Spring 5-2017

The Economic, Health, and Psychological Effects of the Israeli-Palestinian Conflict

Ilana Siegal
Syracuse University

The Economic, Health, and Psychological Effects of the Israeli-Palestinian Conflict

A Capstone Project Submitted in Partial Fulfillment of the
Requirements of the Renée Crown University Honors Program at
Syracuse University

Ilana Siegal

Candidate for Bachelor of Arts
and Renée Crown University Honors
Spring 2017

Honors Capstone Project in International Relations

Capstone Project Advisor: Miriam Elman, Associate Professor, Political Science

Capstone Project Reader: Sandra Lane, Professor, Public Health and Anthropology

Honors Director: Chris Johnson

Abstract

This paper analyzes the economic, health, and psychological impacts of conflict and the effectiveness of United Nations agencies and organizations in addressing these issues. I use the Israeli-Palestinian conflict as a case study, representing intractable conflicts due to disagreements regarding land, religion, politics, and ethnicity. Focusing on the World Health Organization (WHO) and the United Nations Relief and Works Agency (UNRWA), I argue that the effectiveness of WHO and UNRWA programs depends on the economic wellbeing, conflict status, and the level of funding at the time. However, the largest factor impacting the economy, health, and psyche of the Palestinians is Palestine's status as an "occupied territory" which comes with various restrictions and difficulties. Meanwhile, the most important factor impacting the economy, health, and psyche of Israel is its geographic position of being surrounded by unstable Arab nations with governments hostile towards the only Jewish nation.

The theoretical perspectives that I employ in my research include liberalism, neoliberal institutionalism, and constructivism. Constructivism is the most effective theoretical perspective through which to examine my research due to its construction of health and self-determination as human rights. Prior to my analysis, I present a brief history of the Israeli/Palestinian conflict, Israel/Palestine in the UN system, as well as background information on WHO and UNRWA. I use the quantitative method of statistical analysis and qualitative methods of content analysis and archival research. I examine health statistics, economic indicators, conflict statistics, and World Health Assembly agendas. This paper attempts to present both the Israeli and Palestinian narratives regarding the conflict and its effects on the various populations involved.

Executive Summary

Conflict negatively impacts the health and wellbeing of the affected populations and countries' abilities to provide for their citizens' healthcare. However, the effectiveness of international organizations in addressing health-related concerns is less widely studied than the political and economic consequences of conflict. Therefore, I examine the case of the Israeli-Palestinian conflict to determine the long-term effects of conflict on health due to the conflict's intractable nature. I particularly focus on the economic, health, and psychological impacts of the conflict on the various populations involved and the role international organizations play in combatting these issues. The populations affected by the conflict include Jewish-Israelis, Arab-Israelis, Gazan Palestinians, West Bank Palestinians, and Palestinian refugees in the surrounding countries. This paper focuses on all the populations mentioned except Palestinian refugees in the diaspora.

My first chapter discusses my research design and background information on the conflict and the pertinent international organizations. The economic impacts of the conflict are analyzed in my second chapter, which is followed by an analysis of the conflict's impacts on health and healthcare provision in both Israel, the West Bank, and Gaza in the third chapter. Here I present an analysis of the role United Nations organizations and agencies play in addressing the health rights and needs of populations in conflict zones, specific to this conflict. Lastly, I delve into the psychological impacts of the conflict on adolescents, since this is a particularly vulnerable group that has grown up during conflict.

To analyze the economic, health, and psychological impacts of the conflict, I use a mixed-methods approach, in which I employ quantitative and qualitative methods. I use the quantitative method of statistical analysis to examine economic trends, health and healthcare

statistics, and psychological indicators. I use the qualitative methods of content analysis and archival research to examine health and government reports, in addition to World Health Assembly agendas. Additionally, I evaluate the effectiveness of certain programs in addressing the pressing health concerns of the region. The international relations theoretical perspectives I employ include liberalism, neoliberal institutionalism, and constructivism. Due to the construction of health as a human right, constructivism is an effective theoretical perspective through which to examine my research. I attempt to present both the Israeli and Palestinian conflict narratives and population statistics without biases.

I compared the economic, health, and psychological statistics to the periods of conflict, and I found a few general trends. First, I found a correlation between years of increased conflict and an increase in mortality rates, decrease in economic indicators such as GDP, and increased strain on healthcare provision.[1] This pattern was shown during the increased conflict times of 2008, 2012, and 2014, during the fifteen-year period that was studied. Another recurring theme was the prevalent idea in Palestinian and UN reports that "Israeli occupation" is negatively impacting Palestinian health and their government's ability to administer healthcare.[2] These documents all asserted that Palestinian statehood must be addressed prior to the specific economic and health needs. The reports assert that the latter factors will automatically improve with statehood. However, this conclusion is not necessarily true, and it was important for me to keep in mind that the sources were inherently biased, as they were published by the Palestinian

[1] Even though there was an increase in mortality rates during times of conflict, the statistics show that the leading causes of death in Israel and Palestine are not conflict related.
[2] Israelis, Gazan Palestinians, and West Bank Palestinians all experience the conflict differently. Israelis experience missile attacks from Gaza, car ramming attacks, suicide bombings (less frequently now), and random stabbings. Gazan Palestinians experience the blockade, Israeli military operations, and air strikes. West Bank Palestinians experience checkpoints and stone throwing.

Authority and the United Nations, which historically maintain anti-Israel sentiments. Additionally, it was concluded that the conflict has significant negative psychological effects on both sides, with the level of their psychological detriments correlating to their level of conflict exposure.[3]

This project is significant because it combines the many impacts of conflict on populations into one study, including economic, physical health, and psychological health. Additionally, it is important for policy makers and negotiators to understand the positions and priorities of each side. For example, it became evident that the Palestinian government and organizations want to address statehood prior to health concerns, because they believe that self-determination and statehood will automatically improve health and economic indicators. Additionally, this study addresses the gaps in scholarly research regarding the effectiveness of international organizations in addressing the health needs of people in conflict.

[3] Most psychological studies did not differentiate between West Bank and Gazan Palestinians in their surveys. However, I hypothesize that Gazan Palestinians have worse psychological indicators due to their increased exposure to conflict compared to West Bank Palestinians.

Table of Contents

Preface

Growing up in a conservative Jewish family, I have always learned about the Israeli-Palestinian conflict from the perspective of the Israeli-Jewish narrative. As a naïve high school student, it became my dream to solve the seemingly unsolvable Israeli-Palestinian conflict. Upon entering college, I began learning about the Palestinian narrative of the conflict, and I was surprised at the amount of information of which I had never heard. For example, I had never heard of the term "Nakba" or "catastrophe" to reference the 1948 war in which Israel became an independent state. As an International Relations major focusing on the Middle East/North Africa and International Political Economy, I have expanded my studies and perspective on the Israeli-Palestinian conflict. Throughout my undergraduate years, I have also developed a keen interest in global health and realized that I want to become a physician in the future. Working on this capstone has been an integral step in my pursuit of studying global health, on which I hope to expand in the future as a physician and scholar.

Acknowledgements

First, I want to thank **Dr. Miriam Elman** for her time and support as my professor, mentor, and capstone advisor. You have helped foster my interest in the Israeli-Palestinian conflict, answered my many questions, taught me to think critically and question sources, and encouraged me to come to my own conclusions and opinions. Thank you for taking the time to meet with me countless times throughout the past three years and for reading my various capstone drafts.

Second, I would like to thank **Dr. Sandra Lane** for being my mentor, professor, and capstone reader. You introduced me to the areas of global health, public health, and medical anthropology, and I look forward to pursuing these studies in the future. Thank you for taking the time to meet with me throughout the past two years and for reading my capstone drafts.

Third, I want to thank the professors and staff members of the International Relations program. **Dr. Francine D'Amico**, thank you for being a great professor during the IR distinction seminar, for guiding me during my distinction capstone writing, and for advising me throughout the past year. **Dr. Mary Lovely**, thank you for guiding the IR program to new heights. **Dr. Terrell Northrup**, thank you for introducing me to the field of international relations through the introductory course my freshmen year of college. **Amy Kennedy**, thank you for advising me during my first three years of college and for always listening to my crazy ideas and believing that I could achieve them. **Angela Allen**, thank you for conducting all the behind the scenes tasks that enable the IR program to run and for being the smiling face I see every time I walk into the IR office.

I want to thank all the staff of the Honors program for mentoring me throughout the years and ensuring the continuation of the academic opportunities and extracurricular programming for Honors students. Specifically, I want to thank Professor **Christopher Johnson**, **Kate Hanson**, and **Karen Hall** for being my advisors in Phi Beta Kappa, Remembrance Program, and Honors, respectively.

Lastly, I want to thank my **parents, brothers, and extended family** for their continued support throughout my many years of school. My parents have instilled in me a strong work ethic, dedication, and perseverance. Thank you for the continuous "pep talks," encouragement, and distractions when I needed them. I love you all and could not have gotten this far without all your love and support. Thank you.

Chapter 1

Research Design and Background

Research Question and Thesis

The key concepts in my research include the economic, health, and psychological effects of conflict, using the Israeli-Palestinian conflict as a case study, along with the UN agencies and organizations involved in development and healthcare. When discussing the land involved in the conflict, I will use "Israel" to refer to the territory of the 1949 armistice lines and "Palestine" to refer to the West Bank and Gaza, or as the United Nations calls them, the occupied Palestinian territories (oPt), or simply the Palestinian territories. In conducting my research, I ask: How does the Israeli-Palestinian conflict impact the health of the Israelis and Palestinians and the economic status of Israel and the territories? Specifically, what are the psychological impacts of the conflict on adolescents?

Furthermore, how effective are WHO and UNRWA in evaluating and addressing the health issues of the Palestinians and Israelis affected by the Israeli-Palestinian conflict? Effectiveness is measured using the trends in health statistics and healthcare indicators of mortality, mental illness prevalence, and hospital resource data. I argue that the effectiveness of WHO and UNRWA programs depends on the economic status of the territories, the level of conflict events occurring at the time of healthcare analysis and administration, and the level of funding available for health programs and services. However, the most influential factor impacting the provision of healthcare by both governmental and nongovernmental organizations is Palestine's position in the conflict and its status as occupied territory, which comes with various restrictions and difficulties. The most influential factor impacting the economy, health, and psyche of Israelis is its geographic position surrounded by hostile Arab neighbors.

Theoretical Perspective

The theoretical perspectives employed in this research are liberalism, neoliberal institutionalism, and constructivism. Liberalism asserts that international organizations play an important role in state affairs, particularly that WHO and UNRWA maintain a vital role in evaluating and combating the health issues in the conflict. Additionally, liberalism assumes that the international system is an "interdependent one in which there is both cooperation and conflict and where actors' mutual interests tend to increase over time," especially in relation to both security and the economy (Mingst, Karns, and Lyon 2017). The actors involved in my research include the Israeli state, the Palestinian nation, the governments of both sides, and relevant international organizations and agencies. While the interests of these actors are not always mutual, the purposes of the international organizations and agencies are to combat health problems on both sides. However, UNRWA focuses solely on the health of the Palestinian refugee population.[4]

Neoliberal institutionalists build on the basics of liberalism but contend that, "cooperation emerges when actors have continuous interactions with each other" (Mingst, Karns, and Lyon 2017). This assumption can be applicable when thinking about the actors as UNWRA and WHO, which interact with each other having the common goal of providing healthcare for the populations involved in the conflict.

Lastly, constructivism is useful due to the construction of the norm of health as a human right, and the emphasis that international organizations can impact this norm through health

[4] UNRWA includes Israeli-Palestinians in their population count of who can receive services, but UNRWA does not actually operate in Israel, just in the territories and surrounding refugee camps.

programs and policies. Due to this norm, the constructivist lens is an effective theoretical perspective through which to analyze the following research (Siegal, 2016a).

Literature Review

A vast literature examines the health impacts of the Israeli-Palestinian conflict on all populations involved. However, the scholarly research neglects analyzing the role of UN organizations and agencies in addressing issues such as health and healthcare.

