are trying to find ways, but it is very difficult because we really think the objective of ending the occupation is difficult to quantify. Do we measure with the number of media publications? Do we measure it with the number of patients who have access to health care? Do we measure it with our influence on public policy? All of this is true, but we do not yet have a good way to measure these.

Even when the objective of the program is evident to all members of the organization, the way to evaluate the impact of the work is extremely difficult as it often involves personal opinions, narratives, public sentiment, and other subtle perceptions and attitudes that are hardly quantifiable. For example, the Executive Director of PHR-I suggested that often the successes and failures of PHR-I can not be measured or even seen in any real or tangible way:

What I know is that anyone who either works or volunteers with PHR-I is transformed. They are not the same person. They see things differently. It is not just about 'me' and how I can keep power for 'my' people, but it is about other societies and other communities. The second thing is that when I, along with other PHR-I members, meet Palestinians, I feel that we are better received than other organizations and the dialogue is more honest. I won't say that it is completely honest or completely open, but it is different and far more personal.

Participants did feel that PHR-I's programs should be evaluated, but were genuinely unsure of how an organization like itself could even begin to measure its impact. One participant stated, “I think it is really ridiculous to look for evidence... There are so many things that can contribute to these conditions - mass movements, human

rights organization, international pressure, and so on. It is hard to analyze it and say what exactly brought it to a certain result.”

All participants felt that despite the fact that there is not a strong evidence-base for their work, and for Peace through Health in general, they are, in a sense, morally obligated to continue: “We do not think that just because we can’t put forward evidence that this is not the best way. We do it because we are politically and morally obliged.”

Similarly, one participant referenced a quote in the novel *The Plague* by Albert Camus:

...a fight must be put up, in this way or that, and there must be no bowing down. The essential thing was to save the greatest possible number of persons from dying and being doomed to unending separation. And to do this there was only one resource; to fight the plague. There was nothing admirable about this attitude; it was merely logical (1948, 128).

Furthermore, one participant felt that while an evidence-base might be imperative when determining whether or not the medical international community should intervene in a specific conflict, those who are doing it from their own community have other kinds of considerations to take into account: “We don’t have any other choice. We don’t have any other address. I don’t think we would be doing this work if we thought that there was no chance for human rights. So we still believe that we have work that should be done and can be done here.”

PtH Mechanisms and PHR-I

The 10 mechanisms of Peace through Health help to lay the foundation of this emerging field, and while they were not developed specifically for evaluation purposes, the participants of the focus group were asked if they thought that these mechanisms could help to support their work in terms of program planning, managing, and/or

evaluating. Overall, participants felt that while the mechanisms provided “an interesting conversation and thoughts for reflection,” they did not feel that the PtH mechanisms or the framework of Peace through Health in general was particularly useful for PHR-I. One participant explained: “We can benefit from this framework, but if we are talking about planning or creating program objectives, I am not sure if I would use these mechanisms, rather I look at the reality and understand what are the needs and I act from that.” One participant stated that Article 14 of the International Covenant on Economic, Social, and Cultural Rights is what frames PHR-I’s work, and that the organization uses its own benchmarks and indicators; but in terms of a specific tool for evaluation, PHR-I does not have such a thing. “I don’t think we have an evaluation tool or a framework like this and I don’t know if we should,” stated another participant.

Finally, the strongest theme that emerged around the PtH mechanisms is that while the majority of participants all felt that PHR-I was fulfilling, in some capacity, some of the mechanisms within the framework, they questioned how this actually contributed to peace-building. The argument, as highlighted previously, is that while PHR-I is, in fact, fulfilling some of these mechanisms, without the support from the public and a responsive and brave government, none, or all, of these mechanisms can actually end the occupation. PHR-I can see the success of its work reflected in the individuals it reaches out to and the response it receives from Palestinian communities, but the effects of its work on a larger peace-building process is unseen. Consider this excerpt from an interview with one of the Project Coordinators of the Occupied Territories Project:

Project Coordinator – I cannot consider our work as peace. We demand equal rights, but I can not see the connection to peace.

Researcher – Do you think there is an indirect connection?

Project Coordinator - In general, PHR-I wants peace and supports the peace process. We also call for negotiations, but not in our daily work. In our daily work we mostly concentrate on how to attack the Israeli mechanism and how to give humanitarian help and advocate for individual cases. We criticise government policies, but how it contributes to peace. I don't understand.

Researcher – Do you think these actions can influence the Israeli public opinion?

