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## Mental health, social distress and political oppression: The case of the occupied Palestinian territory

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This paper presents a brief history of Palestinian mental health care, a discussion of the current status of mental health and health services in the occupied Palestinian territory, and a critique of the biomedical Western-led discourse as it relates to the mental health needs of Palestinians. Medicalising distress and providing psychological therapies for Palestinians offer little in the way of alleviating the underlying causes of ongoing collective trauma. This paper emphasises the importance of separating clinical responses to mental illness from the public health response to mass political violation and distress. Palestinian academic research reframes the mental health paradigm utilising an approach based on the broader framework of social justice, quality of life, human rights and human security. Recognising social suffering as a public mental health issue requires a shift in the emphasis from narrow medical indicators, injury and illness to the lack of human security and human rights violations experienced by ordinary Palestinians. Such a change in perspective requires a parallel change in mental health policies from short-term emergency humanitarian aid to the development of a sustainable system of public mental health services, in combination with advocacy for human rights and the restoration of political, historical and moral justice.

**Keywords:** mental health; occupied Palestinian territory; social suffering; trauma; political oppression

### Introduction

The dominant international discourse on mental health tends to be biomedical, where mental health is viewed as conceptually analogous to physical ill-health and, hence, amenable to a scientific, positivistic line of enquiry. Despite some acknowledgement of the role of cultural and socio-economic factors, these are seen as secondary influences rather than as fundamental to the discussion about how 'mental health or ill-health' might be expressed and understood in a particular society or situation.

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Although a critique of the biomedical approach to health and disease among Palestinians under Israeli military occupation had been put forth as far back as the 1980s (Giacaman 1989), such a critique, focusing on the mental health of a captive and chronically traumatised population, emerged relatively recently (Giacaman 2004, Afana *et al.* 2010). A core question is the extent to which a Western-led discourse can contribute to a realistic understanding of mental health and adequate planning of services in the occupied Palestinian territory (oPt), with its specificity of history, cultures, and prevailing socio-economic and political conditions.

This paper presents a brief history and current status of mental health in the oPt (the West Bank, including East Jerusalem and the Gaza Strip) and seeks to reframe Palestinian mental health utilising an approach based on the broader framework of human rights and social justice, instead of a focus on medical indicators alone. It calls for a shift from international aid policies based on medical mental health determinants and outcomes, to policies which combine a public health approach to mental health with international advocacy for human rights and justice.

### **A brief history of mental health in Palestine**

Whilst the history of mental illness in European societies is characterised by condemnation and exclusion (Murad and Gordon 2002), Arab societies have long had a tradition of caring for the mentally ill in hospitals and in the community. Until the early twentieth century, the primary responsibility for mentally ill people rested with families. Those who were non-violent were allowed to walk the streets and were confined at home only when violent. With the advent of British and French colonialism, this tolerant local approach towards mental illness appears to have been gradually eroded. The introduction of colonial psychiatry – beginning with the British Mandate over Palestine of 1920 – ushered in an era of more coercive practices (Keller 2001).

As happened elsewhere during the colonial era, the theory and practice of psychiatry focused on the ‘indigenous mind’ and its supposed deficits, rather than on the effects of political and racial oppression. In Palestine, the British administration opened a government mental hospital in Bethlehem in 1922 and established a system ‘to admit lunatics to asylums’ (Government of Palestine 1922, p. 70). Asylums and prisons began to serve similar functions with the locking up of the mentally ill as criminals (Keller 2001). Between 1950 and 1967, when the West Bank was annexed to Jordan and the Gaza Strip was placed under Egyptian administration, European psychiatry continued to shape policy on the mentally ill (personal communication with Dr Antoine Dabdoub, 22 April 2005).

With the military occupation of the West Bank and Gaza Strip in 1967, Israel became responsible for the health and welfare of the population there. Yet, the Israel Mental Health Act was not applied to the oPt, and only from the late 1970s, limited psychiatric outpatient services were provided to the population under military occupation (State of Israel, Ministry of Health 1985, p. 69J). Despite the increasing influence of European psychiatry, indigenous understandings persisted, albeit with adjustment to new social realities. For example, up to the 1980s, the inhabitants of Ramallah district villages continued to synthesise new biomedical approaches with traditional beliefs, including ideas about healing based on the need to rid the sick person of evil spirits (Giacaman 1988).

