3. Coping with the "Epidemic of Violence"

The struggle to dislodge the occupying force of the Israelis has incurred many costs for the Palestinians. Perhaps the most immediately obvious of these has been the injuries and casualties suffered at the hands of soldiers and settlers. The beatings, the tear-gas and the shootings have resulted in an unprecedented demand upon medical services and health care facilities in the occupied territories. Before going on to examine how the Palestinians have sought to cope with the mushrooming toll of injuries, disabilities and other health-related problems, it might be worthwhile to sketch out the condition of the Palestinian health services in the West Bank and the Gaza Strip prior to the Uprising.

Background

As with almost every aspect of life (and death) in the occupied territories, the issue of health care has been a focus for polemic and argument. Israelis have selected certain indices and cited particular statistical sources to illustrate the degree of development made in health care under their occupation. Palestinians have selected other indices and quoted their own statistical sources to prove that military rule has damaged the health of the Palestinian people.

What is clear is that in absolute terms the state of health within the occupied territories showed a marked improvement between 1967, when the occupation began, and 1987. By the outbreak of the Intifada, health conditions within the West Bank and Gaza Strip compared quite favourably with those in neighbouring Arab states. However, it is equally clear that when Palestinian morbidity rates are compared with those of Israel, there is a marked disparity.

Thus, if we take infant mortality rates (death in the first year of life) as a key indicator of the general condition of health in a society, we find that in 1985 Israel had a rate of 14 deaths per 1,000 live births. For the West Bank and Gaza Strip, the figure was 70 per 1,000, whilst the figures for Jordan and Syria were 55 and 60 respectively.[1] These figures were compiled by the Israeli Central Bureau of Statistics. They differ markedly from those presented by the Israeli coordinator of health services in the territories, Dr Tulchinsky. In May 1989 he claimed that infant mortality in the occupied territories had dropped to less than 30 deaths per 1,000 live births.[2] Palestinians, meantime, cited a 1981 health survey of three West Bank villages in the Ramallah district which found the infant mortality rate to be around 90 per 1,000.[3]

Statistics are clearly political weapons in this arena, but the figures do seem to indicate a basic trend: health conditions in the West Bank and Gaza Strip, as indicated by infant mortality rates, improved during the period of military occupation prior to the Intifada. The rate of improvement bore

comparison with other parts of the Arab world, but did not overcome the disparity between Palestinian and Israeli states of health. Statistically, it would appear that a Palestinian child born since the beginning of the occupation is between two and five times more likely to die before its first birthday than an Israeli child.

The inequalities in health have not been confined to the Israeli/Palestinian divide, however. As in other societies, there has been a clear pattern of class and gender related inequalities within the Palestinian community, with the children of working-class families, particularly girls, revealing relatively high infant mortality and other morbidity rates. Whether the statistics would have been any different if the Israelis had not occupied the territories is a matter for political point-scoring rather than scientific analysis.

What about the actual health services and facilities? Palestinians have consistently alleged that the provision of health care has always been an integral part of the Israelis' overall strategy of occupation — obstructing the development of indigenous medical facilities in order to render the population dependent upon the Israeli health sector. It is indeed the case that the bulk of the health services within the occupied territories have been supplied through the governmental sector, supervised and controlled by the military government and financed from tax revenue and a voluntary governmental health insurance scheme. Health service provision for the refugees, on the other hand, has remained the responsibility of UNRWA. These two main sources were supplemented by a relatively small private sector and a larger number of hospitals and health centres funded from charitable sources, particularly through the Red Crescent Society. Due to lack of funding, poor coordination between the different sectors, and other reasons associated with the peculiar conditions of military occupation, a pattern of inequality between Israel and the occupied territories with regard to health service provision persisted, compounded by inequalities within the occupied territories themselves.

Statistics tell a part of the story. In 1986 there were approximately eight physicians per 10,000 population in the West Bank and Gaza Strip, one third the figure for Israel where there were 28 doctors per 10,000 population.[4] The hospital bed/ population ratio records a comparable state of affairs, with 1.6 beds per 1,000 population in the occupied territories — a fraction of the Israeli ratio at 6.1 beds per 1,000 population.[5] According to Meron Benvenisti, the average expenditure by the Israeli authorities on health services in the occupied territories up to 1986 was the equivalent of $30 per person per year, by comparison with the figure of $350 per Israeli over the same time period.[6]

Moreover, within the occupied territories, health services have been disproportionately located in the main population centres, and in the central region of the West Bank in particular. Thus, Hebron in the south of the West Bank, with a population of some 300,000, was served by only one hospital. The hospital at Ramallah has a unit for open-heart surgery, whilst at small hospitals such as that at Tulkarm there was a shortage of resources as basic

as equipment for measuring blood pressure. Approximately half the 500 population centres of the West Bank (villages, refugee camps and towns) lacked any form of health care centre.[7] The Gaza Strip, with a population of around 650,000, was served by three main hospitals. In the UNRWA clinics in the Gaza Strip, doctors became accustomed to examining an average of one patient every three minutes — barely enough time to write a prescription! The Rimal Clinic in Gaza City serves almost 60,000 refugees, with each doctor seeing an average of 100 patients a day.