Project Coordinator - We are trying to impact the public opinion by demanding Israeli responsibility for the health of the Palestinian people, but I cannot see how the things we are doing contribute to peace. Again, I am sorry. I don't see myself as a peace worker, no. I see myself as someone who fights the occupation through the medical point of view.

This suggests that the real obstacle to the success of PHR-I's work is quite simply the fact that the conflict has not yet reached a stage of cessation, rather it is ongoing and “there is little evidence that Peace through Health interventions [are] successful during acute conflict” (Buhmann 2005, 309). One participant explained, “The problem is that PHR-I does not agree with the decision makers. We can support the peace process, but when it comes to practice, they are not speaking about East Jerusalem and the right of refugees... We are outside the consensus.”

The amount of international aid that has made its way into Israel and the occupied Palestinian territories under the umbrella of peace work over the last forty years is undoubtedly great, yet all the initiatives taking place “should be adding up to more than it is. The potential of these multiple efforts is not fully realized” (Anderson and Olson 2003, 10). PHR-I does not currently have any formal evaluation process, despite the fact that the organization feels that evaluation is an important component of program management. The problem of ‘how’ continues to hinder the process of evaluation. Clearly, the evaluation of peace outcomes is difficult as it is “essentially contextual and dependent on the surrounding environment” (World Health Organization 2002b, 5).

Nevertheless, PHR-I has no illusion that its efforts alone can create peace. “You can not measure how our specific organization and our specific issue of health can contribute to peace because even if we succeed in meeting our objectives, we don’t know how much of it was us. There are other factors.” My findings suggest that in the context of the Israeli-Palestinian conflict, the contribution that health can make to peace-building, at present, is small and exceedingly difficult to measure because of this very multi-track approach. Each sector can make its own individual contribution, but each contribution will not invariably produce peace. In fact as PHR-I continually noted, its contribution to peace was questionable.

5.2 Conclusions

In using a single qualitative instrumental case study of PHR-I, my research did not seek to generalize to other situations, but rather it sought to answer the questions: *Is Peace through Health an appropriate peace-building response in the context of the Palestinian-Israeli conflict? How are the 10 mechanisms of Peace through Health reflected in the work of Physicians for Human Rights-Israel? And how can Peace through Health be evaluated in regions of intractability to provide evidence for this emerging field?*

In terms of the former, my research suggests that PtH is, in fact, an appropriate response, if a) importance was placed on the political dimension and b) understood in the context of a multi-track approach. Peace through Health is one of the *many* sectors that can contribute to peace, and to overestimate its individual impact would be to ignore the many other factors that would have to be in place if peace is to be realized.

“Peacebuilding is an organic system... No one activity and no one level will be able to deliver and sustain peace on its own” (Lederach 1999, 30). As a unique sector of this very system, Peace through Health has the distinct ability to bridge a genuine link between health and peace, yet Peace through Health cannot afford to ignore politics and in this case study, PHR-I illustrated how critical it was to the credibility and functioning of the organization to take a political stance. In the context of the Israeli-Palestinian conflict, neutrality can be seen as silence, where not taking a position against the occupation is equivalent to turning a blind eye to the violations that are taking place. A recent study by the Feinstein International Centre suggested that the way to be neutral in this conflict is to uphold international law consistently (Fast 2006, 32). PHR-I continually upholds Article 12 of the International Covenant on Economic, Social, and Cultural Rights, highlighting role of health organization in the promotion and protection of the right to health regardless of the perpetrator – Israeli and Palestinian alike.

In terms of the second research question, my research found that the while some of the 10 mechanisms of PtH were reflected in the work of PHR-I, others were not relevant to the organization’s activities. In particular, PHR-I questioned the use of superordinate goals due to the imbalance of power and the suspicion that often arises when these initiatives are proposed. Participants also questioned the mechanism of healing of trauma, citing the limitations of their work in the face of the ongoing conflict, as well as the limitations they face as an Israeli organization. Finally, in terms of PHR-I’s contribution to civic identity, the organization explained that the very nature of the conflict does not support this mechanism. Other mechanisms, however, were enthusiastically embraced, namely the mechanisms of dissent and non-cooperation,

discovery and dissemination of facts, solidarity and support, redefinition of the situation, and the contribution to human security. Furthermore, some mechanisms were received with uncertainty. The role of health organizations in diplomacy, mediation, and conflict transformation was viewed with scepticism, as the majority of participants stressed the fact that PHR-I is not a neutral organization and its role, in this sense, is limited by its strong political stance against the occupation. Finally, while the mechanism of evocation and extension of altruism was evident within PHR-I, some participants questioned the argument that the field of health was by nature altruistic, as they cited examples of physicians participating in torture within Israel and other countries. In brief, participants highlighted that despite the fact that PHR-I does embrace some of the 10 mechanisms, the central message was that the impact the mechanisms could have on peace was limited by the very political context of the Israeli-Palestinian conflict.