The next significant development in the mental health paradigm related to the oPt marked an expansive shift of focus away from mentally ill patients, towards the mental health or ill-health of the Palestinian population as a whole. Until the 1980s, the mental health of war-affected Palestinians, including refugees, had received little attention from health practitioners and humanitarian aid providers. However, in the context of the first Palestinian uprising (first *intifada*) in the late 1980s and the accompanying media attention to Israeli military violence, the emphasis on psychological ‘trauma’ increased, and subsequently became a major concern of international mental health initiatives. This reflected the export of Western cultural trends towards the medicalisation of distress and the rise of psychological therapies. Terms like ‘post-traumatic stress disorder, PTSD’, ‘psychosocial’ and ‘counselling’ rapidly became points of reference in this new realm of humanitarian concern (Summerfield 1999).

In one sense, this ‘trauma’ discourse offered Palestinians the possibility of highlighting causative factors previously rendered semi-invisible: the sociopolitical condition of the Palestinian people and the collective traumatogenic nature of Israeli military occupation and repression (Punamäki 1990). On the other hand, a medicalised response to trauma risked obscuring the social and political meaning attributed by Palestinians themselves to their collective experiences. Despite the contradiction involved, the trauma discourse was adopted as a means of drawing international attention to the distress resulting from political oppression. However, ‘trauma’ treatment in the form of individual counseling and psychotropic medication offered little in the way of alleviating the underlying causes of ongoing collective trauma.

While international agencies adopted Western-designed trauma programmes as a core treatment model in the oPt (Giacaman 2004), Palestinians themselves continued to rely on family support and community intervention. The importance of culturally appropriate responses to trauma has, in recent years, come to be widely accepted as a protective factor in conditions of chronic conflict. After the Oslo Accords in 1993 and the establishment of a Palestinian authority in the oPt, the urgency of care for severe mental disorder was recognised by the newly established Palestinian National Authority Ministry of Health (1997, 1998). But the first quantitative data on mental disorder in the annual reports appeared only after the outbreak of the second Palestinian uprising (second *intifada*) in 2000.

### **Epidemiology of mental disorders**

The annual health reports published by the Palestinian Authority (PA) from 2001–2005 indicate increases in most mental disorder categories (see Table 1). These reports cover the years of the second *intifada* characterised by the intensification of Israeli military occupation measures including the building of the separation wall, extensive land confiscation, the increase in the number of army checkpoints and the siege of the Gaza Strip. Yet, it is unclear whether the upward trends are due to real changes, including those wrought by the violence and social damage caused by Israeli occupation, or due to changes in the methods of gathering information and coverage. For instance, it is known that the prevalence of affective disorders such as depression is dependent on social, economic and political conditions (Zimmerman and Katon 2005). Thus the increase in affective disorders and neurosis may reflect the deterioration of Palestinian life due to increased Israeli sieges, shelling, targeted

Table 1. Incidence rate of reported new cases of mental disorders in the occupied Palestinian territory (oPt) per 100,000 inhabitants.

Mental disorder	2001	2003	2005
Epilepsy	7.5	5.2	10.4
Schizophrenia	7.3	3.8	9.3
Mental retardation	6.8	10	13.4
Affective	5.5	7.4	10.2
Neurosis	5.3	5.1	10.3
Other	4.7	6.3	1.5
Personality disorders	1.9	1.2	1.4
Addiction	1.2	1.5	1.8
Organic	0.9	2.1	3.8

Source: Palestinian National Authority Ministry of Health (2002, p. 64); State of Palestine, Ministry of Health, Palestinian Health Information Center (2004); Ministry of Health – Palestinian Health Information Center (2006, p. 26).

killing and restrictions of movement. Increase in the prevalence of epilepsy, a neurological disorder, may be attributed to obstacles in early detection and optimal treatment due to military sieges and other collective punishment measures. However, it is also possible that incidence figures vary because of a gradually improving reporting system.

Epidemiological studies in the Gaza Strip found women and families lacking support from relatives and community to be more vulnerable to anxiety when exposed to military violence (Punamäki *et al.* 2005a, 2005b). Some studies indicate poorer mental health outcomes in populations exposed to war and disasters, and a strong relationship between losses of family members and distress (Mollica *et al.* 2001, Cardozo *et al.* 2004). A study comparing mental health status in four war-affected societies, including the oPt, Algeria, Burma and Ethiopia, found strong associations between military atrocities and losses and psychiatric distress (de Jong *et al.* 2001). Increased risk of mental health problems was also found among injured young Palestinians (Khamis 2008) and children experiencing family loss and home demolition (Khamis 2005) during the second intifada.