Union of Palestinian Medical Relief Committees

It was as part of an attempt to tackle the unequal and underdeveloped nature of health care provision that the Union of Palestinian Medical Relief Committees (UPMRC) was launched in 1979. Like other Palestinian grass-roots organisations of the time, this movement, staffed by volunteers largely drawn from the medical professions, was established to fill the institutional gaps left by the military government with indigenous agencies aimed at mobilising local people to meet basic community needs. As such, the medical relief committees (MRC) were an integral part of the process of informal institutional resistance to Israeli occupation referred to previously.[8] The aim was to lay the groundwork for a national health service beyond the control of the Israeli authorities, specifically oriented to the needs of the deprived sectors of society, particularly the women and children in the villages, refugee camps and other areas where health services were either non-existent or woefully inadequate.

Amongst the projects they undertook were local health surveys in order to assess the needs of a locality. Self-help preventative health care was promoted through the production and distribution of educational materials dealing with matters of public and personal health. Local women were chosen for special training as para-medics and local health workers, and 17 primary health care centres were established. The wider socio-political dimension of the work of the MRCs was consciously pursued, as the following depiction of the role of the primary health care services illustrates:[9]

> Primary health care services are not only curative services, nor are they only health education and environmental sanitation and immunisation campaigns, among other activities. Primary health care services are also nuclei for community centres, foci where communities can be mobilised to have their needs met, be it in health, or in literacy, in school health or in the provision of health services to the community's nursery schools and kindergartens. Primary health care centres must be at the core of social relations at the community level. For health is not only the absence of disease, but rather the provision of economic, infrastructural and social opportunities that would ensure that a human being can live an active and happy life.

The duality of Palestinian health problems

It was through the work of the MRCs that a peculiar aspect of the Palestinian health profile came to light. Compared to their Israeli neighbours, the Palestinians suffered from a relatively high rate of disease associated with poor environmental conditions and services, such as malnutrition and vitamin deficiency, a number of infectious diseases, anaemia, and a high infant mortality rate. This in itself was not surprising. However, it was also discovered that the population suffered from an accelerating incidence of so-called "modern day complaints" such as hypertension, diabetes, cancer, ulcers, heart disease and psychiatric problems. Thus, whilst research in the late 1970s revealed that three quarters of childhood deaths were due to infectious diseases, the most frequent cause of death among adults was heart disease.[10] In a survey of one area in the West Bank during the mid-1980s it was discovered that 15 per cent of the families had at least one member suffering from hypertension, 10 per cent had a member with diabetes, 7 per cent had a member suffering from asthma, and 7 per cent had a member suffering from psychiatric illness.[11]

This relatively high incidence of stress-related illnesses may be attributed in part to the economic and social changes undergone in the occupied territories since 1967: the changes in lifestyle and consumption patterns resulting from the exposure to their economically dominant neighbour, the substitution of processed Israeli products for home-grown food, the changes in agricultural practice with the increased use of chemical fertilisers and pesticides and so forth. However, a more obvious factor has to be the psychological stress created by living under military occupation.

This "duality" of health conditions within the occupied territories, with new patterns of disease superimposed upon a pre-existing situation where basic health-related problems such as poor sanitation and inadequate water supplies to villages and camps still remained unsolved, was further complicated in the months following the outbreak of the Intifada. The new situation brought with it a new tier of health-related problems, thereby intensifying the demand for creative solutions to an unprecedented "life and death" situation.

The Uprising: its consequences for health

As was seen in the previous chapter, the Israeli occupying forces reacted to the demonstrations, street confrontations and strikes that marked the outbreak of the Intifada by resorting to physical intimidation. The aim, to quote Prime Minister Shamir, was to "put the fear of death into the Arabs of the areas so as to deter them from attacking us anymore..."[12]

Since those early days of December 1987 the beatings, the tear-gas, the rubber and plastic bullets, and the live ammunition have continued to cause injury and death. The physical toll resulting from the direct use of force has been manifest. By the end of 1989, after two years of the Intifada, Palestinian

physicians estimated that they had dealt with somewhere in the region of 30,000 Intifada-related injuries a year since December 1987. They estimated that after three years some 3,000 had suffered major injury involving amputations, colostomies, shattered joints — a figure which included over 100 paraplegics and quadriplegia and approaching 300 (mainly women and children) who had lost an eye. They estimate that 600 a year have been permanently handicapped in one way or another.[13]

These casualties have been the most obvious indicators of the physical suffering endured by the Palestinians during the Uprising. However, like the tip of the iceberg, they represent only the most visible and dramatic consequences for health and well-being of the continued civilian insurrection. There are whole strata of the population whose health has suffered in less immediate but no less real ways than the direct victims of Israeli violence.

