



## INTERVIEW

# Making a Difference: An Interview with Rita Giacaman Working for Health in the Occupied Palestinian Territory

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Rita Giacaman, PharmD, is a professor of public health at the Institute of Community and Public Health, Birzeit University, West Bank, occupied Palestinian territory. She is a founding member of the Institute and has worked there for 31 years. As a researcher and practitioner, she was active in the development of the Palestinian primary health care model, including the use of community health workers. In recent years Rita and her colleagues have been focusing on understanding the impact of chronic war-like conditions and excessive exposure to violence on the health and well-being of Palestinians. Their key findings and the work of other scholars were reported in a series of five papers on health in the occupied Palestinian territory published in the March 2009 issue of *The Lancet* (see references). This edited, abridged interview with Dr. Giacaman is based on my conversation with her in October 2009 by Skype.

Jane Westberg

Associate Editor *Education for Health*

**The Institute of Community and Public Health (ICPH) has been making many significant contributions since you and your colleagues established it in 1978. How would you describe its mission both now and then?**

At the time we didn't think of missions and visions. That came much later. There was a very active group of academics and activists who were teaching at Birzeit University. There were so many university and school closure orders and violations by the Israeli military that Birzeit University was just trying to survive. The survival of academia was important both for educating the future generations and for the survival of the nation.

I wasn't the first one who tried to link academe with society. Birzeit was already involved in social action and community development. For instance, the late Al Glock had already set up a wonderful archeology program, which strove to uncover Palestinian history to demonstrate that we've always been here. Khalil Mahshi, and later on, Hyam Abu Ghazaleh, operated a literacy program catering to mostly women's needs. There are several other examples of how Birzeit University linked academic life to community development.

I was coming back from the University of California Medical Center where I had been trained in the biomedical model. I was starry eyed. We had hope. A collective, critical mass of people was actively resisting occupation, wanting to develop work that was important, relevant, and meaningful for our society.

We had that opportunity in 1979. The Mennonite Central Committee had been doing a super job calling for justice and assisting peasant communities in the Jordan Valley on the West Bank to stay on their land by introducing drip irrigation to improve agricultural production. A friend, Salim Tamari, a social scientist, was beginning to assess the impact of these techniques and asked us to join him and find out about the health of the people there.

That work was transformative. I went with a team who investigated various aspects of life. We were shocked by the conditions in which people lived. I think this is when we discovered what we called "health as a social construction." It was much later that the Commission on Social Determinants of Health endorsed the same idea. ["The conditions in which people live and work can help to create or destroy their health."] It wasn't brightness that helped us discover this. It was life and reality. The poverty, the bad sanitation, inadequate housing, inadequate nutrition altogether made for very high infant mortality rates and very high malnutrition rates.



We discovered that the malnutrition rates among the girls were much higher than among the boys. This linked us to what is now called “gender relations.” At that time we didn’t know the term. At that time we discussed patriarchy and the way in which it conditions health status between boys and girls.

We did research in communities and discovered the theory later. That was one key feature of our work (practice on the ground, leading to understanding and or modifying theory). A second key feature was reversing the pattern of middle class professionals planning from behind their desks and often providing biomedical responses that were irrelevant to what communities needed. Instead, we went to communities and asked them what they needed.

### **What did the communities tell you they needed?**

We realized we can’t romanticize community. Even today we hear international and humanitarian agencies saying, “The community wants this.” My immediate response is, “What community?” Community is characterized by conflict and harmony. Different groups within communities might well need different projects. For example, in a second study in three villages in the vicinity of Birzeit, women pointed to the problems of health care for the children and the need for education. Men pointed to the lack of agricultural roads and the need for mosques for community meetings and discussion, in addition to praying. We were faced with how to prioritize, given that different groups have different needs. We opted for addressing a bit of women’s needs and a bit of men’s needs.

We discovered that you don’t ask communities what they need in terms of projects. There’s a big difference between demand and actual need. You ask, “What are the main problems you face?” And you work with the community to find the solution.