### Mental health services

The PA's Ministry of Health inherited from the Israeli military administration health services that had been neglected and starved for funds during the years of Israeli occupation (Giacaman *et al.* 2009). Mental health was particularly neglected. While the Palestinian Ministry of Health, with support from the World Health Organization (WHO), is continuing to make attempts to expand services beyond the hospital, most services continue to be hospital-based, fragmented and rooted in a biomedically oriented approach (WHO, West Bank and Gaza Office 2006).

Currently, the Palestinian Ministry of Health (2006, p. 35) operates two psychiatric hospitals, one in Bethlehem with 280 beds serving the West Bank, and another in Gaza City with 39 beds serving the Gaza Strip. These hospitals have dominated in formally providing for the mentally ill, with community services remaining patchy. In 2004 the Ministry was operating 13 mental health outpatient

clinics, nine on the West Bank and four in the Gaza Strip. The mental health department of the Ministry of Education and Higher Education assures the presence of school counsellors on a full-time or half-time basis to all public schools. In addition, the United Nations Relief and Works Agency (UNRWA) has been running a mixture of mental health and counselling services within the health and school system in the West Bank and Gaza Strip with programmes fluctuating in response to the vagaries of funding (Steering Committee on Mental Health 2004).

By 2006, a total of 42 outpatient mental health facilities were reported as being operational, serving around 33,000 patients, and included a mix of service providers (governmental, non-governmental and private). The oPt thus provides an illustrative case of the implementation of the medicalised Western paradigm for addressing mental health problems, often at the expense of local and collective healing practices, and failing to recognise and promote resilience. Whilst there have been some improvements, including the development of a mental health policy for the West Bank and Gaza Strip in 2002–2003 (WHO and Ministry of Health, Palestinian National Authority 2006), supported by WHO and other international donors, the system continues to suffer from funding shortfalls. In 2006, there was no specific budget for mental health services in the oPt – an estimated 2.5% of the PA health care expenditures was used for mental health, the bulk of it going to the two psychiatric hospitals. The oPt also continues to suffer from a shortage of trained mental health professionals, with 0.87 psychiatrists (32 in all), 3.43 psychiatric nurses, 0.98 psychologists and 0.21 occupational therapists per 100,000 people in the oPt. Currently, none of the psychiatrists is working exclusively within the PA mental health services.

While the Ministry of Health and WHO are trying to develop a sustainable mental health system in the oPt, at least six international non-governmental organisations either independently or in cooperation with local groups continue to concentrate primarily on Western-style therapeutic intervention regarded by many international organisations as a universal panacea for traumatic experiences, regardless of context and geography. This treatment modality assumes that the pathological effects of war are located inside a person, and can be cured through individual treatment, as if the individual was recovering from an illness rather than suffering from the long-protracted consequences of historical and contemporary political injustice (Summerfield 2002). Yet the fact remains that for many Palestinians, one-to-one counseling is an imported and culturally unfamiliar practice. A household survey completed in the Gaza Strip in the immediate aftermath of the Israeli attack of 8 December to 9 January indicates that only 1% of respondents (representing all adults in the Strip) felt that they needed to talk to professionals about their problems and worries, with the majority preferring to talk with family and friends (UNFPA and FAFO 2009).

### **Social suffering and collective disaster**

The Palestinian narrative of social suffering and political injustice invariably starts with the *nakba* (catastrophe), the events surrounding the creation of Israel in 1948. The disastrous consequences included the loss of much of Palestine – which had been predominantly Arab for over 1000 years – and the forced dispossession and dispersion of more than 700,000 refugees, nearly three-quarters of the Palestinian

population at the time to neighbouring Arab states (Pappe 2006). The 1967 Arab–Israeli war led to further losses, with Israel occupying the rest of historical Palestine. A further 180,000 Palestinians (Aruri 1984), who fled the violence to seek refuge in neighbouring Arab countries, were not allowed to return home. Between the 1967 war and the Oslo Accords of 1993, Israel as the occupying power became responsible for the health and welfare of Palestinians in the oPt.