Imagine a family of ten living in a few rooms, confined there under siege conditions for days on end, allowed outside for an hour every other day, during which time they have to try and obtain the supplies necessary to get through the next 48 hours. Such has been the experience of many village and refugee camp dwellers under curfew. The 7,000 inhabitants of Jalazoun camp, near Ramallah, were under curfew for over a month in the spring of 1988. The soldiers stationed at the camp entrance attempted to stop people entering or leaving, the passage of food supplies into the camp was obstructed, the one hour in 48 when the curfew was lifted did not allow sufficient time for residents to get to Ramallah to stock up with essential items, the stores within the camp could not replenish their shelves. The inhabitants suffered from severe food shortages. Of particular concern was the plight of the youngest — no fresh milk for over a month. The electricity and telephone lines were also cut. People had to resort to burning whatever they could lay their hands on as a substitute fuel supply for the preparation of food. Piles of garbage accumulated in the streets as the sanitation workers were denied entry and the residents did not have sufficient time to dispose of it themselves, giving rise to fear of the spread of contagious disease. Those residents in need of medical treatment were not allowed out to visit doctors, clinics or hospitals. Health care programmes within the camp were totally disrupted. UNRWA medical teams had difficulty in obtaining permission to enter the camp. And underpinning all this, there was the enduring psychological stress and tension of living under siege.

The curfew at Jalazoun took place during the early months of the Uprising, when people were still relatively unprepared. Since then, the regular experience of living under curfew has meant that people have learned how to cope to some degree — holding stocks of food and basic medical supplies within the home and other similar precautionary measures. However, little could have prepared the residents of the occupied territories for the blanket curfew that was imposed during the first three months of 1991 at the time of the Gulf War. Confined to their homes, the majority had insufficient living space to prepare a spare room sealed off in case of gas attack. Moreover, out of the whole population only 50,000 adults were provided with gas masks, and

none were distributed to children. Under the curfew conditions people were unable to gain access to medical services. This included emergency cases and chronic sufferers such as cancer patients who needed regular specialist treatment in Israeli hospitals. The problems were compounded by the fact that an estimated 30 to 40 per cent of medical staff were prevented from travelling to work. The resultant staffing shortage in hospitals and medical centres meant that all preventative treatment and care, including non-urgent operations, had to be postponed for the duration of the curfew.[14]

The sufferings of the population during the Gulf War can perhaps best be read as a microcosm, albeit intensified, of the health situation throughout the occupied territories during the Uprising. Thus, access to medical services has been curtailed in general as, even when there have been no formal military restrictions on movement, people have been reluctant to travel far from their own locality to the centres where the physicians and clinics are based, for fear of harassment by the military. Moreover, due to the difficult economic conditions during the Uprising, people have not had the disposable income to pay for travel and medical fees. This in turn highlights a significant feature of the Intifada — the unequal burden borne by the weakest sections of society. The direct victims of Israeli violence, the wounded and the dead, have been disproportionately drawn from the ranks of the poor, the sons (and daughters) of workers and peasants. Likewise, it has been the women and the youngest children who have suffered most from the collective punishment of curfews. It has been the pregnant, and those already suffering from respiratory diseases and the like, who have suffered most from the effects of tear-gas.

No section of Palestinian society has been untouched by the Intifada, however. Here is one doctor's depiction of the general health situation confronting the medical services in Gaza during the summer of 1988.[15]

> It is well-known that people are suffering more because of the Uprising and the security restrictions. ... The psychological state of the people has meant that a great number of diseases have become incurable. Many new illnesses have appeared. For example, diseases of the digestive system, stomach ulcers — these are due to psychological factors. Chest diseases resulting from tear-gas, which we consider to be poison-gas. It has caused deaths and respiratory diseases among the people, diseases of the digestive system. Many have developed a sensitivity in the chest and many have begun spitting blood from the lungs. Finally, heart diseases of course increase, cancer, skin diseases as a result of burning, illnesses which might have been prevented but for the declaring of closed military zones. There is a lack of water, adequate sanitation in the streets and the houses. All this creates contagious diseases and in the end we're under a lot of pressure because of this increase in disease. There are many problems. During a military ban, people can't get to the clinics for treatment, be they private or government ones.
>
> The problems will become very evident in the future. First of all, many

of the injuries — loss of eyes or limbs — are permanent and this will cause social problems in the future. Many of the cases of miscarriage which result from tear-gas being thrown in large quantities ... these problems will go on as long as the Uprising continues.

The other health problems are psychological problems that people are exposed to. There are a lot of people walking round in a state of hysteria. Hysteria. They are hysterical.

There are economic problems of course. The labourer isn't going to work. The clerk isn't going to work. And with the many taxes, this affects the medical services. He who has to pay taxes doesn't have any money for medical insurance and won't be able to treat his son or himself or his wife or anyone else.