Finally, in response to the last question my research sought to answer, *how can Peace through Health be evaluated in regions of intractability to provide evidence for this emerging field?* My findings suggest that the contribution that health can make to peace-building, at present, is small and exceedingly difficult to measure because of the multiple factors that can contribute to peace-building. The question of ‘how’ continues to hinder the process of evaluation as PHR-I challenges the evidence-based approach and highlights that its activities are based on a real sense of moral and political obligation.

5.4 Areas of Further Research

Further research is needed to explore the impact of health organizations, like PHR-I, that take a political stance. How has their position impacted their activities, their

objectives, and their image? We must fully examine the question Jabbour posed: “*how would consideration of political realities reshape... peace-making efforts?*” (Jabbour 2005, 1211). For PHR-I it has created a sense of trust within the Palestinian community and contributed to building solidarity; however, it has pushed the organization outside of the Israeli consensus. In order to advance the understanding of how health organizations work in highly politicized environments, more research must focus on these organizations that risk ostracism within a particular population when taking a political stance. How does the Israeli community respond to PHR-I’s position? How does it affect their work with other Israeli organizations? These questions must be explored if we are to fully understand the impact of adopting political positions within Peace through Health.

Finally, in terms of the evaluation of Peace through Health, more research must focus on local knowledge and local practices. What are PHR-I’s benchmarks? How do health organizations measure the impact they have on peace? If organizations don’t use an evidence-based approach, how do they evaluate their impact on peace? The evaluation of Peace through Health is in its infancy and more research is needed that examines less the ideological underpinnings and more the realities that are found within the field itself.

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APPENDIX I: SEMI-STRUCTURED INTERVIEW DESIGN

(Estimated Time 1 hour)

OBJECTIVES:

- To introduce PtH and its mechanisms
- To uncover the relationship between PHR-I and PtH.
- To discover PHR-I's understanding of PtH within the context of the Israeli-Palestinian conflict

PART 1: INTRODUCTION

Estimated Time – 10 minutes

I will take a few minutes to again introduce myself and my interest in PHR-I. At this point, all participants will have signed the consent form, but I will again highlight that participation is voluntary and that participants are welcome to leave at anytime. I will also reiterate that the interview will be tape-recorded for my research purposes and that they will be transcribed for my research purposes. At that time, participants will be asked to review the transcripts for their accuracy. Following the completion of my Masters research, the transcripts, tapes, and notes will be held in a locked cabinet for one year and then destroyed.

PART II: INTERVIEW QUESTIONS

Estimated Time – 40 minutes

The questions below will be asked to the interview participants:

- 1) PtH within PHR-I
 - i. How do you see PHR-I operating in a way that embraces aspects of PtH?
 - ii. Do any of the mechanisms of PtH have significance to the operation of PHR-I?
 - iii. Are there any current PHR-I projects that highlight any of these mechanisms?
- 2) PtH as an appropriate peacebuilding response
 - i. Would you have any concerns, on behalf of PHR-I, about identifying with PtH?
 - ii. Do you feel that identifying with PtH could be helpful in terms of program design and implementation?
 - iii. What restrictions/limitations are there to identifying with PtH?
 - iv. Is PtH a likely response in the context of the Israeli-Palestinian conflict?
 - v. Are the mechanisms identified fitting in conditions of conflict?
 - vi. Can you think of any other mechanisms that would better describe the work of PHR-I in terms of peace-building? Do any of these mechanisms not fit with the goals of PHR-I?
 - vii. Could PtH be a workable concept in practice in the context of the Israeli-Palestinian conflict?
 - viii. What challenges are there in attempting to use PtH?
 - ix. How is the current environment conducive or hostile to PtH?

PART III: CLOSING COMMENTS

Estimated Time - 10 minutes

Participants will be invited to openly discuss any questions or topics related to PtH.