Some research analyzes the economic impact of conflict on states. In "Conflict and the Millennium Development Goals," Stewart (2003) uses the MDGs as a measure of economic success. Furthermore, Stewart outlines the different types of conflict and their varying economic impacts on states. The types of conflict include "wars by proxy," revolutionary wars, wars fought for regional independence/autonomy, "wars fought to gain (or retain) political supremacy by particular groups," "wars fought by coalitions of groups to gain political supremacy," and "wars initiated by outside (typically Western) powers" (Stewart 2003). While Stewart did not use the Israeli-Palestinian conflict as a case study, the information regarding the economic impacts of conflict is important to my research since economic health often impacts population health.

A comprehensive overview of health and healthcare in the occupied Palestinian territories is provided by the five-part series published in *The Lancet* entitled "Health in the Occupied Palestinian Territory" (2009).[5] Lead author in the first medical journal article, Rita Giacaman, discusses Palestinian health status and the level of health services provided in the occupied

[5] This study provides a historical timeline of the conflict and how Palestinian health has been affected over time. Giacaman includes health statistics from 1945-2005, but does not include statistics comparing health of Gazan Palestinians before and after Israel's unilateral withdrawal in 2005 and the subsequent election of Hamas.

Palestinian territories. She also examines how Israeli occupation has impacted these statistics. Giacaman argues that even though the health indicators show comparable findings to surrounding Arab countries, the Israeli occupation still negatively impacts the health of Palestinians. The researcher's methods include quantitative analysis of various health indicators (i.e. fertility rates, infant mortality, and numbers of hospitals/clinics and medical professionals per territory), as well as subjective measures of peoples' perceptions of their health. The researcher acknowledges the importance of the role that non-state actors play in the provision of healthcare. Furthermore, Giacaman concluded that the conflict has significantly impacted the health of Palestinians due to important social, economic, and political factors (Giacaman 2009). I build on this study by examining similar health statistics from UN primary sources and analyzing them in the context of the conflict's social and historical implications that Giacaman describes (Siegal, 2016a).

In addition to the scientific, psychological, and public health research conducted on the impact of the Israeli-Palestinian conflict on health, some scholars discuss the role of UNRWA in providing economic and social services for Palestinian refugees. McCann (2016) in, "The Role of UNRWA and the Palestinian Refugees," uses qualitative analysis of previously available research as well as content analysis and archival research of various UNRWA documents. He focused on UNRWA as an intergovernmental agency in impacting the "status" of a nation (McCann 2016). The analysis found that even though UNRWA has provided effective services for the Palestinians, conflict still negatively impacts the Palestinian population.[6] Instead of evaluating the services provided by UNRWA, Shabaneh (2010) in, "Refugees, International

[6] Some are critical of UNRWA because it does not help permanently resettle Palestinian refugees. Instead, UNRWA maintains refugee camps in Israel's neighboring Arab countries.

Organizations, and National Identity: The Case of Palestine," discusses UNRWA's role in constructing a national Palestinian identity. The researcher examines "the extent to which UNRWA unintentionally linked the Palestinians through an unprecedented socioeconomic bureaucracy that helped in preserving their identity through its extensive programs and how the Palestinians' use of this structure contributed to the reconstruction of Palestinian nationalism and identity" (Shabaneh 2010). Since these articles analyze the social services UNRWA provides, I expand on this research by examining the effectiveness of UNRWA healthcare services specifically (Siegal, 2016a).

Other studies research the psychological impacts of the conflict on both populations, with a specific focus on adolescents. Harel-Fisch (2009) in, "Psychological outcomes related to subjective threat from armed conflict events (STACE): Findings from the Israeli-Palestinian cross-cultural HBSC study," develops a measurement tool for determining the health, psychological, and social impacts of the conflict on people's overall wellbeing. Meanwhile, Pat-Horenczyk (2009) in, "Posttraumatic symptoms, functional impairment, and coping among adolescents on both sides of the Israeli-Palestinian conflict: A cross-cultural approach" presents her study on posttraumatic stress and its correlation with exposure to conflict violence. Overall, many scholarly studies exist focusing on solely the economic or psychological impacts of conflict, but few identify the role that governments and international organizations play in addressing these issues through programs and healthcare resources.

In summary, this secondary research focuses on the economic impacts of conflict, the health impacts of the Israeli-Palestinian conflict from a public health and scientific perspective, and the role UNRWA plays in providing services and a forum for a national identity. Additionally, my research works to address the gap in the current literature regarding the

scholarly analysis of the effectiveness of UN organizations and agencies, namely WHO and UNRWA, in addressing health concerns and health care provision.

Research Design

To determine the economic, health, and psychological impacts of the conflict, as well as the effectiveness of UN agencies and organizations in addressing these issues, I analyze multiple economic, health, and conflict indicators from various sources. I use the Israeli-Palestinian conflict as a case study representative of intractable conflicts that arise from differing narratives regarding land, religion, independence, and sovereignty. I focus on the time-period 2000 to 2015 to align with the UN Millennium Development Goals. To contextualize this project, I first present a timeline of the history of the Israeli-Palestinian conflict, a history of Israel/Palestine in the United Nations, the role of the World Health Organization, and the role of the United Nations Relief and Works Agency. Thereafter, I start by analyzing the status of conflict over the fifteen-year period by gathering the number of terrorist incidents and the number of fatalities during this time. Then, I continue through an economic lens, comparing Israel and Palestine's progress in achieving the Millennium Development Goals with that of Western Asia, since the United Nations does not provide a Middle East regional report. Next, I present a compilation of economic data and statistics from Economist Intelligence Unit reports covering the years 2000 to 2015. Afterwards, I move to an analysis of the health status and health care indicators using data compiled from Ministry of Health and WHO reports. Then, I study the changing health priorities outlined in the yearly agendas for the World Health Assemblies. In my last chapter, I present the psychological impacts of the conflict on adolescents.

The purpose of this compilation of data is to determine the effects of the conflict and the role that governments and international organizations play in healthcare provision. I then

compare the economic, health, and conflict statuses over time to determine the patterns and trends that emerge. I use a mixed methods approach, consisting of quantitative analysis using statistical comparison, as well as the qualitative methods of content analysis of WHO and UNRWA documents and archival research of World Health Assembly minutes and documents. More specifically, I compare the various health indicators over time, and align these rates with events occurring in the conflict, as well as health programs instituted by WHO and UNRWA. Determining the relationship among the indicators, conflict events, and programs enables me to gauge the effectiveness of these organizations in carrying out their missions and what aspects impact a program's success**.**

Chapter 2

Conflict Background

History of Israel/Palestine

The history of the Israeli-Palestinian conflict shapes population health conditions and the role of UN organizations and agencies in addressing these concerns.[7] I will provide a brief narrative of the important historical events of the conflict. From 1880 to 1914, in response to worsening persecution, European Jews founded the Zionist movement and immigrated to Palestine, which was part of the Ottoman Empire at the time. In 1918, World War I ended, and Britain gained control of Palestine governing over the Jews and Arabs living in the territory known as British-Mandate Palestine. In 1947, The UN General Assembly suggested a partition-plan of British-Mandate Palestine. The Zionist leaders accepted the plan, but the Palestinians rejected it. In 1948, Israel declared its independence and gained control of large amounts of land. In the Israeli narrative, this war is called the "War of Independence," but it is known as "al-Nakbah" or "the Catastrophe" in the Palestinian narrative, due to the 700,000 Palestinians who fled their homes (Katirai, 2001).

In the 1967 Six Day War, Israel launched a preemptive attack against its Arab neighbors who were lining up tanks along Israel's borders and preparing for war. Israel tripled the size of its territory by gaining the Sinai, Golan Heights, East Jerusalem, West Bank, and Gaza. Then in 1973, "Egypt and Syria organize[d] a surprise attack on Israeli forces in the Sinai Peninsula and the Golan Heights on the day of the Jewish fast of Yom Kippur and the Muslim month of Ramadan" (Katirai, 2001). In 1987, the first Palestinian intifada began in the West Bank and

[7] The table in Appendix I outlines the important historical events and their impact on both Israeli and Palestinian populations. I attempt to include the facts of the conflict, while being cognizant of the differing Israeli and Palestinian narratives.

Gaza. In 1993, Israel and the Palestinian Liberation Organization (PLO) signed the Oslo Accords giving the PLO "limited autonomy (in the occupied territories of the West Bank and Gaza) in return for peace" (Katirai, 2001). Then in 1995, the Oslo II Accord was signed dividing the West Bank into three administrative divisions, Areas A, B, and C. Israel maintains civil and military control over Area C, and the Palestinian Authority maintains civil and military control of Area A. Meanwhile, Israel has military control and the Palestinian Authority has civil control over Area B.

Another intifada started in 2000 after a deadlock in peace talks and Ariel Sharon's subsequent visit to the Temple Mount (Katirai, 2000). Then, in 2005, in a "land for peace" move, Israel unilaterally disengaged from Gaza, "withdrawing all Jewish settlers and military personnel from Gaza, while retaining control over airspace, coastal waters and border crossings" (BBC, 2016). Hamas won Gaza's parliamentary elections in 2006, and they have not held elections since their original election. With Hamas in power, rocket attacks on Israel from Gaza escalated, prompting Israeli raids and military operations in Gaza in response. A pattern has evolved of heightened violence every few years (2008, 2012, and 2014), followed by periods of relative quiet (BBC, 2016).

History of Israel/Palestine in the United Nations

Understanding the history of Israel and Palestine in the United Nations helps to inform researchers and policymakers on the current impact of the conflict on population health. Israel became a member state of the United Nations on May 11, 1949 (UN Data 2013). On November 22, 1967, the UN Security Council passed Resolution 242 emphasizing the "inadmissibility of the acquisition of territory by war and the need to work for a just and lasting peace in which every State in the area can live in security" (UNSC Resolution 242 1967). In 1976, a draft

resolution supported by the majority that called for "the exercise by the Palestinian people of its inalienable national right of self-determination" was vetoed by the United States (The Palestine Question). In September 2011, Palestinian Authority President Mahmoud Abbas Abu Mazen sought full UN membership for a Palestinian State, which was denied. Then in October of the same year, Palestine became the 195th full member of United Nations Educational, Scientific and Cultural Organization (UNESCO). Ultimately, in November 2012, the Palestinian Authority sought non-member state status, and the United Nations voted to accept Palestine as a Non-Member Observer State (United Nations 2016).

Since then, Palestine has signed eight of the nine core international human rights treaties through the United Nations, and Israel has signed seven of the nine (United Nations Treaty Collection). Both Israel and Palestine have not signed onto the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families. Israel has also not signed onto the 2006 International Convention for the Protection of All Persons from Enforced Disappearance (United Nations Treaty Collection).[8] Now the United Nations Information on the Question of Palestine (UNISPAL) collects data regarding "The Question of Palestine" in the United Nations. Historically, United Nations member states are largely anti-Israel and sympathetic to the Palestinian case. Ban Ki-Moon admits that, "Unfortunately…Israel [has] suffered from bias – and sometimes even discrimination" at the United Nations (Muravchik 2013).

[8] For comparison, the United States has signed seven of the nine international human rights treaties, but the US has not ratified many of them (United Nations Treaty Collection).

World Health Organization Role

The World Health Organization (WHO) is the public health branch of the United Nations that was created on April 7, 1948, to "build a better, healthier future for people all over the world" (WHO 2016). It works in more than 150 countries with governments and other partners to address issues such as communicable and noncommunicable diseases, safe drinking water, vaccines, and maternal and infant survival (WHO 2016). In line with constructivism, WHO was founded on the idea that health is a human right, and this assertion is expressed in the WHO Constitution by saying:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition… The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health (Constitution of WHO 2006).

All UN member countries are eligible to become members of WHO by accepting its Constitution. Countries which are not UN members, but wish to become WHO members, may be admitted as members after their application is approved by a majority vote of the World Health Assembly (WHO 2016). While Israel is a full member of WHO, Palestine is considered an observer as a "national liberation movement" and is "entitled to participate as an observer in the sessions and the work of all international conferences convened under the auspices of other organs of the United Nations" by Resolution 3118 (United Nations 1975, 195). The WHO office in the Palestinian territories advises the Palestinian Ministry of Health to encourage stronger health services, address public health issues, and promote research. In doing so, WHO coordinates these efforts with many other partners, including "United Nations agencies, donors, nongovernmental organizations, universities, and the private sector to support the Palestinian Authority to reach their national health development goals" (WHO 2016). Therefore, WHO

works closely with the United Nations Relief and Works Agency described below. On the other hand, Israel's government and private sector provide stronger infrastructure and healthcare resources, so Israel is less dependent on help from the international organizations to deliver healthcare.