Coping with emergency: the initial response to the "epidemic of violence"

Like everyone else, the personnel of the health services were caught unawares by the outbreak of the Intifada. Largely untrained in the skills of trauma medicine, the medical staff were faced with a sudden influx of injured people suffering from broken limbs, bullet wounds of various kinds, and the effects of gas. As the director of the Palestinians' premier hospital, Maqassed in East Jerusalem, observed in 1988, "Israel is one of the most advanced countries in the world in everything related to the treatment of war injured and their rehabilitation... We, in comparison, are at zero."[16]

Apart from the need to acquire the necessary skills whilst "on the job", physicians faced a related dilemma. They had too little time to devote to the care of the chronically ill, such was the demand created by the "epidemic of violence". One doctor employed by UNRWA in the Gaza Strip recalled the predicaments he faced during the early months of the Uprising.[17]

Dealing with incidents is the first priority, injuries and casualties that are occurring in our area. There are new things to deal with which we had only previously read about as medical cases while we were studying. We weren't really prepared for these things — like gas. Unfortunately, when the use of gas started against demonstrators and citizens in the Uprising, we didn't know about the medication to use specifically for its treatment. So our task in treating the patient was extremely difficult, especially with regard to pregnant women in whom we have noticed that the number of miscarriages and still births has increased during the Uprising. We've suffered from a great shortage of laboratory facilities....

There have been many injuries where there was no difference between old people and children. A lot of the injuries I've seen have looked as if they were deliberately inflicted. Bones have been deliberately broken, broken arms, heads deliberately cracked open... Bullet wounds, as they

> call them, rubber bullets or actually rubber casings containing iron or some other metal. I don't know which exactly. As doctors in UNRWA we do what we can and we transfer the cases which require hospital treatment or surgery to a special hospital. There have been many. The numbers are painfully disturbing... We used to see only one or two a day, on an ordinary day. Someone who had stepped on a nail, a car accident... someone who'd fallen off his bicycle, someone who'd cut himself, a small child ... trivial things like that. The incidence of injury has increased.... it comes to more than 15 or 20 a day, if we take an average over 30 days. On some days you get 60 or 70 cases: gas, beating, breaking of bones...
>
> To be a doctor and to have to forego treating someone, treating chronic illnesses and the illnesses that people suffer from in any case, in order to concentrate most of your attention on these new cases, is of course another burden on our medical capabilities.

The burden on those working at the local primary level was made more problematic by the reluctance of patients to be transferred to hospitals where they faced the risk of harassment from Israeli soldiers who proved themselves not above searching the wards for wounded "trouble-makers", and removing them from medical care under arrest. As the orthopaedic surgeon Dr Swee Ang witnessed during her time working in Gaza City's Ahli hospital:[18]

> Dealing with wounds and fractures is just one aspect — perhaps the technical and straightforward aspect. Dealing with wounded patients who are threatened with arrest is the real difficulty ... There are two parties who are victimised in this process. The obvious victim is the patient, but the not-so-obvious victim is the medical team. I felt as though the army was forcing me to violate medical ethics. It was not only denying my patient the right to be treated; it was also denying me the right to treat my patient.

The normalisation of emergency work

The inadequacy of the existing infrastructure in the occupied territories when it came to coping with the epidemic of violence was apparent to all. However, the work and experience of the MRCs prior to the Intifada proved an invaluable base for the mobilisation of personnel and resources to cope with the new situation. The decentralised nature of their organisational structure gave them the flexibility necessary to adapt to new circumstances. Their philosophy and practice of grassroots health care directed towards the underprivileged sectors of Palestinian society provided a crucial background of experience when it came to delivering basic medical services to the victims of violence. In examining the response of the MRCs to the new circumstances, attention will be focused upon the work of the UPMRC, the largest and best known of medical relief networks established under occupation.

By the end of the first month of the Uprising, the Union had begun to

establish the basic pattern of its response to the Intifada. The most pressing need was for the immediate relief of the injured and traumatised. A call went out for volunteer doctors, nurses and other medically trained professionals. Eventually some 800 medical staff were recruited, half of them physicians. They worked in their free time, and were organised on a rota basis into mobile relief teams. Groups of up to a dozen would travel to the scenes of violence to minister to the victims. In the first week that these teams were in operation, 13-19 January 1988, seventeen refugee camps and three villages in the West Bank and Gaza Strip were visited, and 2,599 patients examined, of whom somewhere between 10-15 per cent were suffering from wounds and injuries inflicted by the military — a level of activity that was to continue throughout the following weeks and months.[19] As a doctor in Gaza explained,[20]

> The principal aim of the establishment of the Medical Aid Committee was to raise people's consciousness about preventative medicine.... As soon as the Uprising began the Medical Aid Committee became an emergency service. The tactics of the Committee used to be to have one team throughout Gaza. In the situation of the Uprising we formed three teams. A team for the southern regions, a team for the middle regions, and a team for Gaza Town and the north including Jabaliya and Beit Hanoun. Each team operates independently according to the conditions pertaining in the area where they are working...

It was eventually decided to supplement the eight mobile teams (three in the Gaza Strip, five in the West Bank), by establishing a number of permanent emergency first aid centres in those densely populated neighbourhoods where clashes with the military were an almost daily occurrence.

