Making Lives Under Closure:
Birth and Medicine in Palestine's Waiting Zones

by

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Abstract:

Reproduction is a site for understanding the ways in which people re-conceptualize and re-organize the world in which they live. This dissertation tries to understand the world of birth under the regime of closures and fragmentation that governs the lives of Palestinians. It describes how checkpoints, closures, curfews have come to characterize childbirth in Palestine. It illustrates how the changing infrastructure, economy and discourse around birth produce new experiences of life in the medical sphere and in a family. Oral histories, life histories, doctors', midwives' and mothers' accounts, news reports and literature speak of these new conditions and experiences of birth and life. The meanings and structures of medicine, family and motherhood are thus remade.

Oral histories focus on a history of the health infrastructure and movements in medicine, in particular the *sumud* (steadfastness) movement and the popular health movement. They illustrate how the figure of the doctor overlaps with that of the political leader. They identify the new health infrastructures built to assist birth during the closure which have different politics than the earlier movements, marking the post-socialist age, but show remarkable continuities with them in their emergence, mobilization and hierarchies. These new infrastructures, economies and discourses produce changing stories about birth and changing subjects.

I identify two genres of birth stories, the first, narrated by mothers and the second, collected from newspapers. The former is in the register of the ordinary. The mothers remember the space of the hospital, a socio-economic space signaling class, as well as the trip from home to hospital and back. The stories seem uncanny. Occupation, closures and warfare are simply part of the ordinary. By contrast, the newspaper birth stories are sensational. They tell of checkpoint and prison births, occupation, suffering and resistance. They speak of miraculous redemption but in opposition to mothers' narrations, they are familiar. Finally, listening to the inner worlds of birth-mothers under the impress of economic, political and domestic pressures this dissertation distinguishes "enclosure" as a worldview caused by occupation and family relations, thus re-evaluating meanings of family, motherhood and life.

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the heart, till the end. It is a joy to think of the years to come with you, Ramla and our little one still inside me.

Introduction

Sireen gave birth under siege. She lives in an apartment in the outskirts of Bethlehem. This is her third child. I met her in the room turned birthing clinic in a midwife's house. When her labor had started, she walked around her own living room as long as she could and waited for the contractions to get stronger. She walked around and around for about three hours and then she crossed the street to her neighbor the midwife's house. There had been no way for her to get to the hospital during the siege. Giving birth at the midwife's house was also cheaper. She gave birth quickly. An hour later, her husband came and helped her walk across the street back to their house.

This thesis describes how checkpoints, closures, curfews and waiting have come to characterize childbirth in Palestine. It draws upon fieldwork in the central region of the Israeli Occupied West Bank, in the Ramallah and Jerusalem region during the summer of 2002 and then between July 2003 and June 2004. The timing of my fieldwork is important. I did my research in the midst of the Second Intifada (uprising which started in September 2000). The checkpoints and closures color and chop up the terrain and experiences of the people I talked to and my own interpretations. The closure is what divides each interview from the other and the theme that unites them all.

Many interviewees point out that the recent history of the construction of the Palestinian medical system is essential to understanding its current structure. I therefore start, in a first chapter, by examining oral histories of the construction of the Palestinian health infrastructure identifying two important movements in medicine, one lead by the

PLO that built the essential centralized hospital system and a second lead by a group of physicians educated in the Soviet Union that built a de-centralized system of clinics in rural areas. The second chapter focuses on the new infrastructure of makeshift birthing clinics. I locate these clinics at the intersection of economies of solidarity and conflict, shaped by the discourse of humanitarian aid. In the third chapter, through an analysis of vilification stories and professional biographies, I focus on the overlap between doctors and political authority. The fourth chapter analyzes women's narratives of birth told in the register of the ordinary juxtaposed to the sensational stories of women's birth in the press. It identifies a strange possibly uncanny element to the ordinary stories while it shows how the stories of miraculous redemption from newspapers have become part of the familiar and ritualistic readings of the everyday. The fifth chapter is an attempt at listening to the inner worlds of new mothers. It defines the moment of the post-partum in Palestine as different from the moment of birth. Many women feel that they are going through an intense time of making sense of their new worlds. These narratives of enclosure are about being imprisoned by checkpoints and by relationships within their own homes.