United Nations Relief and Works Agency Role

The United Nations Relief and Works Agency (UNRWA) was established by the General Assembly in 1949 following the 1948 Arab-Israeli War. Its mission is to "provide assistance and protection to a population of over 5.7 million registered Palestine refugees" in Jordan, Lebanon, Syria, the West Bank, and the Gaza Strip (UNRWA 2016). Furthermore, "UNRWA's services encompass education, health care, relief and social services, [refugee] camp infrastructure and improvement, microfinance and emergency assistance" (UNRWA 2016). With its headquarters in Amman, Jordan, and the Gaza Strip, UNRWA is mostly funded by voluntary contributions, as shown in the table below. The United States, European Commission/European Union, and the United Kingdom have been the largest financial contributors to UNRWA in recent history.

Donor Rank	2008	2012	2015
1	EC - $190,290,763	USA - $233,328,550	USA - $380,593,116
2	USA - $187,008,231	EC - $204,098,161	EU - $136,751,943
3	Sweden - $51,568,339	UK - $68,789,127	UK - $99,602,875
4	UK - $37,518,975	Sweden - $54,331,478	Saudi Arabia - $96,000,000
5	Norway - $35,098,941	Norway - $31,583,358	Germany - $91,724,417

(UNRWA Donor Charts 2008, 2012, 2015)

Palestinian refugees are defined as "persons whose normal place of residence was Palestine during the period 1 June 1946 to 15 May 1948, and who lost both home and means of livelihood as a result of the 1948 conflict" which is commonly referred to as the "Nakba," or "expulsion," in the Palestinian narrative (UNRWA 2016). Along with the 750,000 Palestinians directly affected by the 1948 war, descendants of Palestine refugee males are eligible for registration,

making approximately 5 million Palestinian refugees eligible for UNRWA services.[9] UNRWA claims that, "Nearly one-third of the registered Palestine refugees, more than 1.5 million individuals, live in 58 recognized Palestine refugee camps in Jordan, Lebanon, the Syrian Arab Republic, the Gaza Strip and the West Bank, including East Jerusalem" (UNRWA 2016). UNRWA maintains facilities in these camps, along with schools, health centers, and distribution centers in areas outside of the recognized camps. UNRWA plays an important role in administering social services that affect the health status of the people living in the Palestinian territories (Siegal, 2016a).

[9] UNRWA's, and by extension, the United Nations' definition of Palestinian refugees differs from the general definition of refugees, which only includes those immediately affected, and not their descendants.

Chapter 3

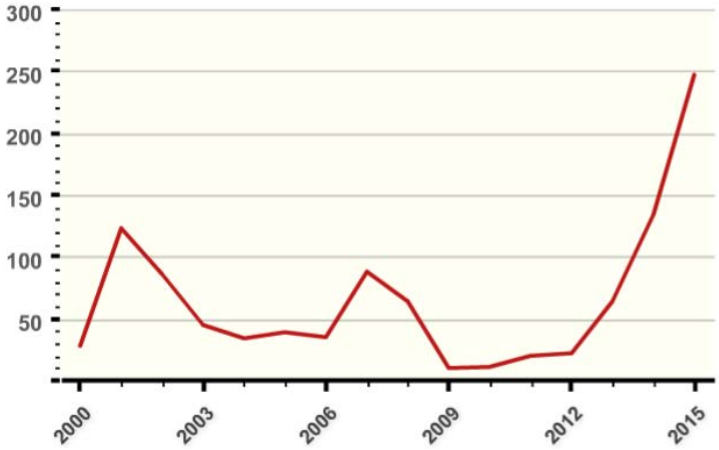
Economic Effects of the Israeli-Palestinian Conflict

Status of Conflicts

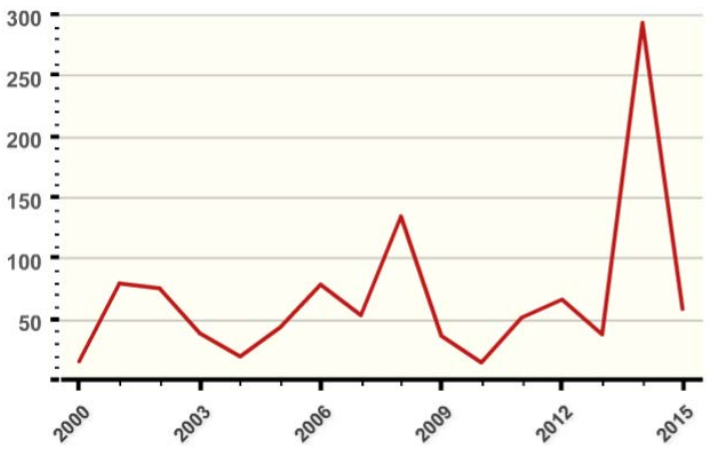
To determine the effects of the Israeli-Palestinian conflict on the economy, I first examine the prevalance of conflict events and casualties. I used the Global Terrorism Database to plot the number of terrorist incidents in both the West Bank and Gaza collectively and in Israel independently. Between 2000 and 2015, there were 1,050 incidents of terrorism in the West Bank and Gaza.[10] This number includes terrorism directed at both Israeli and Palestinian targets, and it also does not diffentiate between the perpetrators of violence. In this case, the perpretrators include Palestinian extremists, Israeli extremists, and unknown parties. The victims are both Israeli military personnel and civilians (mostly settlers) and Palestinians. I used the same criteria of 2000-2015 to plot the incidents of terrorism in Israel, irrespective of perpetrator or victim roles. The number of terrorist incidents during this time-period was 1,089, with the perpetrators including Palestinian extremists, Israeli extremists, Jewish extremists, Hamas, Hezbollah, and unknown parties. The targets varied between civilians and military, and the mechanisms of violence also varied (Siegal, 2016a).

[10] This number does not differentiate between acts of terrorism perpetrated by Hamas and civilians and acts of counter-terrorism conducted by Israel's military, the Israel Defense Forces (IDF). Israel's military conducts raids and military incursions in response to heightened rocket attacks into Israel from Gaza and the construction of terror tunnels from Gaza into Israel. The IDF works to prevent civilian casualties in Gaza, but the nature of Gaza's large population and city landscape, along with Hamas's storage of weaponry in hospitals and schools, make it difficult to prevent civilian casualties.

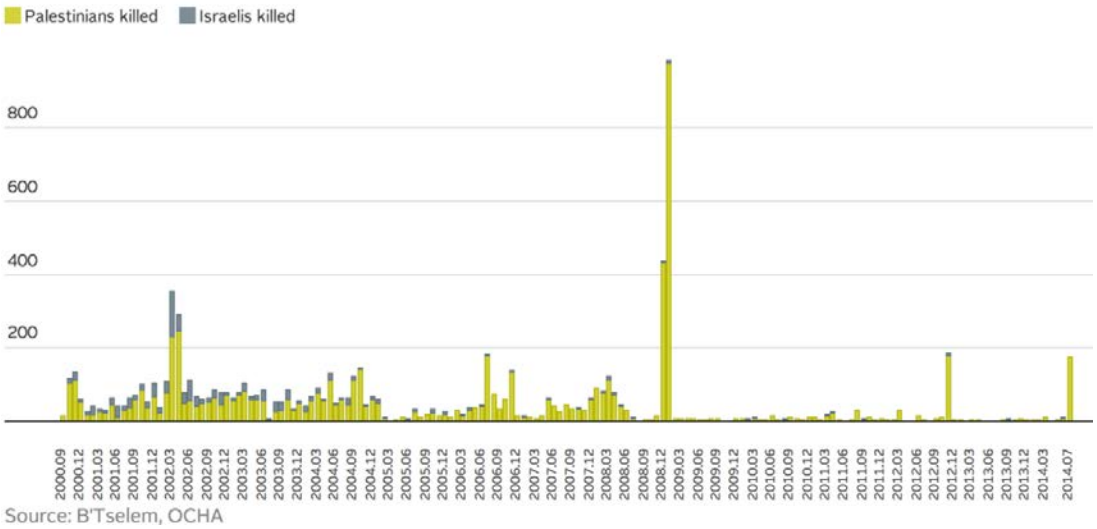
Incidents of Terrorism in West Bank and Gaza 2000-2015
(Global Terrorism Database 2016)



Incidents of Terrorism in Israel 2000-2015
(Global Terrorism Database 2016)



In addition to the number of conflict incidents, I examined conflict-related deaths during the same time period.[11] Most reports that were considered all cited B'Tselem as the source, which is an independent Israeli human rights organization that has "attained a prominent place among human rights organizations" and works to "document and educate the Israeli public and policymakers about human rights violations in the Occuppied Terriotries" (B'Tselem website). The following graph displays the conflict-related deaths of both Israelis and Palestinians from 2000 to 2014, as reported by B'Tselem.



[11] It proved difficult to find an unbiased source with a comprehensive data collection of the conflict deaths.

Millennium Development Goals

Despite the seemingly intractable conflict, both Israel and Palestine have worked towards the Millennium Development Goals (MDGs) set forth by the United Nations. The MDGs were created in 2000 as "the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions – income poverty, hunger, disease, lack of adequate shelter, and exclusion – while promoting gender equality, education, and environmental sustainability" (Millennium Project 2006). From 2000-2015 each country has worked to achieve these goals and has been evaluated on the regional level. Analyzing a country's status based on the MDGs is representative of the overall trajectory and well-being of that country. Palestine's economic and health status as displayed through the MDGs is comparable to the Middle East's progress as a region. Meanwhile, Israel's MDG statistics are better than the regional averages. Since the Middle East is not a region in the UN system, I compiled the results of Western Asia from the Millennium Development Goals progress charts for 2005 and 2015 as shown below (Siegal, 2016a).

Goal 1 - Eradicate extreme poverty and hunger	2005	2015
Reduce extreme poverty by half	low poverty	low poverty
Productive and decent employment	NA	large deficit
Reduce hunger by half	moderate hunger	moderate hunger

Goal 2 - Achieve universal primary education	2005	2015
Universal primary schooling	moderate enrollment	high enrollment

Goal 3 - Promote gender equality and empower women	2005	2015
Equal girls' enrollment in primary school	nearly close to parity	close to parity
Women's share of paid employment	low share	low share
Women's equal representation in national parliaments	very low representation	low representation

Goal 4 - Reduce child mortality	2005	2015
Reduce mortality of under-5-yr-olds by 2/3	moderate mortality	low mortality
Measles immunization	moderate coverage	NA

Goal 5 - Improve maternal health	2005	2015
Reduce maternal mortality by 3/4	moderate mortality	low mortality
Access to reproductive health	NA	moderate access

Goal 6 - Combat HIV/AIDS, malaria and other diseases	2005	2015
Halt and begin to reverse the spread of HIV/AIDS	NA	low incidence
Halt and reverse spread of malaria	low risk	NA
Halt and reverse the spread of tuberculosis	low mortality	low mortality

Goal 7 - Ensure environmental sustainability	2005	2015
Reverse loss of forests	small area	NA
Halve proportion of population without improved drinking water	high coverage	high coverage
Halve proportion of population without sanitation	high coverage	high coverage
Improve the lives of slum-dwellers	high proportion of slum-dwellers	moderate proportion of slum-dwellers

Goal 8 - Develop a global partnership for development	2005	2015
Internet users	NA	high usage

(Millennium Development Goals Reports 2005 and 2015)

As a region, the Middle East improved upon or remained stagnant in all indicators across the eight goals. From 2005-2015, the Middle East improved in the following targets: reducing extreme poverty by half, universal primary schooling, equal girls' enrollment in primary school, women's equal representation in national parliaments, reduce mortality of under-5-yr-olds by 2/3, halt and reverse the spread of tuberculosis, halve proportion of population without improved drinking water, and halve the proportion of population without sanitation. Meanwhile, the Middle East remained unchanged in the following indicators: reduce hunger by half, increase women's share of paid employment, reduce maternal mortality by ¾, and improve the lives of slum-dwellers.