### **Did your social action also take other forms?**

Between 1981 and 1987 we were actively engaged in what is called Palestinian Social Action Resisting Occupation. That was a non-violent movement, resisting occupation by building independent Palestinian institutions and working to fulfill people’s needs. At the time two-thirds of the population was living in villages. That’s quite a contrast to now when more than half of the population lives in urban areas. In the 80s most of the health services were centered in urban areas, so two-thirds of the population was not getting the services they needed. In the context of colonization and land grabbing, villagers also needed help in staying on the land despite very harsh conditions.

This social action began in 1978 with the women’s movement that provided basic support for women, like literacy programs, and nursery schools and kindergartens taking care of young children. If women were to participate in the national movement, they had to be able to read, and they had to have safe places where their children could play and learn. The women’s movement filtered into health, agriculture, the student movement etc. Those were the hay days where we had hope, where we had action, where we were unified. We worked to build institutions outside the control of the Israeli military. This is how the Palestinian primary health care model emerged.

We were doing things for which there weren’t words at the time, like university-community partnerships. We at the university linked up with social action that was composed mostly of doctors, nurses, and other health professionals who were providing services to rural areas. When they first began, the health professionals took their own cars and supplies. It was a personal and a collective initiative. Pretty soon European NGOs [nongovernmental agencies] providing aid began to notice the importance of this movement, so they provided very small grants, for example, for buying an ambulance that made it possible to have infant weighing equipment, medications, and a team including a doctor, nurse etc.



As the movement grew we realized that you can't deal with people's health without having a permanent clinic and without dealing with the broader determinants of health.

**What was the role of your Institute, ICPH, in all of this?**

We were involved from the beginning in a cycle of work. First, was needs assessment. Second, was planning with local NGOs because they were going to execute the plan. Third was training. Fourth was implementation, monitoring, and building what is now called a health information system. We simply called it "records" then. Finally, there was evaluation. When the project was on its feet, we academics would leave so that the NGOs would take on the project and develop it further.

A second fundamental feature of our work is that we don't just do theory. Third, we don't just do research for the sake of doing research. We do research in order to influence action and policy. Training and education come in between. Even today these are still defining features of our activities.

**Please talk about your educational programs at ICPH, including your role in educating community health workers.**

Throughout the 80s until 1996 we didn't have formal educational programs at the Institute, but we understood the importance of training community health workers who are the core of primary health care - the fundamental links between the clinic and the community.

Alma Alta indicated that there are three pillars for primary health care: 1) intersectoral collaboration; 2) community participation; and 3) equity. It's hard to operationalize those things without the community health workers. Primary health care dictated the need for new types of human resources. The community health workers come from the communities themselves. They know the community. They know the politics. They know the divisions. They know the context in which disease occurs. They also know who else in the community is working for development. This allows for intersectoral collaboration. They can activate the community into groups to discuss health and even help them solve some of their health problems.

We weren't the first to train community health workers. Bethlehem University, with whom we cooperate and for whom we have great respect, trained male community health workers at the university level and awarded a two-year diploma. The program failed, but it was an excellent learning experience for all of us. The Bethlehem program had only been open to people who had completed a high school education. At that time in villages, only young men met this qualification. The problem with male community health workers is that in the context of the traditional Palestinian culture, men cannot enter homes. Also, women do the large majority of health care in the family.

We set up a program for village health workers, which was about a year in length. We requested trainees with more than six years of schooling. All the trainees were women. We set up primary health care centers in seven villages in the vicinity of Birzeit University. We employed a wonderful midwife, Sitt Fawzia. She was one of the strong women role models in Palestine at that time. She had been working with her husband for WHO in Afghanistan. He died so she came back home. She was a gold mine. She helped train the community health workers and visited the homes. She didn't just listen to the fetus' heartbeat; she did primary health care and problem solving. For example, an emaciated 6-month pregnant woman came into the clinic. Without breaking the taboos against speaking against family, Sitt Fawzia learned that the mother-in-law was preventing the pregnant woman from eating by locking up food in the closet. Sitt Fawzia solved the problem by visiting the house and talking with the husband and father-in-law. Without mentioning the problem, Sitt Fawzia told the men how important it was for the woman to eat so the baby would do well. The problem was solved.