The first uprising (*intifada*), from 1987 to 1993, represented the culmination of rising Palestinian popular resistance against the Israeli military occupation. Israel tried to maintain control with a series of increasingly repressive measures, which included school and university closures, house demolitions, deportations, land confiscations, mass arrests and the systematic use of torture during interrogations. Yet, the Israeli military was unable to contain the determination of unarmed civilians, including schoolchildren and adolescents, who mobilised and engaged in widespread grassroots movements that were predominantly non-violent. In the course of the first *intifada*, over 1500 civilians were killed (one-quarter were children), with many thousands injured (Gerner 1991).

The secretly negotiated Oslo Accords between the government of Israel and the Palestine Liberation Organization seemed to offer a glimpse of hope to a population exhausted by the intense resistance and repression of the previous years, but only for a brief period. The PA was in charge of a, albeit small, proportion of the West Bank and Gaza Strip as negotiation issues related to final borders, the return of the refugees and the status of Jerusalem were deferred for the coming years. This period was marked by an increase in international aid and a proliferation of international and non-governmental organisations assisting the newly established PA. The number of Western donors in the West Bank and Gaza Strip during these years ranged from 130 to 200 (Challand 2006). However, the years after the Oslo Accords passed by with little notable progress particularly on the main negotiation issues and with a continuation of Israeli colonisation of the West Bank and Gaza Strip. In September 2000, the second *intifada* erupted, fuelled by widespread discontent over the failure of the peace process to address accelerating Israeli settler colonisation of occupied Palestinian lands and to achieve progress on final negotiations, and by the shortcomings of the PA (Hammami and Hilal 2001).

Since then, the violent Israeli response to this second Palestinian *intifada* has led to even more difficult, dangerous and insecure living conditions for Palestinians. A network of hundreds of army checkpoints and road barriers, curfews, detentions, the indiscriminate use of lethal force against civilians, land confiscations and house demolitions has negatively affected the living conditions of practically every single Palestinian. More than 4800 people, overwhelmingly civilians, and including over 950 children, were killed by Israeli military action between 29 September 2000 and 12 June 2008 (B'Tselem 2008). Indeed, the monthly tallies of children killed by Israeli gunfire during the second *intifada* have, at times, doubled those of the first *intifada*, with large numbers being seriously wounded and disabled (Baker and Kanan 2003).

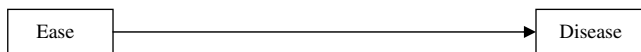
In defiance of international law, the Israeli decision in 2002 to construct the Separation Wall, was proclaimed as a means to secure Israel's borders. In fact, this has meant the confiscation of thousands of hectares of fertile Palestinian agricultural land, leading to the general worsening of economic conditions. By 2003, 59% of the West Bank and Gaza Strip population was living under a poverty line of US\$2.1 per day, with the number of poor having tripled during the 27 months following

September 2000 (The World Bank 2004). Although Israel withdrew its settlers from the Gaza Strip in the year 2005, it continues to maintain an iron grip on Gaza's borders, regularly closing them to the passage of people and goods, including medical supplies. The recent war on the Gaza Strip in December 2008 led to the deaths of more than 1300 Palestinians as well as scores of injuries and the devastation of infrastructures and homes. The continuing embargo of medical and building supplies into the Gaza Strip is inflicting untold hardship on an already impoverished population exposed to massive Israeli air strikes and bombing, including phosphorous bombs.

Six decades have passed since the *nakba* – there is now a third generation of refugees in the camps – without a just and viable solution for the Palestinian people. The mass trauma of successive wars, military occupation and life in refugee camps over the years has created a heavy dependence on international aid. In addition, Palestinian refugees, inside and outside the oPt, continue to rely on UNRWA for health, educational and other basic services. The heavy financial dependence on a multiplicity of donors with different agendas has contributed to an undermining of Palestinian attempts to build a health system out of existing services, including the mental health service.

Thus, framing the history and current situation of Palestinians within the discourse of social suffering calls into question the process by which the meanings and thoughts of Palestinians themselves have been stripped of their contextual validity. This delegitimisation is partly a consequence of reducing Palestinian experiences of violations and injustice to the prevalence of symptoms and the status of mental illness, which has the effect of further undermining the Palestinian call for justice.

Palestinian researchers have spent the past decade on the development of an alternative approach to mental health, which does not rely exclusively on medical symptoms, but which also links mental health to indicators of social well-being and quality of life (Giacaman *et al.* 2007, Mataria *et al.* 2009a). This approach places social suffering within an ease–disease continuum ranging from mental well-being to mental disease. Depending on context, the majority of Palestinians, who live in severe distress as they endure the suffering and trauma of chronic warlike conditions, are seen as oscillating in the grey areas between ease and disease.