While Palestine is not technically a state, it has worked towards reaching the MDGs, and The Palestinian National Authority published a report in 2012 called, "The National Strategy to Achieve the MDGs by 2015."[12] The report outlines requirements necessary to achieve the MDGs which include "liberation and the establishment of the independent Palestinian state," "strengthening institution building and developing governance," "the responsibility of the international community," and "improving coordination and local partnership" (The Palestinian National Authority, 2012). While the report includes these four requirements, it asserts that, "the occupation is the major impediment to the realization of these goals and to comprehensive development that can benefit all sectors of society" (The Palestinian National Authority, 2012). The report discusses each goal in depth regarding Palestine's status as of 2012 and projections for 2015. However, the discussion of each goal stresses that an "independent Palestinian state" would better be able to achieve the goals that are hindered by the "Israeli occupation." For

[12] I was unable to find a final report evaluating whether Palestine reached the MDG targets by 2015.

example, it states that "restrictions imposed by the Israeli occupation…prevent all citizens from equal access to health care services" (The Palestinian National Authority, 2012). Therefore, the MDGs are not an effective measure of progress in Palestine due to the lack of statistical analysis post 2015 and the fact that the "requirements" for goal attainment had not been met by 2012 (Siegal, 2016a).

Meanwhile, according to a UN progress report from 2013, Israel had reached or was on track to reach all the MDGs, placing them above most Middle Eastern countries. As of 2013 Israel reported having very low hunger, high enrollment in universal primary schooling, equal girls' enrollment in primary school, high share of women's paid employment, moderate representation of women in national parliament, low mortality of under-5-year-olds, low maternal mortality, and low mortality from tuberculosis. Israel also reported an increase in forestation, high coverage of population with access to improved drinking water and sanitation, and high Internet usage (MDG Country Progress Snapshot: Israel, 2013). Therefore, despite the conflict, Israel's government has successfully worked to improve the economic and health status of its citizens.

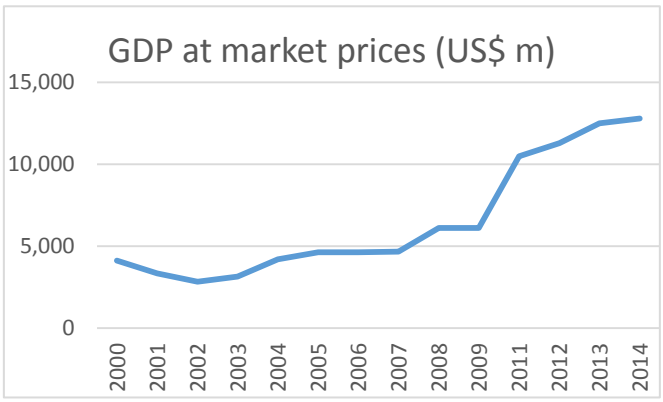
Economic Status

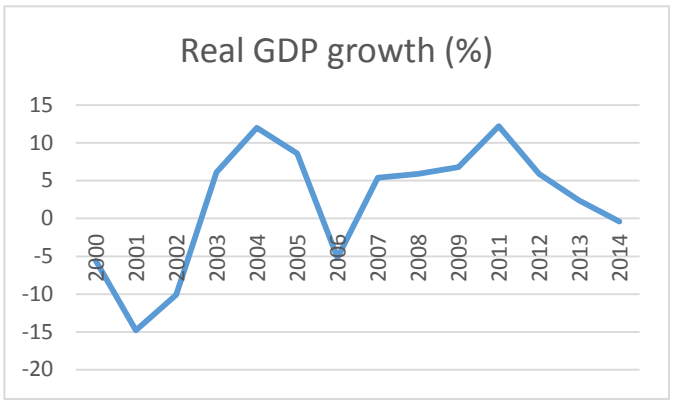
I hypothesize that the status of a state's health and healthcare can be reflected in the status of the economy. Therefore, to evaluate the health of Israel and Palestine's economy, I compiled economic indicators from the years 2000 to 2014 from reports produced by Economist Intelligence Unit. These indicators show that the Palestinian economy "has been struggling for years, owing to the conflict with Israel and the consequent closure policies it put in place, which restrict the movement of Palestinians" (Economist Intelligence Unit, 2016). Additionally, the Palestinian economy and government are largely dependent on international donors to sustain

themselves, and donors are more likely to fund "infrastructure development if peace looked more likely" (Economist Intelligence Unit 2016). Therefore, the status of the Palestinian economy depends on the Palestinian relationship with Israel at any given time, which impacts the movement of people and goods and the likelihood of receiving donor support (Siegal, 2016a).

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2011	2012	2013	2014
GDP at market prices (US$ m)	4,116	3,329	2,831	3,144	4,198	4,634	4,619	4,672	6,108	6,117	10,500	11,300	12,500	12,800
Real GDP growth (%)	-5.6	-14.8	-10.1	6.1	12	8.6	-5.2	5.4	5.9	6.8	12.2	5.9	2.4	-0.4
Consumer price inflation (av; %)	2.8	1.2	5.7	4.4	2.9	3.5	3.8	2.6	9.9	2.8	2.9	2.8	1.7	1.7
Population (m)	2.92	3.06	3.22	3.42	3.5	3.6	3.7	3.8	3.9	4	4.1	4.2	4.3	4.4
Exports of goods fob (US $ m)	400.9	290.3	240.9	270	401	435	450	647	670	-	1,051	1,134	1,133	1,255
Imports of goods (US $ m)	2,383	1,352	1,513	1,952	2,737	3,115	3,245	3,825	4,123	-	-4,832	-5,271	-5,816	-6,651
Current-account balance (US $ m)	-1,023	-	-	-	-1,516	-1,152	-913	-417	535	-	-2,070	-1,821	-2,384	-1,386
Exchange rate (av) NIS: US$	4.077	4.203	4.74	4.554	4.482	4.488	4.457	4.108	3.588	3.933	3.58	3.86	3.61	3.58

(Economist Intelligence Unit 2005, 2010, and 2016)





(Economist Intelligence Unit 2005, 2010, 2016)

While the GDP at market prices has steadily increased since 2002, the real GDP growth percentage has fluctuated, with a dip in 2006, presumably due to the election of Hamas in the Gaza Strip and subsequent border closure. Furthermore, the consumer price inflation of 9.9% in 2008 can most likely be attributed to the global financial crisis at the same time. Additionally, Palestine's GDP of 12.8 US$ billion is the lowest compared to 19 other Middle Eastern

countries, of which Israel is ranked fourth highest (Economist Intelligence Unit, 2016). The steadily increasing Palestinian population has created a densely-populated living situation with potentially adverse health effects. Overall, these statistics indicate that the Palestinian economy is significantly depressed.[13]

On the other hand, Israel's economy is relatively stable, especially in comparison to other countries in the region, presumably due to its strong government and relationship with the United States. Below is a table with various economic indicators. Note that the population estimates "do not include foreign workers resident in Israel (both illegally and legally), who comprise just under 10% of the workforce, but do include Israelis resident in the West Bank and Gaza Strip" (Economist Intelligence Unit, 2005). Israel has experienced steady population growth over the past 15 years, as shown in the table below.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
GDP at market prices (US$ b)	-	113.8	104.2	110.4	116.9	129.8	137.2	-	-	-	-	-	-	-	-
Real GDP growth (%)	6.2	-0.3	-1.2	1.7	4.4	4.9	5.7	5.4	4.2	0.8	3.7	4.5	3.0	4.4	3.2
Consumer price inflation (av; %)	1.1	1.1	5.7	0.7	-0.4	1.3	2.2	0.5	4.6	3.3	2.7	3.2	1.8	1.9	0.5
Population (m)*	-	6.4	6.6	6.7	6.8	6.9	7.1	7.2	7.3	7.4	7.6	7.8	7.9	8.1	8.2
Exports of goods fob (US $ m)	30,800	27,968	27,535	30,099	36,584	40,101	42,856	49,800	57,200	45,900	54,300	62,500	63,700	66,300	63,300
Imports of goods (US $ m)	34,200	-31,014	-31,229	-32,337	-38,473	-43,870	-47,804	55,800	64,400	46,000	55,700	70,500	75,300	78,200	71,200
Current-account balance (US $ m)	-1,300	-1,580	-1,288	796	1,473	4,274	7,450	4,500	2,200	7,600	5,700	-400	-1,500	-1,600	11,200
Exchange rate (av) NIS: US$	4.08	4.21	4.74	4.55	4.48	4.49	4.50	4.11	3.59	3.93	3.75	3.58	3.87	3.86	3.58

(Economist Intelligence Unit Reports, 2001, 2005, 2008, 2009, 2010, 2011, 2012, 2015)

[13] "Palestinian economy" refers to the economies in both Gaza and West Bank, which are run by different governments and experience the conflict in very different ways. Gaza's economy is more depressed than that of the West Bank, but I was unable to find separate indicators for the two territories. Instead, all indicators include the West Bank and Gaza together.

(Economist Intelligence Unit Reports, 2001, 2005, 2008, 2009, 2010, 2011, 2012, 2015)

The real GDP growth percentage in Israel fluctuated from 2000-2014, experiencing large dips in 2002 and 2009, potentially due to increased violence from the second intifada and Operation Cast Lead, respectively. Overall, Israel's real GDP growth percentage is higher than that of the Middle East as a region and the world. Furthermore, Israel's economy is the fourth strongest in the region, after Saudi Arabia, Iran, and the United Arab Emirates (Economist Intelligence Unit, 2015). The next chapter evaluates the impacts of the conflict and economic status on the provision of health services in both Israel and the Palestinian territories.

Chapter 4

The Impact of Conflict on Health and Healthcare

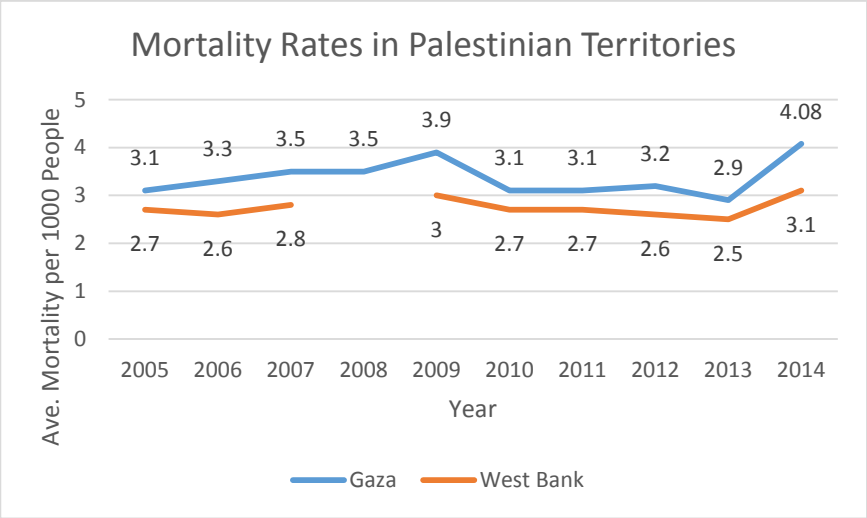
Status of Health

The Israeli-Palestinian conflict has adversely affected the people's health in both Israel and the West Bank and Gaza. The state of the Palestinians' health will be evaluated first, followed by Israelis' health. The State of Palestine Ministry of Health's 2016 report on the "Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan" for the sixty-ninth World Health Assembly outlines the status of health, provision of healthcare, and necessary steps to improve healthcare access and quality of administration. It also reiterates the assertion that "the health sector has faced significant challenges resulting from the impact of the Israeli occupation on the Palestinian people and Palestinian institutions" (Awwad, 2016).