In 1986–87, my colleague, Laura Wick, and I (both from ICPH) helped the Palestinian Medical Relief Society (PMRS) establish a village health workers school. (We didn't think it was our role as an Institute to do this because it wasn't a university thing.) PMRS was one of the first social action groups. Now it is a major NGO providing basic health care services to the populations of the West Bank and Gaza Strip.

We collaborated with PMRS in developing the village health workers' curriculum. Today the now two-year long program is accredited, and there is a hostel where the students are housed. PMRS trains community health workers not only for itself but also for others. PMRS brings in women from the different regions and villages of the West Bank. (Unfortunately right now they can't bring in anyone from the Gaza Strip because of the hermetically sealed borders between Gaza and the West Bank caused by the Israeli military.)

Several of us from the Institute participate in the training of the community health workers. We also participate in the training of physicians who plan to work for the PMRS. Most physicians who work here graduated from medical schools that do not provide training in primary care, so the principles and values of primary care are the focus of this mandatory in-service training.

### **Why did you and your colleagues at the Institute choose not to start your diploma in primary care and your MPH programs until the mid 1990s?**

Earlier we were against setting up post graduate programs because at that time we felt that training community health workers was the way to move forward. We were under occupation, and most of the services were controlled by the Israeli military. In 1993 the so-called Oslo Peace Accords, which brought no peace, led to the handing over of selected spheres, including health, to the Palestinians. With this new Palestinian control over health care services, we understood the need to set up both a diploma in primary care and an MPH teaching program to help in building capacity for the handover.

So in 1994 we completed a needs assessment covering all of the West Bank and the Gaza Strip. Then we developed a curriculum with the assistance of people from Birzeit and other local universities as well as with people from WHO. In 1996, we launched the program. We have graduated 231 students to date. (We prefer that our classes remain small.)

### **Who are your students?**

They have changed over time on purpose. The first three or four years we mostly admitted doctors and nurses. Then we began to admit primary and secondary school teachers because the Minister of Education and Higher Education initiated a wonderful scheme called school health, which focuses on the non-biomedical aspects of health. We felt that if you really want to influence the future, you go to the schools, not only to the clinics. When the Minister of Education began hiring school counselors, we also admitted them to our program. We choose teachers and counselors who are either currently running the school health program or intend to run it.

The school health program has activities during the school hours. But what's more important is that after school, student representatives participate in planning and implementing the program. The voice of young people is heard. This directs the programs to students' needs, not what teachers and others perceive those needs to be.

At our Institute, we have a range of students including teachers, counselors, statisticians, and mid-level managers in ministries, in addition to doctors and nurses. Over the years we have found that upper level policies are unyielding. Often, Palestinians don't



decide about health policies. International aid determines health policy. The aid and the ministers keep changing. But we have found that without worrying about policy, de facto practices can be built in at the mid-level.

One of our physician graduates was assigned the position of Director of School Health in the Education Ministry. The Ministry employed a physician probably because they thought that school health was about the biomedical. But our graduate knew better and began to combine the biomedical with what he had learned and to link with us. Then he sent us people to train in the MPH. By now about four or five MPHs from our program are working with him. He couldn't have made changes alone, so he brought in others and supported himself with a critical mass of people who think in the same way. When you have graduates holding important positions at this middle level, they can affect change.

About one-third of our alumni are in key positions and are doing very well. That's a good start.

#### **Yes indeed. How would you describe your teaching program?**

It's not just what we teach but how we teach that makes the difference. We bring our social action experience to class. This means that the curriculum has to be constantly changed and modified.

We have modules that have cross cutting issues and overarching themes, linking all courses together. Courses are an invention of the university. They are like sectors. We keep saying, "People don't live in sectors. They live in community." So you have to be holistic.

Most of our students work part-time and study part-time. We visit them and the alumni in their workplaces and discuss their problems. We also find out how the system is changing. (It seems to be changing very rapidly here.)

#### **Why and in what ways is the health care system changing rapidly?**

Lots of international aid groups are here, wanting to do their own thing. The Americans want to do it the American way; the French want to do it the French way; the Italians the Italian way etc. This makes for fragmentation and very rapid changes.