***

Here on the slopes of hills, facing the dusk and the cannon of time
Close to the gardens of broken shadows,
We do what prisoners do,
And what the jobless do:
We cultivate hope.

Under siege, life is time

Between remembering its beginning

And forgetting its end

The siege is waiting (*al-hisar huwa al-intithar*)

Waiting on the tilted ladder in the middle of the storm.

Alone, we are alone as far down as the sediment

Were it not for the visits of the rainbows.

Four excerpts from Mahmoud Darwish's Poem *State of Siege* (2002)

Intizar

Intizar means waiting. The best way to describe living in Palestine today is to think of the act of waiting. Many people feel like they are in a constant state of siege, and like Mahmoud Darwish's popular poem, feel that "the siege is waiting, waiting on a tilted ladder in the middle of the storm." Waiting at a checkpoint, waiting for the curfew to be lifted, waiting for her permit to be issued, waiting for her brother to get out of jail, waiting for her boss to pay her, waiting her turn to show her papers, waiting for labor to start, waiting for her mother to be able to visit her. Over the course of my fieldwork, waiting was a constant preoccupation in the stories I was hearing, the newspapers I was collecting and the literature I was reading. It was also a concern in my own fieldwork and life on the field. Simply waiting cannot of course explain everything about diverse people, their pasts and experiences. I do not mean to suggest that the people I worked

with were overwhelmed by waiting or were resigned to wait. Often, the waiting did not stop them from continuing their lives, giving birth, raising children, studying, making alliances, talking and doing politics. But waiting is a condition that patiently recreates for us scenes from the past, that characterizes this space of being in-between places, of trying to reach someone or somewhere. An instant of remembering what it feels like to wait and a ground chopped up by checkpoints comes back to life for me[1].

But if that is true, if waiting is such a primordial experience in the lives of people in Palestine, what does it matter in a place where the media shows us people dying from bullets everyday, others fleeing their homes, others blowing themselves and a dozen other people up? What point is there in recalling this frustrating, boring, ordinary condition of waiting? Should we care that people are in a state of waiting when what is at stake in this "violence prone zone" are lives, land, rights, security, livelihoods, nations and states?[2] It seems to me that we should: the politics, society and future of the place can only be fully understood if we view both the heroic and sensational as well as the everyday and ordinary. It is in the everyday that Palestine knows its terrain, its architecture, its

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[1] My fieldnotes are full of references to my own and to other people's waiting periods during the day. On the 24th of October 2003, I wrote in my fieldnotes: You get used to waiting. You wait in line at a checkpoint. You show your papers and wait for the soldier to decide whether you are adequately equipped to pass. You need to give birth, you wait to find out whether you are aloud to get to the hospital. There is a curfew; you wait for the curfew to be lifted. You need to travel, you wait for the authorities to give you permission to leave. Or you wait for the authorities to give you the permission to reside in a certain area. Some wait for their loved ones to get out of jail. Others wait for charities to distribute food. And others wait to get back to their homes. Waiting is just part of life as usual here. It is part of the struggle of everyday life. Once you've waited out and gotten permission to get/live where you want to go to or be, you have a claim to that space or to that right. If you had stopped waiting, you would have lost that right, you would have given up the fight. But if you wait long enough, you might win. So you always wait. Waiting gives you a feeling that you are in between places, not quite there. It also gives my research and life on the field a chopped up sense. But it is part of life as usual here.

[2] "Violence prone zone" is the term often used in political science to designate places with chronic, new kinds of conflicts and instabilities such as the Balkans for example. It gives people in these zones an inherently dangerous kind of subjectivity. I use it here however to emphasize the contrast I am trying to make between thinking of this place as a zone of political violence and thinking of it as a zone of waiting.

practices and the basic realities of its life. In this thesis, I am interested in the everyday, the ordinary. I reflect upon the situation as being chronic, quotidian and ordinary, as well as upon the kinds of life, the kinds of waiting and loneliness people from this zone of political violence live.