Location	Population
West Bank	2,860,987
Gaza Strip	1,821,479
East Jerusalem	419,108

Age Range (years)	Percentage (%)
0 - 5	15
6 - 14	24.4
15 - 64	57.7
65+	2.9

(Awwad, 2016)



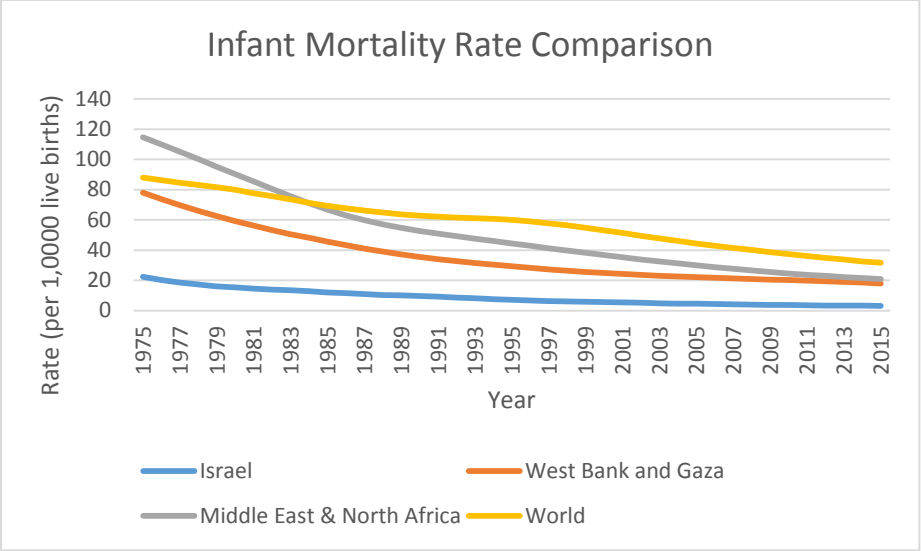
The mortality rates above show a relatively stable trend, with a notable increase between 2008 and 2009 and 2013 and 2014. This likely can be attributed to the wars between Israel and Gaza in 2008 and again in 2014. However, the mortality rate did not significantly increase

during 2012, when Operation Pillar of Defense took place against Hamas in the Gaza Strip. Even though Gaza and the West Bank are subject to recurrent violence, deaths due to violence are not included in the list of the principal causes of death. Instead, the principal causes of death in Palestine in 2014 are as follows: cardiovascular disease (29.5% of recorded deaths), cancer (14.2%), strokes (11.3%), diabetes (8.9%), respiratory diseases (5.4%), perinatal mortality (5.2%), accidents due to several causes (5.2%), renal failure (3.9%), and infectious diseases (3.3%) (Awwad 2016, 9). Many of these causes are due to noncommunicable diseases, which indicates a level of development ahead of countries that suffer primarily from communicable diseases, such as tuberculosis (Siegal, 2016a).

Meanwhile, the leading causes of death in Israel are like those in the Palestinian territories. The top ten causes of death in Israel include ischemic heart disease (10.8% of recorded deaths), stroke (5.8%), diabetes mellitus (5.7%), Alzheimer's and other dementias (5.3%), trachea/bronchus/lung cancers (4.9%), kidney diseases (3.7%), colon and rectum cancers (3.6%), chronic obstructive pulmonary disease (2.8%), breast cancer (2.6%), and lower respiratory infections (2.4%) (Israel: WHO Statistical Profile, 2015). The crude mortality rate improved from 2000 to 2013. It was 6.0 per 1000 population in the year 2000 and 5.3 per 1000 population in the year 2013 (Rosen, 2015). Additionally, as shown in the graph below, Israel's infant mortality rate is lower than that of the Palestinian territories, and both are lower than the averages in the Middle East and the rest of the world. While the leading causes of death in both populations are not conflict-related, both populations face detrimental psychological consequences, as discussed in chapter five.

Age Range (years)	Percentage (%)
0 - 14	27.73
15-24	15.52
25-54	37.15
55-64	8.51
65+	11.09

(CIA World Factbook 2017)



(The World Bank, 2017)

Status of Healthcare Provision

The provision of and access to healthcare is limited in the Palestinian territories due to lack of control, funding, mobility, and resources. According to WHO, the Ministry of Health in the West Bank runs 50 hospitals with 3,502 beds, while the Ministry of Health in the Gaza Strip has 30 hospitals with 2,437 beds. Meanwhile, civil society organizations have 30 hospitals (2,437 beds), and the private sector runs 16 hospitals with 512 beds. UNRWA runs 1 hospital with 63 beds, and the military medical services in Gaza have 3 hospitals with 138 beds (Awwad 2016). Furthermore, to see a specialized doctor in the areas of general surgery, other surgical sub-specialties, internal medical, pediatrics, psychiatry, and more, a patient must go to a Ministry of Health hospital, since the other hospitals lack these specializations (Awwad 2016).

Moreover, "the Ministry of Health is the only institution in Palestine that makes beds available for the treatment of mental and psychological disorders. Two hospitals have such beds: one in the Gaza Strip, with 25 beds, and the other in the West Bank, with 180 beds" (Awwad, 2016, 12). Additionally, there is only one mental hospital each in both the West Bank (180 beds) and in Gaza (40 beds), which combined serve a population of 4.5 million. Also, there is only one

psychiatric training program and only one psychiatrist working in Palestine at the time of this report (Awwad, 2016, 16). Psychotherapy and mental healthcare services are provided by many private clinics and nongovernmental organizations in both the West Bank and in Gaza. "Published data shows that, in total, there are 20 psychologists in the West Bank and the Gaza Strip, although we believe that the figure is closer to 30" (Awwad, 2016, 16). Therefore, if there are 30 psychologists for the entire population (4,682,467 people) of the West Bank and Gaza, then there is approximately 1 psychologist per 156,082 people.[14] This data suggests that the Ministry of Health (overseen by the World Health Organization) and other healthcare administrators, including UNRWA, have inadequate resources, in terms of hospitals, funding, and healthcare providers to serve the population, especially regarding mental illness (Siegal, 2016a).

Israel has a National Health Insurance (NHI) system "that provides for universal coverage," and the Ministry of Health is responsible for the health of Israel's citizens and adequate functioning of the health care system (Rosen, 2009). Eight percent of Israel's GDP accounts for healthcare, and of this amount, "hospitals and public clinics account for approximately 40% of national health expenditure, and dental care accounts for a further 10%" (Rosen, 2009). Further information regarding the breakdown of Israel's financing towards healthcare can be seen in the tables below. Israel has an abundant supply of physicians, 3.5 per 1000 population, but the number of physicians in Israel is growing slower than other countries, so a shortage of physicians is projected (Rosen, 2009). Among the many duties of the Ministry of Health is "overseeing the operation of the Government's 11 acute care hospitals, 8 psychiatric

[14] In comparison, there are approximately 33.9 licensed psychologists per 100,000 people in the United States (APA 2014).

hospitals and 5 chronic disease hospitals" (Rosen, 2009). As of 2005, Israel had about 5,350 psychiatric beds, which means 1.07 beds per 1000 population over 15 years of age. Of this number, 7% of the psychiatric beds were in general hospitals, and the remaining 97% were in psychiatric hospitals (Rosen, 2009). There are also many private, mental health practitioners in communities. Due to the prevalence of conflict, Israel has developed effective emergency services and management for both times of peace and increased terrorism.

Table 3.2 Health expenditure by type of service, 2004

Public clinics and preventive care	41%
Hospitals and research	39%
Dental care	9%
Private physicians	4%
Medicines and medical equipment purchased by households	3%
Government administration	1%

Source: CBS 2008a.

(Rosen, 2009)

Distribution of current expenditure by operating sector (2004):

Government and local authorities	9%
Health plans	34%
Other non-profit-making institutions	7%
Market producers	50%

(Rosen, 2009)

World Health Assembly Agendas

After compiling all the economic, health, and conflict statistics, I conducted a content analysis of the World Health Assembly yearly agendas on "Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan" to determine Palestine's priorities regarding health on an international stage.[15] I examined the Palestinian agendas from 2000, 2005, and 2010, as well as an Israeli statement against the continuation of these agendas at the World Health Assembly. My content analysis process is shown in Table 1 of the Appendix,

[15] I would have conducted a content analysis of Israeli documents to determine their priorities, but I was unable to find them in the online archives.

in which I describe the list of agenda priorities, and I code for positive, neutral, and negative language in each agenda. I deemed language as "positive" if it encouraged peace and cooperation, "neutral" if it was referencing a conflict player or health concept, and "negative" if it blamed the other side or incurred political connotations that are potentially unproductive to peace and reconciliation (Siegal, 2016a).

In line with the constructivist notion of health as a human right, all the agendas examined begin by noting the importance of the WHO Constitution, "which affirms that the health of all people is fundamental to the attainment of peace and security" (53rd World Health Assembly, 2000). Additionally, each agenda stresses the adverse effects of Israel's "occupation" on the health of the Palestinian people. The agendas express the need for the "Palestinian right to self-determination including the option of a State," as well as "freedom of movement of persons and goods within the Palestinian territory" (53rd World Health Assembly, 2000).

While there are significant recurring themes throughout the yearly agendas including the Palestinian right to self-determination, Israel as the "occupier," and increasingly negative language towards Israel, there are also items of concern specific to each time-period. For example, the 2005 agenda discusses the need for assistance in dealing with the aftermath of the Israeli withdrawal from Gaza (58th World Health Assembly, 2005). Meanwhile, the 2010 agenda mentions the importance of UNRWA, food insecurity, and Israeli misconduct against Palestinian medical personnel (63rd World Health Assembly, 2010). All the agendas contain negative language towards Israel and the "occupation," except for one statement that asserts, "Initiation of cooperation between the Israeli Ministry of Health and the Palestinian Ministry of Health which emphasizes that health development is best enhanced under conditions of peace and stability" (53rd World Health Assembly, 2000). The language in the subsequent agendas suggests that the

Palestinian hope for cooperation diminished as the years in the conflict progressed. The increasing use of the words "occupied" or "occupation," from 9 times in 2000, to 14 times in 2005, to 38 times in 2010, showcases Palestine's increasing frustration with the conflict (Siegal, 2016a.

All the reports end with calls to action directed at Israel, the director general of WHO, and the international community. The 2000 agenda states that Palestine "calls upon Israel not to hamper the Palestinian Ministry of Health in carrying out their full responsibility for the Palestinian people" (53rd World Health Assembly, 2000). Five years later, this rhetoric intensifies by saying that Palestine "calls upon Israel, the occupying power, to halt immediately all its practices, policies, and plans which seriously affect the health conditions of civilians under occupation" (58th World Health Assembly, 2005). While the language directed towards Israel is negative, the language used towards the international community positively requests financial assistance and general support.

In response to these yearly agendas, Israel published a statement in 2015 criticizing the political nature and counterproductivity of the reports. The opening statement reads:

> The State of Israel objects to the consideration of the agenda item…and calls for the deletion of this from the agenda of the World Health Assembly. This item is clearly a politically motivated one whose only purpose is to single out one Member State – Israel (68th World Health Assembly 2015).

The Israeli statement continues by saying that the agenda items discussing the health in the occupied territories are a waste of valuable time and resources that could be dedicated to other, more pressing regional issues, such as the Syrian refugee crisis. My content analysis of these agendas demonstrates Palestine's priorities regarding health and healthcare on an international stage and displays the increasingly tense relationship between Palestine and Israel (Siegal, 2016a).

Chapter 5

The Psychological Impacts of the Conflict

The World Health Organization defines mental health as "not merely the absence of mental illness, but as a state of well-being in which all individuals can realize their individual potential, cope with day-to-day stress, and work productively and usefully in a way that contributes to their local communities" (Awwad, 2016). A significant proportion of both populations have been facing recurring conflict and developed PTSD and other mental illnesses as a result.

Psychological Studies

Many studies have been conducted in recent years to determine the psychological effects of the conflict on adolescents, since they are a particularly vulnerable population. Some of the results differ in terms of which populations are affected more heavily, but a correlation was found between increased exposure to trauma and violence and prevalence of mental illness. One in-depth study developed assessment tools to measure the "differential rates of exposure to the conflict, the association between exposure and the severity of posttraumatic symptoms (PTS) and the inter-relationships among PTS, functional impairment, somatic complaints and coping strategies" (Pat-Horenczyk, 2008, 688). This study found the following statistics, which are divided by affected population and displayed in a table format in Appendix III.