Nationally, we have one of the largest packages of aid, and it doesn't seem to be doing much good. The reason is that we have to deal with the broad determinants of health. We have to deal with justice. We have to deal with checkpoints. Even the World Bank says so. Without a radical improvement in the very strict measures imposed by Israel, we're not going to move forward significantly.

#### **Despite these enormous challenges, you do seem to be moving forward. As a researcher, activist, and teacher, you are addressing the broad determinants of health. In your role as teacher what courses do you teach at the Institute?**

I teach the first two courses in the MPH program that run throughout the first year: social epidemiology, then primary health care. These are foundation courses. I also teach a course called "Community Assessment." Integrating the information obtained in all other courses, students in community assessment conduct a study based on what they have learned. The course is about the heart of hearts of public health, which is team field research and work and learning from each other. The students work in teams and generally choose topics that are relevant to their daily lives. In 2003, students wanted to study a typically neglected topic - the impact of the 2002 invasions on the psychosocial status of ambulance drivers. When we brought ambulance drivers into focus group discussions aimed at understanding their experience, everyone started crying because the ambulance drivers, who had experienced so much trauma, started crying.



Every week students go to their workplace, research something and present it. Last semester, with their approval, I had them go back to their grandmothers and elderly women to collect definitions and idioms of health in the local culture. Why have we discarded this information? Some of it is very useful and brings in people's voices to learning.

### **How long does it take to complete the diploma in Primary Care?**

One year. The diploma is for a broad group of people. The two-year long MPH is more advanced. If you complete the diploma in Primary Care with a certain grade point average, you can enter the MPH program.

### **In March of 2009, The Lancet featured an important series of articles on health in the occupied Palestinian territory. You played a key role in this series and had the support of your local colleagues as well as a broad group of international scientists.**

This was a very important series because it was the first time Palestinians and others had a chance to explain their lot in scientific terms. The series wouldn't have been done if Richard Horton, the editor of *The Lancet*, hadn't come here and seen the situation himself. He was shocked by what he saw. He commissioned us to describe our reality and open up a debate.

It was an arduous process that took us two years to complete. We were writing about our lives. We had to write in an understated way and let the data speak for themselves. We chose data that would speak to the West. So, for example, we weren't so much quoting ourselves as we were quoting Israeli human rights organizations. We have an equivalent body of information, but if we presented our information, some people would have charged that we were biased.

We included people who had written about these issues in the past, so we ended up with some 40 co-authors. About half were Palestinians from Birzeit University and other local institutions. The other half were internationals. The articles went through an extremely rigorous peer review process, with both internal and external international reviewers.

### **Have there been any spin-offs?**

I hope that people are reading the articles, which they seem to be. A couple of months ago, I learned there had already been 90,000 downloads of the articles. Several of us have been going on speaking tours. For a long time journals did not want to deal with the Palestinian question. We were boycotted I suppose. Maybe Richard Horton did more than producing the series itself. Maybe he helped journal editors realize that it is okay to have the Palestinian scientific voice heard.

### **With all the challenges and trauma, how do you keep your spirits up?**

Resilience over time and repeated experiences. Another way of saying this is that we have developed tough skin. Social support and the knowledge that our trauma is collective and spares no one. Also, that sense that the moral imperative is ours. Right now people are down. They are not feeling like acting because there are no options in sight. But things change and they'll get activated again because there is no choice. It is a struggle for survival.

I'm very happy with my life here. I've never regretted coming back from the U.S. I'm a U.S. citizen too. I was born in Bethlehem, two kilometers away from where Jesus Christ was born. Our family emigrated to the States as a result of the 1967 war. I opted to come back, like others. I've never regretted it once. I've had 31 years of life with meaning. Every step of the way entailed working for survival and building institutions. When I look back at ICPH and where we are today in comparison to where we were then, I find it a great achievement. It's not a personal achievement. It's a collective achievement. Without the activists at Birzeit



University, without Palestinian social action, without the support of the university administration, and without the wonderfully committed and inspiring ICPH team of faculty, researchers and staff, we couldn't have done it.

**Thank you and best wishes with your important work.**

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