The waiting zones of Palestine are topographical, military, political, experiential and historical. I write about Palestine's waiting zones (in the plural) because it is chopped up into parcels of land by checkpoints, settlements and bypass roads. At the same time, it is a waiting zone (in the singular) because it is a form of communal experience, politics and orientation towards the world of many people in the West Bank and Gaza.

Waiting is an experience of time. Darwish writes: "Under siege, life is time. Between remembering its beginnings and forgetting its end." We use the past to make sense of the present. Historically, Palestine practiced waiting zones of *sumud* (steadfastness), *sumud muqawim* (resistant steadfastness) and *sabr* (patience). These are part of a discourse of Palestinian modernity. They are tactics of endurance in front of repetitive and seemingly never ending oppression. They explain the length of the present and past and the certainty of a better future. It is a mobilizing and organizing motto linked to the idea of developing and modernizing the occupied territories by building its infrastructures of medicine, education, agriculture and industry.

I find that waiting provides a thematic unity to what I heard, observed, read and lived. Experientially, the tone of the term waiting encompasses the contrasting registers of speech and emotions that feed into an attitude of courage, fear, cynicism, idealism, dread and hope. All of these accompany the waiting of the routine, daily life under

closure. It is both systematic and unpredictable. Herein lies the heart of this outlook onto the world.

The word for waiting in classical Arabic is *intizar*, the title of a recent film by Palestinian film-maker Rachid Mashharawi. *Intazara* means to wait, to await, to anticipate, to expect, to have patience, to be patient, to request a delay or respite, to ask something of someone (Wehr 1994). Patience, *sabr*, is integral to the Arabic *intizar*. Sabr is a symbol of Palestinian modernity. It is the title of a novel by well-known writer Sahar Khalifeh. It is the root of a common girl's name, Sabreen. It is a common expression people exclaim as they wait: "sabreen", we are patient. In dialect (Palestinian and Syrian), it refers to both patience and the common cactus, the prickly pear. It is common knowledge in Palestine, that whenever you drive through Israel and you see sabr, the cactus, you know that at that spot lies a destroyed Palestinian village because villagers used it to barricade their homes from their goats. Sabr is strong and survived the war. Sabr is a marker of the past (an Arab past). Sabr is looking towards the future. It requires strength to calm down the anger and frustration of waiting. It is in itself a resistant sort of waiting.

The imagery of sabr, the cactus, supports a resistant form of waiting and remembering of a Palestinian past. Furthermore, the same plant is the foundation for a symbol of the Zionist movement. The word is derived from the Hebrew word *tzabar*, the name for the cactus. It is an allusion to a strong cactus of the desert. Sabras were born in Israel to Zionist immigrants seeking to create a "new" society. The term was part of a movement to empower the Israeli born Jew as opposed to a Diaspora Jew. It was part of a discourse of a "return" to the Biblical Jew and a "return" to the land as opposed to the

intellectual objectives of the stereotypical Diaspora Jew. The cactus is the vehicle for re-membering buried pasts. That the same symbol brings to life the past of two conflicting nations is symptomatic of the modern Eastern Mediterranean. But that a common plant be the marker of these pasts and nations gets at the heart of what I am trying to point to in the experience of sabr. It is an ordinary, repetitive, patient and durable form of waiting.

In his *Waiting: the whites of South Africa* (1985), Vincent Crapanzano sees that the experience of waiting as a constant preoccupation in the mixed, English and Afrikaans community he studied. It is an expression of a deep seated fear of political change and of one day having to connect, to build a relationship with most of the people surrounding them. In Palestine today waiting is not only a state of mind but also a practical everyday matter. In these episodes of waiting every day, I see both the resistant waiting of sabr as well as a frustrating waiting full of longing and dread identified by Crapanzano. It is both a condition that is stifling and one that gives hope. "Waiting—the South African experience—must be appreciated in all of its banality. Therein lies its pits—and its humanity," wrote Crapanzano in his introduction to the concept of waiting.