APPENDIX II: FOCUS GROUP INTERVIEW DESIGN

(Estimated Time 2 hours)

OBJECTIVES:

- To introduce PtH and its mechanisms
- To uncover the relationship between PHR-I and PtH.
- To discover PHR-I's understanding of PtH within the context of the Israeli-Palestinian conflict

PART I: INTRODUCTION

Estimated Time – 10 minutes

I will take a few minutes to introduce myself and my interest in PHR-I. At this point, all participants will have signed the consent form, but I will again highlight that participation is voluntary and that participants are welcome to leave at anytime. I will also reiterate that the focus group will be tape-recorded for my research purposes and that they will be transcribed for my research purposes. At that time, participants will be asked to review the transcripts for their accuracy. Following the completion of my Masters research, the transcripts, tapes, and notes will be held in a locked cabinet for one year and then destroyed.

PART II: PEACE THROUGH HEALTH AND ITS MECHANISMS

Estimated Time – 20 minutes

The 10 mechanisms of PtH as identified by the Centre for Peace Studies at McMaster University will be written on a large sheet of paper and posted on the wall for all participants to see. A discussion around the mechanisms, including an explanation of each mechanism will take place. Participants will be invited to think about the work of PHR-I as I explain the mechanisms.

PART III: FOCUS GROUPS QUESTIONS

Estimated Time - 75 minutes

The questions below will be asked to the focus group.

- 3) PtH within PHR-I
 - i. How do you see PHR-I operating in a way that embraces aspects of PtH?
 - ii. Do any of the mechanisms of PtH have significance to the operation of PHR-I?
 - iii. Are there any current PHR-I projects that highlight any of these mechanisms?
- 4) PtH as an appropriate peacebuilding response
 - i. Would you have any concerns, on behalf of PHR-I, about identifying with PtH?
 - ii. Do you feel that identifying with PtH could be helpful in terms of program design and implementation?
 - iii. What restrictions/limitations are there to identifying with PtH?
 - iv. Is PtH a likely response in the context of the Israeli-Palestinian conflict?
 - v. Are the mechanisms identified fitting in conditions of conflict?
 - vi. Can you think of any other mechanisms that would better describe the work of PHR-I in terms of peace-building? Do any of these mechanisms not fit with the goals of PHR-I?
 - vii. Could PtH be a workable concept in practice in the context of the Israeli-Palestinian conflict?

- viii. What challenges are there in attempting to use PtH?
- ix. How is the current environment conducive or hostile to PtH?

PART III: CLOSING COMMENTS

Estimated Time - 15 minutes

Participants will be invited to openly discuss any questions or topics related to PtH.

APPENDIX III: PARTICIPANT CONSENT FORM

Institute for Dispute Resolution
MADR Program
Fraser Building, Room 123
Box 2400, Stn CSC
Victoria BC V8W 3H7
Canada
250.721.8777

Participant Consent Form

Peace through Health: A Case Study of Physicians for Human Rights-Israel

You are invited to participate in a study entitled *Peace through Health: A Case Study of Physicians for Human Rights-Israel* that is being conducted by Judy Kitts, a graduate student in Dispute Resolution at the University of Victoria. You may contact Judy Kitts if you have further questions at 0526562475(kittsjl@uvic.ca).

As a graduate student, I (Judy Kitts) am required to conduct research as part of the requirements for a degree in Dispute Resolution. It is being conducted under the supervision of Dr. Budd Hall. You may contact my supervisor at bhall@uvic.ca or 001.250.721.8474. In the event of any issues that may arise in the conduct of my research at PHR-I, please also feel free to contact Miri Weingarten from PHR-I at 0546995199 (miri@phr.org.il)

Purpose and Objectives

In recent years the Israeli-Palestinian conflict has been framed as a public health problem, “highlighting the role of health workers in preventing and mitigating destructiveness” (MacQueen and Santa Barbara 2000, 293). The purpose of exploring Peace through Health (PtH) within Physicians for Human Rights-Israel (PHR-I) is to provide information concerning the applicability of PtH within the context of the Israeli-Palestinian conflict and to uncover and assess the evaluation tools and methods that have been created to demonstrate the link between peace and health. Research that draws the links between PtH and PHR-I is necessary to help build the evidence base of PtH.