Within this worldview, clinical and technical language fails to capture the range and nuances of experience related to an array of ill-health states. Ongoing research (Giacaman 2010) reveals that as Palestinians on the West Bank oscillate back and forth on an ease–disease continuum, local expressions and idioms describe a holistic state of health, encompassing both the physical and the mental. These expressions include: something is wrong with him (*malo ishi*); wilted (*dablan*); not happy (*mish mabsut*); not able (*mish qader*); low energy (*habet*); no energy to complete daily activities (*ma fish mruenh*); down (*kayes*); tired (*ta'ban*); broken or achy (*mkasswar*); ill (*ayyan*); and finally, sick (*marid*). These expressions convey varying degrees of compromised well-being, with the last, *marid*, formalised as an ill-health condition usually endorsed by a doctor's visit and/or prescription.



Similarly, research in the Gaza Strip also demonstrates that people use different idioms to describe traumatic experiences, depending on their severity and social context. For example, *sadma*, which refers to sudden shocks, is used to express feelings about different types of painful events, but is inappropriate for representing the repeated traumatic experiences of the people of the strip. *Faji'a*, or tragedy, refers to a major loss and more severe and long-lasting traumatic events compared to *sadma*. *Musiba* (calamity) refers to a loss with long-term consequences, and is seen as testing endurance and ability to handle adversity. These idioms assist in the communication of suffering referring to collective as opposed to merely individual experiences. They are not diagnostic entities that require treatment but terms through which distress is expressed and social support mobilised (Afana *et al.* 2010). Thus the suffering related to the trauma of war that Palestinians endure is both individual and collective and is expressed as a continuum of stressor severity with no clear boundaries representing distinct syndromes.

### A public health and Quality of Life approach

There is an urgent need for a more comprehensive and culturally informed conceptualisation of the ways in which social suffering related to protracted political injustice and conflict affect mental and somatic health. A public health approach, based on a Quality of Life model is increasingly being used to assess health outcomes by drawing on what individuals report the quality of their life to be (Hanh *et al.* 2005). This approach may assist a complementary shift of focus from individual and pathologised diagnoses and symptoms, to the capture of the collective dimensions of both suffering and resilience, not otherwise tapped within a paradigm of mental illness.

In a 2004 study, Palestinian adolescents recorded the lowest Quality of Life scores out of 35 participating countries (Currie *et al.* 2004, Giacaman *et al.* 2004). Using the WHO Quality of Life scales, Palestinian quality of life in 2005 was found to be 'very poor'. Palestinian scores were significantly lower in all four domains (physical, psychological, social and environmental) than most of the 23 countries participating in WHO's International Field Trials (Mataria *et al.* 2009a). In addition, the study participants reported high levels of fears, threats to personal and family safety, and fears about their future and the future of their families (see Box 1).

#### **Box 1. Reported feelings, fears, worries and threats in a random representative adult population sample of the occupied Palestinian territory.**

- One in two Palestinians fear for themselves in their daily life.
- Almost all Palestinians fear for their family's safety in their daily life.
- Almost two in three Palestinians feel threatened by losing their home, their land or being forcibly uprooted and dispossessed.
- Almost all Palestinians worry over their future and the future of their families.
- Almost one in two Palestinians live with distress, anxiety, worry and grief.
- Almost one in three Palestinians feel incapacitated.
- More than one in three Palestinians feel deprived.
- More than one in three Palestinians feel that suffering is part of their life.
- More than one in three Palestinians are fed up with life.

Thus, the value of a Quality of Life approach lies in its ability to reveal, describe and analyse the quality of everyday lives of ordinary Palestinians. It provides the possibility of discerning the balances between strain and resources, and views people as active subjects in the assessment of their lives. It also offers a new perspective on how to comprehensively evaluate the human costs of conflicts, and links a history of social and political injustice to negative health outcomes, as has been found elsewhere (Shephard 2002).

A public health model effectively shifts the focus from individual trauma to the suffering of a collective population affected by conflict. This model requires that the unique Palestinian social, cultural and historical context is taken into account in the proposed processes of healing and recovery. According to this perspective, military violence and political conflict are part of a broad public health problem. Attempts to measure the social suffering of populations affected by complex political emergencies are therefore part of an overall approach that places the demands for rights and justice at the centre of global health.