Palestinian Youth:

57.8% of the Palestinian students reported very severe exposure to political violence, 41.8% reported moderate to severe exposure, and only 1% reported no exposure to political violence beyond media coverage (Pat-Horenczyk, 2008). After assessing the student sample for posttraumatic stress symptoms, it was found that 37.2% of Palestinian students reported

symptoms meeting the criteria for full PTSD, and 12.1% reported symptoms meeting the criteria for partial PTSD (Pat-Horenczyk, 2008). The study also evaluated functional impairment as a determinant of mental health, by evaluating impairment in four domains, including school functioning, social domain, family relationships, and after-school activities. It was found that 25.3% of students reported functional impairment in one domain, 19.4% reported functional impairment in 2 domains, 17.2% in three domains, and 12.1% in all four domains of functioning. Of these domains, impairment in school functioning was the most common, with 61.0% of students affected (Pat-Horenczyk, 2008). Somatic complaints, such as headache, stomach ache, difficulty sleeping, etc. were evaluated to determine the correlation between physical symptoms and exposure to political violence. It was found that 29.9% of Palestinian students reported one or two somatic complaints, 38.1% reported three or four complaints, and 12.9% reported five or six complaints. This study revealed that the adolescents who reported very severe exposure to violence also reported more somatic complaints than those who reported moderate exposure (Pat-Horenczyk, 2008).

The last measured evaluation was of the coping strategies among students exposed to political violence. It was found that the most frequently used coping strategies among Palestinians included accepting reality, religion, and distraction. Furthermore, adolescents who reported severe exposure to violence also reported using more adaptive, as well as maladaptive, coping strategies than adolescents in the moderate to severe exposure group (Pat-Horenczyk, 2008). Due to the nature of conflict and types of violence employed, a much higher percentage of Palestinians have been exposed to political violence, and they reported higher rates of posttraumatic stress symptoms, functional impairment, somatic complaints, and use of coping strategies than Israeli students (Siegal, 2016b).

Israeli Youth:

Meanwhile, 35.4% of the Israeli students reported very severe exposure to political violence, 21.8% reported moderate to severe exposure, and 42.8% reported no exposure beyond media coverage (Pat-Horenczyk, 2008). The assessment of the prevalence of posttraumatic stress symptoms among Israeli adolescents revealed 6.8% of students reporting symptoms meeting the criteria for full PTSD, and 8.6% of students reported symptoms meeting the criteria for partial PTSD (Pat-Horenczyk, 2008). Using the same indicators for functional impairment, 15.9% of Israeli students who were studied reported functional impairment in one domain, 7.6% in two domains, 2.1% in three domains, and 1.4% in all four domains. A correlation was found between the severity of posttraumatic symptoms and the extent of functional impairment (Pat-Horenczyk, 2008). Additionally, the most commonly used coping strategies among Israelis included accepting reality, distraction, and active coping. As is consistent with the Palestinian sample, Israelis in the moderate to severe exposure group reported using more adaptive, as well as maladaptive, coping strategies than those who reported no exposure (Pat-Horenczyk, 2008). Even though less Israelis reported exposure to political violence, the number is still significant. Over half of the Israeli adolescents studied reported exposure to "conflict-related violence, either by having been personally involved or by having known someone who was killed or injured, or indirectly, through near-miss experiences, such as having planned to be near the site where the event occurred" (Pat-Horenczyk, 2008). These results and experiences make sense given the type of violence directed at Israel, which is mostly random intervals of violence following periods of comparative quiet (Siegal, 2016b).

Variation Among Palestinian Populations:

There are many different populations that are included in the term "Palestinian." The populations that this term can include are Arab-Israelis, Palestinians living in the West Bank, and Palestinians living in Gaza. Each of these populations experiences the conflict very differently based on their proximity to Israel, their government, and restrictions placed upon them by both the Israeli and Palestinian governments. Arab-Israelis, constituting more than 1 million people, are citizens of Israel, living within Israel's recognized borders, and have equal rights as Jewish-Israelis. Palestinians living in the West Bank, 2.5 million, are living within the West Bank under control of the Palestinian Authority, with restrictions to their movement between the West Bank and Israel and within Israel itself. Lastly, Gazan Palestinians, 1.4 million, are living within Gaza's border, under governmental control of a US-recognized terrorist group, Hamas, with no ability to leave Gaza, except under limited circumstances (Smith, 2007). Since these populations are living under vastly different conditions, it makes sense that the ways in which they experience the conflict and the status of their mental health are different as well.

One study focused on the psychological effects of the conflict on these populations by creating a new scale (STACE) that measured "levels of subjective perceptions of threat/fear due to exposure to armed conflict events and its predicting association with six psychosocial and behavioral outcomes covering (1) poor mental health, (2) positive well-being, (3) risk behaviors" (Harel-Fisch, 2010). The results show that the lowest STACE level was seen among Jewish Israeli children (5.23), followed by Arab Israeli (7.56), Palestinians in the West Bank (12.76), and Palestinians in Gaza (14.6), who are "exposed to the highest level of combined frequency, intensity, and fear from armed conflict events" (Harel-Fisch, 2010). However, even though Israeli Arabs showed the lowest level of STACE, they showed the highest levels of posttraumatic

symptoms, psychosomatic symptoms, and risk behaviors (Harel-Fisch, 2010). The higher levels of health problems and behaviors among Israeli-Arabs could be "attributed to other social determinants related to social inequality and are not unique to armed conflict" (Harel-Fisch, 2010). Even so, Israeli-Arabs rate higher for level of life satisfaction and positive health and life perceptions than the Palestinian children from the West Bank and Gaza (Siegal, 2016b).

Gender Differences:

Studying the gender differences in how adolescents experience the conflict is important, since this is a critical time in terms of identity and development. Therefore, the gendered effects of the conflict on Palestinians will be assessed first, followed by that on Israeli adolescents. Among the Palestinian participants in the above-mentioned study, Palestinian boys reported more severe exposure and direct involvement, and girls reported more moderate exposure, such as being a witness to political violence (Pat-Horenczyk, 2008). While boys may experience more instances of violence, girls have a higher presence of depressive-like symptoms. One explanation for these results is the way "boys and girls are socialized in the OPT, with societal norms allowing greater freedom to boys, especially of movement outside the domestic sphere or the school, and consequently leading to higher exposure among boys, compared to girls" (Giacaman, 2007). Therefore, the differences in level of exposure, and the emotional impact on each gender can be partly explained by the differences in cultural and social positions for girls in the territories.

One of the studies did not find any notable gender differences in exposure among Israeli adolescents, potentially because of the "unpredictable and arbitrary nature of the violence experienced in Israel, where attacks occur in unexpected places where girls are as likely to be present as boys" (Pat-Horenczyk, 2008). Another study that focused completely on gender

differences as it relates to mental health and exposure to violence among Israeli-adolescents found some differences that showed mixed patterns. This study found that females experience more internalizing behavior (such as anxiety, depression, etc.), while males experience more externalizing behavior, especially substance abuse. However, girls with high exposure to violence showed significantly higher levels of substance abuse, equivalent to males, potentially pointing towards a trend of self-medicating (Slone, 2015). The risk-taking behaviors that were evaluated include fighting, smoking cigarettes, using drugs, driving dangerously, having unprotected sex, drinking alcohol, hitchhiking, playing Russian roulette, stealing, disobeying school authorities, disobeying parents, dysfunctional eating, breaking the law, carrying weapons, running away from home, and injuring oneself. The most common risk-taking behavior seen in total was fighting, accounting for 57.2% of respondents, of that 75.6% males and 36.8% females. The only risk-taking behavior in which females reported higher participation was running away from home (Slone, 2015). While the trend of females showing internalizing behaviors and males showing externalizing behaviors more frequently is well documented, the reason behind this is unclear in the studies evaluated for this project (Siegal, 2016b).

Indirect Factors Affecting Mental Health

There are many risk factors and social determinants of poor mental health among Israelis and Palestinians living within the conflict. These include, but are not limited to, historical trauma, social factors, political factors, and cultural factors. The theory of historical trauma comes from Native American history, which is a population that is "experiencing historical loss symptoms (e.g., depression, substance dependence, diabetes, dysfunctional parenting, unemployment) as a result of the cross-generational transmission of trauma from historical losses (e.g., loss of population, land, and culture)" (Brown-Rice). Even though this concept was

developed in relation to Native Americans, it can be applied to all the populations affected in the Israeli-Palestinian conflict. The Jewish-Israelis have the collective history of repeated persecution, most prominently in the Holocaust. New research even indicates that genetic changes stemming from trauma suffered by Holocaust survivors can be passed onto their children (Thomson, 2015). A similar historical trauma case can be made for the Nakba, or expulsion, experienced by Palestinians in 1948. This historical trauma can be compounded by the difficult social and political situation the people on both sides are forced to endure (Siegal, 2016b).

Mental Health Services

Israel:

One report claims that health care accounts for approximately 8% of Israel's GDP. There is a universal coverage of the population via an NHI system, "providing access to a broad benefits package including physician services, hospitalization, medication and so on" (Rosen, 2009). However, long-term care and psychiatric services are not included in this NHI system, but some public funds are available to partially cover these services. Furthermore, over the past few years Israel has been implementing a health reform plan that transfers the responsibility for community mental health care from the Health Ministry to the Health Maintenance Organizations (Even, 2013). In July 2013, 39 new mental health clinics were opened, which expanded the number of patients gaining access to mental health services by 40%. Additionally, the increase in minors gaining access to mental health services was projected to increase by 70% (Even, 2013). This structure alters the use of primary care doctors for mental health services, but it enables patients to be seen by specialists, such as psychologists and psychiatrists, for their necessary treatment of mental illnesses.

Palestinian Territories:

While there is no defined budget for mental health services in the territories, it is estimated that 2.5% of the Ministry of Health's healthcare expenditures are directed towards mental health. Of this portion, 73% is spent on psychiatric hospitals. Furthermore, the population has free access to services and essential psychotropic medicine, and all mental disorders are covered by social insurance. However, some people must pay for antipsychotic medication and antidepressant medication out of pocket which can cost up to 15-23% of the daily minimum wage (WHO-AIMS, 2006).

Findings and Recommendations

Many of the psychological studies conducted express the need for developing "community-based programs for preventing and alleviating PTS symptoms and related distress" (Pat-Horenczyk, 2008). One study suggests the importance of providing secondary prevention and mental health treatment in schools and clinical settings to address the growing numbers of post-traumatic stress symptoms and "related distress" among adolescents (Pat-Horenczyk, 2008). However, while these studies suggest the need for "community-based programs," they fail to suggest specific ways in which these programs can be developed and implemented. While it might be the responsibility of the policy makers, clinicians, school administrators, and the government to provide such services, the need for them is undeniable.

Considering the economic, health, and psychological impacts of the Israeli-Palestinian conflict simultaneously enabled me to identify a few trends. First, I found a correlation between years of increased conflict and the increase in mortality rates, decrease in economic indicators such as GDP, increased strain on healthcare provision, and increased prevalence of mental health

issues. In the fifteen-year period analyzed, this pattern was evident during the increased conflict times of 2008, 2012, and 2014.

Another recurring theme was the role that the "Israeli occupation" plays in hindering the capabilities of the Palestinian Authority and various UN organizations to provide adequate social and health services to the Palestinian people. This rhetoric was evident in the UNRWA reports, WHO reports, report on the Millennium Development Goals, as well as the World Health Assembly agendas. All these documents asserted that independent Palestinian statehood was a prerequisite to providing the necessary services to the population. Therefore, analyzing the effectiveness of the WHO and UNRWA health programs proved difficult due to the disclaimer that Palestinian statehood has not been achieved, and therefore, significant improvements are still needed.

Throughout my research, the liberalist theoretical perspective was present due to the emphasis of the importance of international organizations in addressing the health concerns of both populations. Moreover, the constructivist theoretical perspective was consistently held throughout all the documents that assert health as a human right. Due to this norm construction, the World Health Organization, and by extension, the United Nations, could arguably be the norm entrepreneur for the ideas of human security and health as a human right for all irrespective of gender, ethnicity, and refugee status.