This research, through focus groups, interviews, document/literature analysis, and direct observation, will help to contribute to the evidence of this growing field by contributing to the collection of data concerning the existence of these programs, the effectiveness, and the tools PHR-I uses to evaluate their work. The observations that are drawn from the thematic analysis of the data harvested from the Physicians for Human Rights-Israel will provide insight on how health can influence peace in the context of a seemingly intractable conflict. These observations will allow me to provide suggestions that can be applied to refine the activities of current health organizations that are working in regions of conflict. Finally, in documenting the features of evaluation in PtH in this context, I can offer a series of recommendations concerning evaluation and assessment tools. These recommendations can be presented to the community of PtH in the form of publication.

The research question is: *Is Peace through Health an appropriate and viable contribution to the larger peace-building processes in the context of the Palestinian-Israeli conflict, and if so, how has it been evaluated to provide evidence of this emerging field?*

Participants Selection

You are being asked to participate in this study because in order to answer the research question about Peace through Health in regions of conflict, it is necessary to recruit participants who work directly in the field of health within this context. As a member of PHR-I, you have the knowledge, expertise, and experience needed to explore Peace through Health within the organization.

What is involved?

If you agree to participate voluntarily in this research, **your participation will include the participation in a focus group of approximately three hours. If you consent, your participation will also include a one-on-one interview that will not exceed one hour.**

I consent to participate in the focus group

I consent to participate in an interview

I consent to participate in the focus group and an interview

I will record the interviews and focus group (audio only, not video) to create a complete record of data and I will also take notes about my impressions of the interviews and focus group in terms of non-verbal communication. During my direct observation of the programmes I will only take notes that keep programme participants' identities confidential due to potential confidentiality issues. I will track reactions and responses using a system that allows me to identify individuals for research purposes, but keeps their identity confidential for the purposes of writing my thesis.

Giving the sensitive nature of PtH, member validation will allow all participants to review the transcripts for verification. Since data collection and analysis will be conducted in an iterative mode, observations may often trigger new interpretations, which again could lead to a new question and/or possibly a new stakeholder.

Inconvenience

Participation in this study may cause some inconvenience to you, including devoting time to the research (i.e. interview and/or focus group).

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

The potential benefits of your participation in this research include benefits to you as a participant, PHR-I, and the emerging community of Peace through Health. You may benefit from the information provided during the focus group about Peace through Health; PHR-I will benefit from an external assessment of PHR-I's programs in terms of Peace through Health and a list of

recommendations concerning the evaluation of these programs; and this project will add to the overall body of knowledge of how health can influence peace in the context of a seemingly intractable conflict. These observations will allow me to provide suggestions that can be applied to refine the activities of current health organizations that are working in regions of conflict. Finally, in documenting the features of evaluation in PtH in this context, I can offer a series of recommendations concerning evaluation and assessment tools. These recommendations will be presented to the community of PtH in the form of publication.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. Should a participant choose to withdraw at any point the research obtained through their participation in the study will only be used if the individual gives their consent to use the materials already acquired. If they require that their involvement in the study be removed completely, all documentation (both audio and written) that includes the participant will be destroyed and all data that has been acquired from the participant will be removed from the study. Options for use of the data will be offered such as using only parts of data collected, withdrawing contributions entirely, or to make references to individuals more general. The participant will then sign a document agreeing to limited and specific consent.

To make sure that you continue to consent to participate in this research, I will verbally recap the details of your consent and the voluntary nature of your participation at each stage of your participation (focus group and interview). By signing this consent form, you are giving consent to both stages of participation outlined above.

Anonymity

Anonymity means that no one, including the researcher, is able to associate responses or other data with individual participants. In this case anonymity will be limited during the data-gathering phase of my research as the methods of data collection (focus groups and interviews) will compromise your anonymity.

Confidentiality

Confidentiality means the protection of the person's identity (anonymity) and the protection, access, control and security of his or her data and personal information during the recruitment, data collection, reporting of findings, dissemination of data (if relevant) and after the study is completed (e.g., storage). In terms of confidentiality, I will use pseudonyms and change identifying information and features in any written reports or publications and oral presentations. Tapes and transcripts will not be labelled in ways which could compromise anonymity, and identifying information (such as contact information) will be stored separately from the data.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: presentations at scholarly meetings; publication to University of Victoria's online thesis database; dissemination of my Masters thesis; publication as an article; and public access by providing Physicians for Human Rights with a copy of my thesis.

Disposal of Data

Data from this study will be disposed of following two years after completion of my Masters in Dispute Resolution by erasing electronic and audio data, and shredding paper copies.

Contact

In addition to being able to contact the researcher and the academic supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria at ethics@uvic.ca.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.