Hence, I ask: What do people under occupation have to say about everyday life? What is the everyday (an allusion to some kind of normality or consistency) in this place which has undergone one social and political upheaval after another? What do people have to say about the course of life in this space called area C, area B and even area A on the map, the areas where there is the shadow of a Palestinian state and the heavy weight presence of an Isreali state? How do people make sense of their changing social conditions and selves using different media and tools? What kind of lives, "emergent forms of life" (Fischer 2003) do people from this zone of violence live?

There are many ways to describe this place under closure. When I think of it, I remember the town of Ramallah where I grew up and where I lived during my research. I remember its neighboring hills, its olive trees, a yellowish color in the summer, the crowded market on Saturday, the village of Beitunia, the village of Birzeit and the university where my parents worked, Natasha, my neighbor and close friend, Miss Botros, my Arabic teacher, Donn, a family friend and my teacher, the street I hated where the chicken store was, on one side the chicken were in cages, on the other, the unwanted remains of chickens lay on the ground near the garbage, black stains on the street from the tires that burnt during the morning demonstrations, the sound of live bullets zapping by like mad wasps, rain water flowing down the streets like rivers, Israeli soldiers looking through their binoculars from the top of the building at the bottom of our street, roadblocks of rocks, the fig tree in the back yard.

But this small town I remembered from my childhood had grown and changed tremendously in the ten years between the day I started university in the United States and the day I went back to live and do research in 2003. I had visited regularly, but only for short periods of time. And it sank in after almost a decade that this place had changed so much since my departure for university. The town of Ramallah was much more populated; buildings had sprouted everywhere; Israeli soldiers were no longer to be seen; there was a Palestinian police force (although one progressively battered and reduced, then finally driven off the streets by the Israeli military); there were Israeli military checkpoints all around the town. It was now so much of an economic and cultural center for the surrounding villages that on a Saturday morning it is so crowded on the sidewalks

of the main street that you need to push your way through the street. If you go down town by car, it is ordinary to be in traffic for a half hour. Ramallah itself used to be a village looking towards the cities of Jerusalem to the South and Nablus to the North. Now, people came from these towns and surrounding villages to Ramallah.

To understand this change, I need to say a bit about the recent history of the closure and borders that made Jerusalem more difficult to reach and Ramallah a cultural and political center.

Historical topography

Palestine, once a province of the Roman Empire, was part of the Ottoman *Bilad al-Sham* or Greater Syria. After the Egyptian occupation of the early nineteenth century, its accepted regional outlines – not administrative borders, were very similar to those that became familiar by the time of the British mandate a century later. After World War one and the collapse of the multinational Ottoman Empire, Syrians chose independence and Palestinians, as reported by the King-Crane Report commissioned by President Wilson, expressed themselves without any reservations in favor of their inclusion in the would-be State. The policies of the victors, France and Britain, saw things differently, and Syria (without Transjordan, Lebanon and Palestine) became a French mandate, while Palestine was mandated to the British, who administered it for the first time as a separate entity, bounded by the sea, and by the British and French dependencies of Egypt, Syria, Lebanon and Transjordan.

In 1947, the UN decided to partition Palestine between a Jewish and an Arab State; this decision led directly to the armed confrontation which resulted in the expulsion of 750 000 Palestinians, the creation of the State of Israel over 78 % of Mandate

Palestine, and the division of the remaining parcels, the Gaza strip and West Bank, between Egypt and Jordan respectively. In addition to those hundreds of thousands who were driven over the border to Transjordan (which became the Hashemite Kingdom of Jordan) Lebanon and Syria, over 100 000 Palestinian Arabs became subjects of the Israeli State (in which they were granted citizenship and placed under military rule for nearly a decade); the rest remained in the Gaza strip, where they were joined by refugees from Southern Palestine-Israel, or the West Bank, where the majority of villagers lived side by side with the residents of two dozen refugee camps from then on. Palestinians were now bounded from each other by various sets of hostile borders. West Bankers were annexed to Jordan, so that their eastern border opened up, while their western borders closed down. Gazans were not annexed by Egypt. Instead they remained penned into a very small area of southwestern Palestine.