### **The challenges ahead**

The conditions imposed by the ongoing Israeli military occupation of the West Bank and siege of the Gaza Strip are obstructing social and economic development in the oPt. When a nation is struggling with day-to-day survival, the development of evidence-based mental health policies and services is unlikely to be a priority.

The lack of development combined with the instability of the political situation present an environment that is hardly conducive to the development of a sustainable mental health system. In fact, the international influence, beginning with the colonial psychiatric hospitals, followed by the more contemporary patchwork of international and local NGOs and an uncoordinated and poorly supervised plethora of services, has had mixed effects. While some patients with severe mental illness have been able to access necessary treatment, other Palestinians have seen their social suffering (mis)diagnosed as clinical pathology (Batniji *et al.* 2009). Such palliative approaches are arguably not the most appropriate or clinically expedient responses to a generalised state of ill-health and compromised well-being, as has been suggested in other settings of conflict (Zarowsky 2004).

A mental health policy for Palestinians must deal with several challenges. Mental disorders and the social suffering of war are two distinct challenges, which both need to be addressed. An integrated model, which distinguishes mental illness from social suffering, must serve a twofold purpose: the diagnosis and treatment of severe and acute mental illness in addition to the development of coherent mental health strategies aimed at strengthening community health services for the identification and follow-up of clinical treatment. At the same time, a social and political response to mass suffering, with the reversal of historical injustice as its primary aim, is an equally urgent priority for the protection of Palestinian mental health.

A key problem in developing an integrated and sustainable mental health system in the oPt is the dependence of the health budget on humanitarian and international aid and hence, its susceptibility to priority and guideline changes by the donor community. Relief and emergency have repeatedly been the focus of donor health programmes rather than long-term development, compromising sustainability and future self-sufficiency (Mataria *et al.* 2009b). Donor assistance

often accords with donor countries' own practical and political agendas and risks undercutting local development visions and strategies (Hanafi and Tabari 2005). Indeed, international aid for Palestinians has opted to focus on either humanitarian emergency aid or global agendas which are not necessarily relevant to the needs of Palestinians. Instead, international aid should address the root cause of suffering, low life quality and well-being, as well as the advocacy for justice.

Even though international donors emphasise sustainability, funding for 2–3 year project cycles, in fact, contributes to the opposite effect. By the time a project is finally able to take off and to work towards sustainability the cycle is over, staff are dismissed and a whole new cycle starts all over again. Not only does this type of 'development' aid lead to a waste of funds, it contributes to the demoralisation of the workforce and compromises community agency towards social change. Rather than accepting the narrow perspective of donors with their budget restrictions and limited understanding of the local context, we emphasise that it is crucial to recognise that the entire political and economic arrangement is non-sustainable under military occupation. Given the context, any 'development' will not be sustainable until a political solution is achieved. A society operating under checkpoints and economic siege lacks the freedom to 'sustain' the services that are created (Wolfensohn 2005).

The Palestinian experience, informed by comparative understandings, demonstrates the importance of separating the clinical response to severe mental illness from the population-wide response to mass political violation. An adequate response to the former involves improved diagnosis and treatment in the health system, while the latter calls for a social and political response in pursuit of justice. Blurring the two, as has often been done by well-intentioned health professionals, makes access to necessary services for the mentally ill difficult, while inappropriately attributing pathologies to a resilient, though suffering population. The emphasis on the victimisation of children in the Gaza Strip took the focus away from their sense of empowerment (Collins 2004). Palestinian young people defy chaos and severe risk factors by establishing routine and normality within their daily lives (Mansour 2003). Social capital, in the form of a tight network of family support, peers, friends, caring adults, clubs and schools, nurtures and sustains their sense of optimism and hope (Nguyen-Gillham *et al.* 2008).

Rather than a narrow medical perspective there is an urgent need for the reconceptualisation of Palestinian mental health using a public health approach, based on the broader frameworks of social justice, quality of life, human rights and human security. To frame health in conflict as a broad public health issue shifts the emphasis from an outcome based on medical indicators, injury and illness to social suffering and human rights violations experienced by ordinary Palestinians. Such a change in perspective will require aid agencies to shift their development aid policies away from short-term emergency humanitarian aid to longer term development in consultancy with local academic expertise, and necessarily in combination with strong international advocacy for the respect of Palestinian human rights and the restoration of historical, political and moral justice.

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