One of the many obstacles with which the medical teams had to contend was the problem of gaining access to patients within closed military zones, such as when curfews were in operation. On one occasion a mobile dental clinic was marooned in the village of Kufr Ni'meh for two weeks during a curfew. For the predominantly middle class residents of Beit Sahour (where, to the casual visitor, it seems as if every other family possesses at least one member who is either a doctor of medicine or of philosophy) curfews presented rather less of a problem. They formed their own mobile clinic, going from house to house treating the sick and the wounded.[21]

However, not all Palestinian communities had such indigenous resources upon which to call during curfews. In May 1988 the village of Kufr Malek, in the Ramalla district, was under curfew for over 40 days. Word was passed out via neighbouring villagers that there was a desperate need for medical services. Some two dozen volunteers decided to take up the challenge and, carrying all their equipment by hand, succeeded in entering the closed area by means of back roads and little known paths. As they made their way towards the centre of the village they attracted quite a number of villagers. Eventually they were confronted by a squad of Israeli soldiers, who demanded to know their purpose. Whilst negotiations ensued, some of the

volunteers began there and then to examine those of the villagers displaying obvious signs of injury. Faced with something of a *fait accompli*, the soldiers (one of whose number was himself a trained nurse) allowed the "intruders" to set up their clinic in a nearby house. The team of general practicioners, pediatricians, dentists, pharmacists, technicians and nurses succeeded in treating nearly 200 patients during the day, in addition to providing the community with basic first aid training.[22]

Despite such successes, it became increasingly apparent that as the use of various forms of collective punishment placed more and more centres of population under siege conditions with ever greater frequency, a change of approach was required. Instead of a whole team of volunteers trying to enter a closed area, a single doctor was sent to stay for four or five days before being replaced. As one doctor explained:[23]

> We have faced many problems in the course of our work as a result of the imposition of curfews and security sieges ... This used to create big problems for us. So, we changed our tactics to deal with this business of closed military zones. We placed a doctor or nurse in each area under military ban. They would let us know what they needed and we would send it to them. ... This method worked very well. We were able to provide the people with medical services.

Another innovation of the UPMRC was the establishment of a "roaming physiotherapist" programme. Prior to the Intifada there had been a permanent physiotherapy centre based in Nablus in addition to a couple of physiotherapists who used to visit rural areas. With the dramatic increase in the numbers of those suffering limb injuries from beatings and gunshot wounds, this embryonic community-based programme was adapted to one of home visits to those struggling to regain mobility. An important part of their work was to convince people that physiotherapy was not the luxury they had traditionally considered it to be, but was an essential form of therapy. They also concerned themselves with teaching family members basic patient-management techniques, focusing on elementary massage and physiotherapy that would help in the rehabilitation of the wounded.

The training of lay-people in methods of health care and first aid constituted the second major component of the work of the UPMRC. It was a natural extension under the emergency conditions of the basic health education work that had always been a priority of the Union. Before the outbreak of the Intifada it had begun publishing leaflets, pamphlets and posters as part of its health education programme. In addition, it had established a training school for village health workers in association with the Community Health Unit of Birzeit University, where predominantly women trainees received a basic grounding in various aspects of personal, public and community health over a period of nine months. This work continued during the Intifada, but in addition a crash programme for educating the public in the rudiments of first aid treatment was also launched. As in other constructive forms of

community-based resistance activity during the Intifada, women were particularly prominent in this health education programme.

From the earliest days of the Uprising volunteers were recruited to prepare and pack first aid kits for mass distribution. They were handed out at meetings and lectures where medical personnel would explain the rudiments of wound and fracture management. By the end of the first year of the Intifada 860 lectures had been given, attended by around 22,000 people, at which 12,000 first aid kits were distributed. Although the packing and distribution of the kits was initially based in Jerusalem, within a few months this was decentralised to regional centres.

Following the establishment of the popular neighbourhood committee infrastructure throughout the occupied territories in the spring of 1988, members of the MRCs worked closely with local women's committees and health committees, training people in basic methods of first aid. The physicians and medical professionals, in their turn, learned from the local people of their own "make-do" remedies, such as the use of onions, lemons, and even eau de cologne to counteract the effects of tear-gas.

By mid-February 1988 a third dimension of the UPMRC's work was launched. The upsurge in the numbers of injured had revealed a desperate shortage of blood supplies for transfusion purposes. It was therefore decided to initiate a Blood Typing and Donation Campaign, a drive to screen the population for blood type so that any emergency need for blood transfusions could be met with the minimum of delay from local donors. By November 1988 somewhere in the region of 25,000 people had been screened and their blood type recorded. The value of this project was proven over and over again. In one recorded case, following an army helicopter attack on the villages of 'Arura and 'Abwein in the Ramallah district, 22 people with the required blood type presented themselves at Ramallah hospital within half an hour of the emergency call to the Union. The worth of this programme was revealed in rather more dramatic fashion in October 1991. Within a short time following the shootings on Temple Mount, people were flooding towards Maqassed and Augusta Victoria Hospitals in East Jerusalem to offer blood, each one of them knowing their blood type. Maqassed took blood from 250 volunteers that day.[24]

A fourth element of the work of the UPMRC was to improve the level of coordination and cooperation between the different tiers of the health service. Prior to the Intifada the provision of health care had not been immune to the deleterious effects of political factionalism, leading to the wasteful duplication of services in some areas where rival nationalist groups associated with different charitable and voluntary associations competed with each other in the provision of medical and health care facilities. Closely associated with the mainstream of Fatah, the UPMRC itself had not remained unaffected by the emergence of an institutional rival in the form of the Popular Committees for Health Services. The new found degree of unity between the nationalist factions during the Intifada, under the leadership of the UNC, along with the unprecedented urgency of the situation, proved a powerful stimulus to

greater cooperation between the different sectors of the Palestinian health service. As the number of serious injuries grew, it was obvious to all that the lives of the patients very often depended upon their rapid transfer to hospital where the necessary expertise and equipment was available.