Information from my research can be significant for policy makers to understand the priorities of the Palestinian people in addressing statehood prior to health concerns, because they believe that an improved economy and health indicators will come with statehood. However, it cannot be proven that Palestinian statehood is required to improve the economic and health success of the nation. Therefore, the Palestinian Authority and Hamas should be working

towards these improvements in the meantime. Additionally, my research identifies the gaps in research regarding the effectiveness of international organizations in addressing health concerns. WHO, UNRWA, and other UN agencies and organizations publish reports of their progress, but there is little scholarly research evaluating the validity of these firsthand claims. Ultimately, analyzing the economic, health, and psychological effects of the conflict simultaneously enabled me to evaluate the non-political impacts of the Israeli-Palestinian conflict on the various populations affected.

Future Research

In the future, I hope to expand upon my research by collecting data that more clearly differentiates the effects of conflict on various populations. For example, I want to examine the differences in healthcare administration between East and West Jerusalemite Palestinians. Additionally, collecting data that explicitly represents the differences between Gazan and West Bank Palestinians would more accurately depict the effects of conflict on these populations.

Additionally, I would like to examine statistics provided by the Coordinator of Government Activities in the Territories (COGAT) to determine the amount of people, aid, and resources that enter and leave the territories daily. I also hope to examine the numbers of Palestinian healthcare personnel working in Israel over time. Ultimately, there are many ways upon which to expand my current research that would enhance our understanding of the economic, health, and psychological effects of the Israeli-Palestinian conflict.

Appendix I: History of the Israeli-Palestinian Conflict

Date	Israeli Narrative	Palestinian Narrative
1880-1914	European Jews founded the Zionist movement in response to worsening persecution. Jews immigrate to Palestine, which was part of the Ottoman Empire (Katirai, 2001).	
1915-1917	Nov. 1917 – Balfour Declaration British government signs the declaration that supports "the establishment in Palestine of a National Home for the Jewish people" (Katirai, 2001).	1915 Hussein-McMahon Correspondence "Britain pledged to support Arab independence if Hussein's forces revolted against the Ottomans" (Katirai, 2001).
1918	WWI – Britain wins control of Palestine from the Ottoman Empire. Britain governs over the Jews and Arabs living in the territory known as British-mandate Palestine (Katirai, 2001).	
1947	UN General Assembly suggests partitioning British-mandate Palestine into two separate states, one for Jews and one for Arabs. "Fighting breaks out soon thereafter, as all the surrounding Arab states rejected the partition plan" (Katirai, 2001).	
	"Zionist leaders accepted the proposed partition for tactical and strategic reasons" (Katirai, 2001).	"Palestinians considered the proposal unrepresentative of the demographic distribution of Jews and Arabs living in Palestine at that time, and so rejected it" (Katirai, 2001).
1948	"Zionist leaders proclaimed the state of Israel. Fighting breaks out between the newly declared state of Israel and its Arab neighbors as British troops are leaving the country" (Katirai, 2001).	
	War of Independence – "Some 700,000 Palestinians leave what had been British-mandate Palestine. Israel gains control over large tracts of land, including some five hundred Palestinian villages" (Katirai, 2001).	"al-Nakbah" or "the Catastrophe" – "Some 700,000 Palestinians flee or are driven from what had been British-mandate Palestine. Israel annexes large tracts of land and destroys some five hundred Palestinian villages" (Katirai, 2001).
1948-1967	"Ongoing skirmishes between Israel and its Arab neighbors" (Katirai, 2001).	
June 5, 1967	"Six Day War" – Israel conducts a pre-emptive attack against surrounding Arab countries because their armies were lining up tanks on Israel's border. In six days, "Israel roughly triples the size of territory under its control" by gaining Gaza, the Sinai Peninsula, West Bank,	"al-Naksah" or "the Setback" – "Israel seizes Egyptian, Syrian, and Jordanian territory…Israel begins establishing settlements in the West Bank, Gaza, and Sinai Peninsula. Palestinians view this as a violation of international law regarding territory seized during war" (Katirai, 2001).

	Golan Heights, and East Jerusalem (Katirai, 2001).	
	UN Security Council passes Resolution 242 emphasizing "the inadmissibility of the acquisition of territory by war and the need to work for a just and lasting peace in which every State in the area can live in security" (Resolution 242).	
1972	"Palestinian gunmen kill 11 Israel athletes at the Munich Olympics" (Katirai, 2001).	
1973	"Egypt and Syria organize a surprise attack on Israeli forces in the Sinai Peninsula and the Golan Heights on the day of the Jewish fast of Yom Kippur and the Muslim month of Ramadan" (Katirai, 2001).	
	Yom Kippur War – "Israel saw the war as a military victory because it maintained possession of the Sinai Peninsula and the Golan Heights" (Katirai, 2001).	Ramadan War – "Egypt and Syria made initial gains but retreated after Israeli counter-attacks. Because they successful carried out a surprise attack, the war was a political victory for Egypt and Syria" (Katirai, 2001).
1978-1981	Egypt, Israel and the US sign the Camp David accords, in which Israel agrees to return the Sinai Peninsula to Egypt in return for peace. Egypt's president Anwar Sadat became unpopular with Arabs, and Egypt was expelled from the Arab League because of the peace treaty.	
1987	Palestinian "Intifada" (uprising) begins in West Bank and Gaza.	
	Israel tried to suppress the "riots," but "a united Palestinian public continued its protests and demonstrations for six years…More than 20,000 people were killed or injured between 1987 and 1993" (Katirai, 2001).	"The Intifada was in protest of continued Israeli occupation of the West Bank and Gaza and involved demonstrations, strikes, riots, and violence. The most symbolically important act of the Intifada was the stoning of Israeli security forces and civilians, often performed by young men and boys" (Katirai, 2001).
1993	Israeli and Palestine Liberation Organization (PLO) negotiators begin peace talks that result in the signing of the Declaration of Principles in Washington (Oslo Accords).	
	"Israel recognizes the PLO and gave them limited autonomy (in the occupied territories of the West Bank and Gaza) in return for peace" (Katirai, 2001).	"The PLO in turn gave up its claims to Israel's territory as defined by its borders before the 1967 war. The Palestinians also agreed to end the Intifada and establish security in the West Bank and Gaza" (Katirai, 2001).
2000	"Israel unilaterally withdraws from the area of Lebanon it was occupying since 1982. And in July, a peace summit between Palestinian and Israeli leaders and negotiators at Camp David ends deadlocked over competing claims to Jerusalem and the issue of Palestinians refugees" (Katirai, 2001).	
	Ariel Sharon visits Temple Mount, prompting violence from Palestinians leading to another intifada.	

2002	Israel launches Operation Defensive Shield on West Bank "after spate of Palestinian suicide bombings" (BBC 2016).
2005	Israel unilaterally disengages from Gaza, withdrawing "all Jewish settlers and military personnel from Gaza, while retaining control over airspace, coastal waters and border crossings" (BBC 2016).
2006	"Hamas Islamist group wins Palestinian parliamentary elections. Rocket attacks on Israel from Gaza escalate. Met with frequent Israeli raids and incursions over following years" (BBC 2016).
2008	Hamas fires significant number of rockets into Gaza, prompting Israel's month-long invasion of Gaza (BBC 2016).
2012	"Israel launches week-long military campaign against Gaza-based armed groups following months of escalating rocket attacks on Israeli towns" (BBC 2016).
2014	"Israel responds to attacks by armed groups in Gaza with a military campaign by air and land to knock out missile launching sites and attack tunnels" (BBC 2016).

Appendix II: World Health Assembly Palestine Agendas and Israeli Response Statement

	Priority – Placement in Agenda (Coded: Topic 1, Topic 2, …of #)	**Terminology – Coded "Positive" (+ Frequency)**	**Terminology – Coded "Neutral" (+ Frequency)**	**Terminology – Coded "Negative" (+ Frequency)**
World Health Assembly – Palestine 2000	1st – WHO Constitution 2nd – UNSC Resolutions 242, 338, 425 3rd – Peace talks 4th – Lift closures 5th – IGO, NGO assistance 6th – Requests: - Free circulation/movement - Technical assistance to support health programs - Funding - Health assistance programs - Report on implementation	Agreement (3) Cooperation (2) Peace (8) Gratitude (1)	Health (27) Self-determination (1) Syria (2) Israel (6)	Occupied (9) Hamper (1)
World Health Assembly – Palestine 2005	1st – WHO Constitution 2nd – Previous resolutions 3rd – Water resources 4th – "Enhanced X-ray machine" at border-crossings 5th – Gratitude towards IGOs, NGOs 6th – Requests: - Fact-finding report - Assessment of "enhanced X-ray machine" - Israeli withdrawal from Gaza - "Health-related technical assistance" - Handicapped and injured - Development of human resources - Report on implementation	Cooperation (1) Peace (1) Gratitude (1)	Health (18) Israel (7)	Concern (2) Deterioration (1) Humanitarian crises (1) Occupation/Occupied (14) Restrictions (1) Deploring (1)

World Health Assembly – Palestine 2010	1st – WHO Constitution 2nd – Previous resolutions 3rd – Blockade 4th – Restrictions on movement 5th – DEMANDS Israel: - End closure - End policies affecting food and fuel shortages - Comply with ICJ opinion about wall - Facilitate healthcare access for Palestinians - Ensure safe passage for ambulances - Improve living conditions - Facilitate transit of medicines - Assume responsibility for humanitarian needs - Halt closure - Respect UNRWA 6th – URGES member states, IGOs, NGOs: - Help overcome health crisis - Meet humanitarian needs - Pressure Israeli government - Remind Israel - Human rights orgs - Support Ministry of Health - Provide financial assistance 7th – EXPRESSES: - Appreciation for international donor community - Appreciation for Director-General 8th – REQUESTS: - Support	Agreement (2) Cooperation (1) Peace (1)	Health (37) UNRWA (2) Israel (17)	Grave (3) Occupation/occupied (38) Military (2) Concern (5) Emergency (2) Deterioration (1) Crisis (5) Food insecurity (1) Suffering (3) Casualties (1) Wall (2) Blockade (1)

	- Submit fact-finding report - Support establishment of medical facilities - Provide technical assistance - Provide health and veterinary services - Support development of health system - Establish teams to treat Palestinians in Israeli jails - Make detailed report available - Report on implementation			
Response Statement of the Israeli Government 2015	1st – Objects to consideration of agenda items and calls for deletion 2nd – WHO should remain professional and not be swayed by political nature of reports 3rd – Improving health situation in Palestinian territory 4th – WHO should focus on "deteriorating situation in Syria" instead 5th – Political nature of health debate in Golan, especially with Syrian crisis happening	Improving (1) Negotiations (1) Bilateral (2)	Health (22) Syria (8) Palestinian (4) Israel (9) World Health Assembly (7)	Political (4) Challenges (1) Disturbing (1)

Appendix III: Findings from Pat-Horenczyk's Psychological Study

		Palestinian (%)	Israeli (%)
Exposure to Political Violence	Very severe exposure	57.8	35.4
	Moderate to severe exposure	41.8	21.8
	No exposure beyond media	1.0	42.8
Symptoms Meeting Criteria For PTSD	Full PTSD	37.2	6.8
	Partial PTSD	12.1	8.6
Functional Impairment In: - School functioning - Social domain - Family relationships - After-school activities	1 domain	25.3	15.9
	2 domains	19.4	7.6
	3 domains	17.2	2.1
	4 domains	12.1	1.4
Somatic Complaints: - Headache - Stomach ache - Difficulty sleeping	1 or 2 somatic complaints	29.9	22.6
	3 or 4 somatic complaints	38.1	5.2
	5 or 6 somatic complaints	12.9	0.6

Works Cited

American Psychological Association. June 2014. "How Many Psychologists Are Licensed in the United States?" *Monitor on Psychology*. Accessed December 14, 2016. http://www.apa.org/monitor/2014/06/datapoint.aspx.

Awwad, Jawad. 20 May 2016. "Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan." *World Health Organization*: A69/INF./6. Accessed October 8, 2016. https://unispal.un.org.

BBC News. April 19, 2016. "Israel Profile - Timeline." BBC News. Accessed December 14, 2016. http://www.bbc.com/news/world-middle-east-29123668.