Apart from the risk of arrest and harassment from Israeli troops whilst in the hospital, patients and their relatives faced the serious financial problem of meeting the medical charges. At the local primary level patients were charged only a nominal fee for the treatment they received, but under the conditions of economic hardship during the Intifada the costs of hospitalisation became prohibitive for many Palestinians. Thus, one of the first tasks taken up by the UPMRC was to negotiate with the charitable hospitals for a number of free beds to be made available to those patients who could not afford the cost of treatment.[25] A fund-raising campaign was also launched to help the families of the injured meet medical costs.

The situation with regard to the Israeli-administered government hospitals was more difficult. Only a minority of Palestinians were covered by the government health insurance scheme. Several months into the Uprising the Israeli authorities sought to increase hospital charges. They insisted that patients be charged for three days treatment in advance (the equivalent of £300) before they were admitted to government hospitals. To their credit, the directors of the government hospitals refused to implement the instructions, arguing that it was the responsibility of the ruling authority to provide medical treatment for the victims of war. Faced with such determined opposition, the head of the "civil administration" finally gave way and served official notice that Palestinians injured by the Israeli army could be treated in government hospitals without charge.

Health care as an instrument of collective punishment

The attempt to raise the charges for hospital treatment was only one element in the attempts of the Israeli authorities to interfere with the provision of medical aid for the casualties of the Intifada. This has led to allegations that health care has been used as an instrument of collective punishment.

Thus, whilst hospital fees were being raised, the actual health budget for the occupied territories was being reduced. In particular, the funds earmarked for the treatment of Palestinians in Israeli hospitals was slashed. Prior to the Intifada, the Israeli government had always justified its relative underfunding of the secondary and tertiary sectors of the Palestinian health service on the basis that specialist facilities were available in Israel for Palestinians in need of such treatment. As such there was no need to duplicate services. This explanation had always been read by Palestinians as a thinly-disguised rationale for maintaining the situation whereby Palestinians were rendered dependent upon their Israeli occupiers for adequate health care.

Rejecting the humanitarian appeals of Israeli and Palestinian doctors alike, Defence Minister Rabin justified the health service cuts as an economic necessity. The tax revolt in the occupied territories had so reduced the income

of the civil administration that corresponding cuts had to be made in expenditure on health services in the territories. Such was his argument. His promise was that "the minute that our budgetary situation improves, we will return to our past practices".[26]

The message was plain — if the Palestinians wanted to enjoy government health facilities, including continued access to the specialist treatment available in Israeli hospitals, then they should resume their tax payments and wind down their resistance activities. Physicians were appalled. The head of internal medicine at Tel Aviv's Belinson hospital was just one of those to express their concern at this mockery of medical ethics:[27]

> We are shocked to see the extent to which the authorities are using medicine as a stick to beat people with, and I don't mean just against those wounded in the Intifada, but also against the sick among the civilian population.

Similar sentiments of concern were expressed at press conferences in Israel and elsewhere by Israeli and Palestinian physicians. Tales of Palestinian children being denied treatment in Israeli hospitals, some of them dying as a consequence, were a public relations nightmare for the Israeli authorities, coming as they did in the wake of international concern at the policy of beatings and unnecessary force being used against protesters. In January 1989 the policy was reversed.

It is obviously very costly for an occupying power concerned about its international image as a humanitarian regime to be revealed as directly interfering with the provision of medical aid to those in need. During the course of the Intifada there have been allegations that soldiers have prevented ambulances from picking up those injured in confrontations with the army. It has been charged that on occasions soldiers have commandeered ambulances in order to enter "no-go" areas. There have also been numerous reports of military personnel interfering with the attempts to minister to the wounded and of soldiers entering hospitals to apprehend injured suspects. Allegations have also been made that medical personnel have been singled out for harassment and intimidation.

All these charges have been levelled against the Israeli security forces at some time or another during the Intifada, and they have proved extremely damaging. It is one thing to dismiss allegations made by Palestinians as propagandist in purpose and substance, it is quite another thing when allegations concerning the violation of medical rights emanate from relatively unimpeachable sources such as Israeli physicians and representatives of the international medical community. Thus, the report of the North American-based Physicians for Human Rights, published in the summer of 1988, attracted media attention throughout the world, whilst the work of the Tel Aviv based Association of Israeli and Palestinian Physicians, which was formed early in 1988 in response to the way medical ethics were being abused during the Intifada, has proved to be an on-going irritant to the Israeli state authorities.

Faced with the damaging consequences of its own policies, Israel began to seek rather more indirect ways of using medicine as a means of punishing the Palestinians. A key method was that of administrative delay and bureaucratic obfuscation. This ranged from withholding travel permits requested by Palestinian physicians to attend overseas conferences, through the delay in granting permission for the installation of a telephone at the hospital in Hebron, up to the alleged 18 months it took for the Swedish-funded rehabilitation centre at Ramallah to obtain the necessary documentation to allow it to open.

One of the better documented cases of bureaucratic interference in the provision of medical aid concerns the Palestinian ambulance service. It became apparent during the early days of the Intifada that this underdeveloped service needed to be modernised and extended in order to cope with the casualties of the conflict. The problems faced by the Palestinians in obtaining the necessary permission to operate the new ambulances bordered on the Kafkaesque. Difficulties in obtaining the necessary import permits resulted in the decision to purchase ambulances made in Israel. There was then the problem of obtaining the necessary operating licenses. The Israelis made this contingent upon there being specially licensed ambulance drivers to operate the vehicles. The prospective drivers would have to take and pass a training course, just as Israeli ambulance drivers did. But before taking the course, unlike Israeli drivers, they needed the permission of the Civil Administration, who in turn needed reassuring that the drivers had paid all their taxes and had a satisfactory security clearance. Those who passed this obstacle, and successfully completed the course, were then forced to wait several months before actually receiving the driving licences necessary for the ambulances to be awarded their operating permits.

For the Israelis, such bureaucratic delays enabled them to assert their control over the provision of health care, whilst avoiding the stigma of appearing to play the dirty game of punishing the victims of ill-health and injury. Moreover, a security-related reason could invariably be produced to justify their "caution". Thus, a spokesperson for the West Bank Civil Administration was able to explain with regard to the case of the ambulances:[28]

> We believe there are links between some medical organisations and groups that are not medical ... Because the situation is very delicate today we have to check to see that the PLO or other extremist groups are not part of the request... So, they have to be checked out to know exactly why they are trying to get permits for those ambulances.

For the Palestinian medical institutions, the circumvention of the Israeli reluctance to grant operating permits for ambulances did not present too great a problem. Normal commercial vehicles were purchased by some of the medical committees, and then converted into "quasi-ambulances" of varying degrees of medical sophistication. Another tactic involved listing the ambul-

ances as "health buses", thereby side-stepping the need for specially licensed drivers.

Conclusion

With the ingenuity born of necessity, the Palestinians have had to cope with the demands on the medical services during the Intifada as best they could, and with a considerable degree of success. The pre-Intifada trend towards increasing dependence upon Israeli medical facilities has been reversed. As in other spheres of life, the crisis facing the medical and health care institutions has forced the personnel to overcome past rivalries, born to a significant degree out of political factionalism. The result has been that in the process of responding to situational imperatives, the infrastructure of a Palestinian national health service has begun to emerge. In this regard, Palestinians can look towards the future with some degree of justifiable optimism.

However, there has been mounting concern regarding the future of the disabled and handicapped. As early as spring 1988 Dr Al-Namari of Maqassed hospital was warning:[29]

> The problem of treatment and recovery is small compared to the huge problems related to the rehabilitation of the disabled and his absorption into the community. ... The hospital is only a way station ... At one time they would lock up a handicapped person in a back room so that no one would see him. We have already passed this stage. Those injured in the Intifada are received with honour by their friends, but the average family still lacks the knowledge and the psychological readiness to deal with someone who is disabled...

As the Intifada has continued, the shortages of such basic items as wheelchairs, artificial limbs and other aids have grown increasingly acute. However, these immediate concerns have been overshadowed by worries over the long-term future of the disabled, the vast majority of whom are aged under 18 years, in a society lacking the institutional, material and psychological resources necessary for their rehabilitation.[30]

For the young victims of the Intifada, their status as heroes is continually reaffirmed during their hospitalisation. Friends, family, dignitaries and hospital personnel are in attendance. They are at the centre of concern and attention. Honour requires that they display the necessary signs of steadfastness, resolution and high morale. The secondary trauma comes when they are discharged. The majority of them are from poor families in villages and refugee camps. They return to the family home, confined, lacking mobility, dependent on others — separated from the life of collective struggle that goes on outside. In such circumstances dreams about the national destiny of the Palestinian people can give way to nightmares about their own personal future. The consequent depression, in the absence of adequate therapeutic support services, can be profound — and has led to suicide in a number of

cases. Support services are similarly lacking for those who have suffered the less visible traumas of imprisonment.

It has become increasingly clear to those involved in the medical care of the victims of Israeli violence that a massive injection of funds, expertise and facilities will be needed if the physiological and psychological wounds inflicted upon a whole generation of young Palestinians are to be healed. Hopes of such an input of finance took a severe jolt in the months following Iraq's invasion of Kuwait, as the loss of funds from the Gulf States placed all Palestinian institutions, including those in the medical sector, in dire financial straits. Construction work on new hospitals at Tulkarm and Hebron had to be halted, whilst plans for a new UNRWA hospital in Gaza had to be shelved.[31] There was particular concern at Maqassed Hospital, where 70 per cent of its $15 million annual budget came from the Gulf States, the majority of it from Kuwait.[32]

In such circumstances, it would be extremely short-sighted of the Israeli authorities to gloat at the plight of the Palestinians and their medical institutions. Both societies face the prospect of coping with a generation that has been brutalised to some degree or another in the course of the confrontations that have been a daily feature of the Intifada.