Brown-Rice, K. Examining the theory of historical trauma among Native Americans. Retrieved March 29, 2016, from The Professional Counselor website: http://tpcjournal.nbcc.org/examining-the-theory-of-historical-trauma-among-native-americans/

B'Tselem. "Statistics." Accessed November 14, 2016. https://www.btselem.org/statistics.

"Country Report: Israel." The Economist Intelligence Unit. December 1, 2012. Accessed April 26, 2017. http://country.eiu.com/israel.

"Country Report: Israel." The Economist Intelligence Unit. December 6, 2011. Accessed April 26, 2017. http://country.eiu.com/israel.

"Country Report: Israel." The Economist Intelligence Unit. November 2001. Accessed April 26, 2017. http://country.eiu.com/israel.

"Country Report: Israel." The Economist Intelligence Unit. November 2, 2010. Accessed April 26, 2017. http://country.eiu.com/israel.

"Country Report: Israel." The Economist Intelligence Unit. November 3, 2009. Accessed April 26, 2017. http://country.eiu.com/israel.

"Country Report: Israel." The Economist Intelligence Unit. November 5, 2008. Accessed April 26, 2017. http://country.eiu.com/israel.

"Country Report: Israel." The Economist Intelligence Unit. October 1, 2005. Accessed April 26, 2017. http://country.eiu.com/israel.

"Country Report: Israel." The Economist Intelligence Unit. October 1, 2015. Accessed April 26, 2017. http://country.eiu.com/israel.

"Country Report: Israel." The Economist Intelligence Unit. October 8, 2010. Accessed April 26, 2017. http://country.eiu.com/israel.

"Country Report: Palestine." The Economist Intelligence Unit. November 1, 2000. Accessed November 14, 2016. http://country.eiu.com/palestine.

"Country Report: Palestine." The Economist Intelligence Unit. November 12, 2015. Accessed November 14, 2016. http://country.eiu.com/palestine.

"Country Report: Palestine." The Economist Intelligence Unit. October 8, 2010. Accessed November 14, 2016. http://country.eiu.com/palestine.

Even, D. (2013, May 13). Israel planning major expansion in mental health treatment. Retrieved March 29, 2016, from Haaretz website: http://www.haaretz.com/israel-news/israel-planning-major-expansion-in-mental-health-treatment.premium-1.523670

Fisher, Max. 2014. "Every Person Killed in Israel-Palestine since 2000." Vox. Accessed Nov 13, 2016. http://www.vox.com/2014/7/14/5898581/chart-israel-palestine-conflict-deaths.

Giacaman, R. (2007). Individual and collective exposure to political violence: Palestinian adolescents coping with conflict. *European Journal of Public Health*, *17*(4), 361-368. http://dx.doi.org/10.1093/eurpub/ckl260

Giacaman, Rita, Rana Khatib, Luay Shabaneh, Asad Ramlawi, Belgacem Sabri, Guido Sabatinelli, Marwan Khawaja, and Tony Laurance. 2009. "Health in the Occupied Palestinian Territory 1: Health Status and Health Services in the Occupied Palestinian Territory." *The Lancet* 373: 837-849. Accessed October 10, 2016. doi: 10.1016/S0140-6736(09)60107-0.

Harel-Fisch, Y. (2009). Psychological outcomes related to subjective threat from armed conflict events (STACE): Findings from the Israeli-Palestinian cross-cultural HBSC study. *Child Abuse and Neglect*, 623-638. http://dx.doi.org/10.1016/j.chiabu.2009.12.007

"Health Conditions in the Occupied Palestinian Territory Including East Jerusalem and in the Occupied Syrian Golan." Fifty-Eighth World Health Assembly. May 23, 2005. Accessed November 14, 2016. https://unispal.un.org/DPA/DPR/unispal.nsf/d0911f77d9bb1f14852574050052b8d6/fbb49ed072e1b2eb8525700d006f2c0f?OpenDocument&Highlight=0,health.

"Health Conditions in the Occupied Palestinian Territory Including East Jerusalem, and in the Occupied Syrian Golan." Sixty-Third World Health Assembly. May 20, 2010. Accessed November 14, 2016. https://unispal.un.org/DPA/DPR/unispal.nsf/d0911f77d9bb1f14852574050052b8d6/ecadc124eef7ccc68525772f00711793?OpenDocument&Highlight=0,health.

"Health Conditions Of, and Assistance To, the Arab Population in the Occupied Arab Territories, Including Palestine." Fifty-Third World Health Assembly. May 20, 2000. Accessed November 14, 2016.

https://unispal.un.org/DPA/DPR/unispal.nsf/d0911f77d9bb1f14852574050052b8d6/8deb4975e207c2a0852574e1006d1c45?OpenDocument&Highlight=0,health.

"Information on More than 150,000 Terrorist Attacks." Global Terrorism Database. Accessed November 14, 2016. https://www.start.umd.edu/gtd/.

Katirai, Negar. "History of the Israeli-Palestinian Conflict." POV. 2001. Accessed April 29, 2017. http://pov-tc.pbs.org/pov/pdf/promiese/promises-timeline.pdf.

"Israel: WHO Statistical Profile." World Health Organization. January 2015. Accessed April 28, 2017. http://www.who.int/gho/countries/isr.pdf?ua=1.

McCann, Paul. 2008. "The Role of UNRWA and the Palestine Refugees." *Palestine - Israel Journal of Politics, Economics, and Culture* 15/16: 83-89. Accessed November 14, 2016.

"MDG Country Progress Snapshot: Israel." United Nations. August 2015. Accessed April 28, 2017. https://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2015/Snapshots/ISR.pdf

"Millennium Development Goals: Progress Chart." United Nations. 2005. Accessed November 14, 2016. http://www.un.org/millenniumgoals/pdf/mdg2005progresschart.pdf.

"Millennium Development Goals: 2015 Progress Chart." United Nations. 2015. Accessed November 14, 2016. http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG 2015 PC final.pdf.

Mingst, Karen A., Margaret P. Karns, and Alynna J. Lyon. 2017. *The United Nations in the 21st Century*, 5th Edition. Boulder, CO: Westview Press.

"Mortality rate, infant (per 1,000 live births)." The World Bank. Accessed April 28, 2017. http://data.worldbank.org/indicator/SP.DYN.IMRT.IN?contextual=aggregate&end=2015&locations=PS-IL&start=1975&view=chart.

"Multilateral Treaties Deposited with the Secretary General." United Nations Treaty Collection. Accessed December 15, 2016. https://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&clang=_en.

Muravchik, Joshua. November and December 2013. "The UN and Israel: A History of Discrimination." World Affairs Journal. Accessed December 24, 2016. http://www.worldaffairsjournal.org/article/un-and-israel-history-discrimination.

Pat-Horenczyk, R. (2009). Posttraumatic symptoms, functional impairment, and coping among adolescents on both sides of the Israeli-Palestinian conflict: A cross-cultural approach. *Applied Psychology, 58*(4), 688-708. http://dx.doi.org/10.1111/j.1464-0597.2008.00372.x

"Pledges to UNRWA (Cash and In Kind) for 2012 - Donor Ranking." UNRWA. December 31, 2012. Accessed December 14, 2016. https://www.unrwa.org/sites/default/files/All_donors_ranking_overall.pdf.

"Pledges to UNRWA (Cash and In-Kind) for 2015 - Overall Donor Ranking in USD." UNRWA. December 31, 2015. Accessed December 14, 2016. https://www.unrwa.org/sites/default/files/2015_donors_ranking_overall.pdf.

"Resolution 242." United Nations. November 22, 1967. http://israelipalestinian.procon.org/sourcefiles/1967-UN-Resolution-242.pdf.

Rosen, Bruce, Ruth Waitzberg, and Sherry Merkur. "Israel Health System Review." *Health Systems in Transition* 17, no. 6 (2015). Accessed April 28, 2017. http://www.euro.who.int/__data/assets/pdf_file/0009/302967/Israel-HiT.pdf?ua=1.

Rosen, B., & Samuel, H. (2009). Health systems in transition. *European Observatory on Health Systems and Policies, 11*(2). Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0007/85435/E92608.pdf

Shabaneh, Ghassan. 2010. "Refugees, International Organizations, and National Identity: The Case of Palestine." *New Political Science* 32 (2): 215-236. doi:10.1080/07393141003722057.

Siegal, Ilana. "The Impact of Conflict on Palestinian Health: A United Nations Perspective." International Relations Distinction Capstone, Syracuse University, 2016a.

Siegal, Ilana. "The Psychological Effects of the Israeli-Palestinian Conflict." Midterm Paper for ANT 463 Global Health, Syracuse University, 2016b.

Slone, M., & Mayer, Y. (2015). Gender differences in mental health consequences of exposure to political violence among Israeli adolescents. *Children and Youth Services Review*, 170-178. http://dx.doi.org/10.1016/j.childyouth.2015.09.013

Smith, C., & Myre, G. (2007, June 17). Comparing the two territories. Retrieved March 29, 2016, from The New York Times website: http://www.nytimes.com/2007/06/17/weekinreview/17smith.1.html?_r=0

"Statement of the Government of Israel to the Sixty-Eighth World Health Assembly." Sixty-Eighth World Health Assembly. May 15, 2015. Accessed November 14, 2016. https://unispal.un.org/DPA/DPR/unispal.nsf/d0911f77d9bb1f14852574050052b8d6/5f7524d664de195c85257e490053b4d3?OpenDocument&Highlight=0,health.

Stewart, Frances. 2003. "Conflict and the Millennium Development Goals." *Journal of Human Development* 4 (3): 325-351. doi:10.1080/1464988032000125737.

"The National Strategy to Achieve the MDGs by 2015." UNESCO. June 2012. Accessed November 14, 2016. http://planipolis.iiep.unesco.org/upload/Palestine/Palestine_MDG_2012.pdf.

"The Palestine Question." Division for Palestinian Rights. January 1, 1980. Accessed November 14, 2016. https://unispal.un.org/DPA/DPR/unispal.nsf/0/38D6C47FC5FB0CDD852575D6006C70D4.

"The World Factbook: ISRAEL." Central Intelligence Agency. January 12, 2017. Accessed April 28, 2017. https://www.cia.gov/library/publications/the-world-factbook/geos/is.html.

Thomson, H. (2015, August 21). Study of Holocaust survivors finds trauma passed on to children's genes. *The Guardian*, Genetics. Retrieved from https://www.theguardian.com/science/2015/aug/21/study-of-holocaust-survivors-finds-trauma-passed-on-to-childrens-genes

"Top 20 Overall Donors to UNRWA in 2008 - All Funding Categories." UNRWA. February 11, 2009. Accessed December 14, 2016. https://www.unrwa.org/sites/default/files/Top 20 Donors to UNRWA in 2008 - Overall Contributions.pdf.

"UN Data | Country Profile | Israel." Accessed November 14, 2016. http://data.un.org/CountryProfile.aspx?crName=Israel.

United Nations. March 14, 1975. "United Nations Conference on the Representation of States in Their Relations with International Organizations." Accessed November 14, 2016. http://legal.un.org/diplomaticconferences/repofstates_intlorgs-1975/docs/english/vol2/a_conf_67_proposalsplenary.pdf.

United Nations. November 22, 1976. "Resolution 242." http://israelipalestinian.procon.org/sourcefiles/1967-UN-Resolution-242.pdf.

"UN Millennium Project | About the MDGs." UN Millennium Project | About the MDGs. Accessed November 14, 2016. http://www.unmillenniumproject.org/goals/.

UNRWA. "Who We Are UNRWA." UNRWA. Accessed November 14, 2016. http://www.unrwa.org/who-we-are.

WHO-AIMS Report on mental health system in West Bank and Gaza. (2006). Retrieved March 29, 2016, from World Health Organization website: http://www.who.int/mental_health/evidence/west_bank_and_gaza_who_aims_report.pdf

World Health Organization. 2016. "Who We Are, What We Do." Accessed November 14, 2016. http://www.who.int/about/en/.

World Health Organization. October 2006. "Constitution of the World Health Organization." Accessed November 14, 2016. http://www.who.int/governance/eb/who_constitution_en.pdf.