Advocates of non-violent means of struggle have traditionally affirmed the importance of waging conflict without losing sight of the humanity of the opponent. The price that both Israelis and Palestinians risk having to pay is that in the process of "demonising" each other, they will also lose something of their own humanity. It should not be forgotten that the young Palestinian who grabbed the wheel of a packed bus causing it to plunge down a precipice killing 16 Israelis in July 1989 acted on his own, in a terrifying attempt to avenge the fate of his friend, who lay in Maqassed Hospital — crippled by Israeli bullets.

The concern of medical personnel about the long-term psychological damage inflicted upon the young during the Intifada is one that is widely shared. Nehaya al-Helo has referred to studies that show that Palestinian children have forfeited their childhood during the Intifada:[32]

> They do not play like normal children elsewhere in the world. Their games reflect their daily life: children with stones facing heavily armed Israeli soldiers. The older children carry makeshift toy guns while the little ones throw make-believe stones at them. Some pretend to be hit and fall to the ground while their friends carry them to hospital.

It has been scenes like these that have constituted one of the driving forces behind the efforts of parents, teachers and educationalists to maintain some form of educational system in the face of the tremendous obstacles created by an occupying power determined to make the people of the West Bank and Gaza Strip pay dearly for their resistance.

Notes

1. Israel Ministry of Health, *Report to World Health Organisation*, 1986, p 8.
2. *JP*, 25 May 1989.
3. R. Giacaman, *Life and Health in Three Palestinian Villages*, Birzeit University, 1986, p 144.
4. Figures cited in *An Overview of Health Conditions and Services in the Israeli Occupied Territories*, Jerusalem: Union of Palestinian Medical Relief Committees (UPMRC), August 1987, p 12.
5. Ibid., p 15. Figures calculated from Israeli statistics for 1986.
6. M Benvenisti, *The 1986 Report*, Jerusalem: West Bank Data Base Project, 1986, p 17.
7. *Overview of Health Conditions*, op. cit., p 13.
8. See Chapter 1 on informal institutional resistance.
9. *Overview of Health Conditions*, op. cit., p 47.
10. J H Puyet, *Infant Mortality Studies Carried Out Among Selected Refugee Camp Communities in the Near East*, Vienna: UNRWA, 1979.
11. Union of Palestinian Medical Relief Committees and Community Health Unit, Birzeit University, *Profile of Life and Health in Biddu: Interim Report*, 1987.
12. *JP*, 26 January 1988.
13. Figures quoted by Dr R Al-Namari at *Workshop on Health, 1990: Time For Peace*, 31 December 1989. See also *AF*, 10 December 1990, pp 8-9. See also *AF*, 10 December 1990, pp 8-9.
14. See report of *B'Tselem*, reviewed in *AF*, 18 February 1991, p 4.
15. Interview with doctor at Shafa Hospital, Gaza, June 1988, *VFG*.
16. Dr R Al-Namari, quoted in *New Outlook*, June 1988.
17. *VFG*.
18. Dr Swee Ang, *G*, 28-29 January, 1989, p 3.
19. This estimate is based on the figures for the first five months of the Intifada, during which time 28,000 patients were seen, of whom nearly 12 per cent (3,300) were suffering from wounds caused by the army. See UPMRC, *Emergency Newsletter no. 6*, April 1-May 15, 1988.
20. *VFG*.
21. See *NFW*, v 7, no 4, 3 April 1991, pp 12-13 for a description of the Beit Sahour Medical Centre.
22. See UPMRC, *Emergency Newsletter no. 6*, April 1-May 15, 1988.
23. *VFG*.
24. See *AF*, 10 December 1990, pp 8-9.
25. This resulted in financial difficulties for charitable hospitals such as Maqassed, which reported a deficit of $12,375,000 for 1989. *Statement of Al-Makassed Islamic Charitable Society, 1988-89*, p 26.
26. Quoted by Tom Segev in *HaAretz*, 6 January 1989.
27. Professor Emanuel Theodor, quoted by Elfi Pallis, *MEI*, 3 February 1989.
28. Quoted in J Levin, *The Palestinians' Ambulance Problem: a Health Care Catch-22 in the West Bank and Gaza*, mimeo, 1989, p 9.
29. Quoted in *Koterest Rashit*, 18 May 1988.
30. During the Uprising three new rehabilitation centres were established: Friends of the Patient Society at Ramallah, Arab Rehabilitation Centre at Beit Jala, and Beit Sahour YMCA Rehabilitation Centre. See *AF*, 10 December 1990, pp 8-9.
31. *G*, 30 August 1990, and *FT*, 28 September 1990.
32. N al-Helo, "The trauma of growing up in Palestine", *AF*, 13 August 1990, p 7.