In June 1967, as a result of the Six-Day War, the West Bank and Gaza was conquered by the Israeli army and put under occupation. But their borders, which closed off to the Jordanian east, now opened up within the confines of Israeli rule, and for the next two decades, movement was virtually free as between Gaza, the West Bank, and Israel. At this time, Palestinians came to know their occupiers by working as urban or rural laborers for them, and also, for their young men, going through their prison services. In 1987, with the outbreak of the Intifada or Palestinian uprising, the Israeli army started to gradually and sporadically reduce mobility.

During the 1991 Gulf War, at the very time the government of Prime Minister Yizhak Shamir and the Palestinian delegation headed by Dr. Haidar Abd-al-Shafi began to meet following the Madrid Peace Conference, the Israeli Army instituted its first

closure policies as we know them today. During the early and mid-1990s, when negotiations with Palestinians appeared to show that they might culminate in the creation of a Palestinian state, it was important for the Israeli government to isolate Jerusalem from the rest of the Occupied Territories, thus establishing Jerusalem as inside Israel as pre-negotiations as "facts on the ground." Checkpoints were set up on all main roads leading to Jerusalem and also separated Gaza from the West Bank, mandating special permits to go back and forth. In 1994, after the first Palestinian suicide bombings in Israel, closures were further strengthened.

Since September 2000, the Israeli army has generalized the use of checkpoints throughout the occupied territories, making it as difficult to go from one village to another, as it had long been to get to Jerusalem.

By 2005, the Israeli state was in the process of erecting a wall which is eventually to envelop the West Bank, reducing its surface by a tenth or an eighth. At the same time it evacuated the Gaza Strip, leaving one and a half million people, enclosed between Israel and Egypt. Israeli plans for the West Bank are going on apace, and a system of barriers, walls, roadblocks and settlements are intended to isolate the north from the south, and both from the east (Jericho) if and when a permanent settlement is reached or imposed.

In the meantime, closures are a part of everyday life varying and depending on place and time. All West Bank roads are dotted with checkpoints, several hundred in all. During periods of heightened military activities closures were accompanied by blanket curfews, imposed and lifted over time and in various places. During the two major military incursions into Ramallah in 2002, it was risky to stand in front of a window while the city was under curfew. During a July curfew, on the other hand, children could

play soccer in the streets. The term closure in Palestinian public discourse encompasses a set of policies designed to separate cities and villages from one another, to restrict mobility, and to render Palestinian life and movement insecure.

More than once, in collective taxi rides between Ramallah and the checkpoint to get to Jerusalem, I heard a joke told in many parts of the world which reflects this and other histories of imprisonment: the story of the wise man who had a wife who complained about their small house. There was a wise man who had a wife and five children. They lived in only one room. That is all they could afford. They had two chickens and a sheep which they kept in their front yard. The wife complained to her husband saying: Oh husband, when will you make enough money for us to buy a bigger house with a room for the children and a living room and a kitchen and room for ourselves? I am tired of living in this small house. The wise man said: Ok, you are tired of this small house, I will do something about that. He brought in the chickens to the house. Now, the roof of their room housed the wise man, his wife, his five children and two chickens. A few days later, the wife said: Oh husband, for god's sake, the house is so small we have no room. We need a larger house. So the husband said: Ok, I will do something about it. He brought in the sheep. The roof of their room was now housing the wise man, his wife, the five children, two chickens and a sheep. A few days later, the wife said: Oh husband, I can't bare this. Our house is too small. We need a bigger house! So the wise man said: Ok! And he put the two chickens and the sheep back out into the front yard. Ah, said the wife, we have space to move. Now I feel free!

Politics and the Everyday

The research is based on fieldwork in the central West Bank, however it is not bounded in this small area. People's stories cross checkpoints and borders through satellite television, telephone lines and by word of mouth. This work is about a story broadcast on television about a woman giving birth in a car at a checkpoint in the Northern West Bank and doctors explaining to me how they assist births by phone. It is about lay people showing me where they assisted births and experts complaining that they have to change their practices in order to adhere to a set of local conditions. It uses written documents and conference minutes of some PNA meetings to tell the story of how they envisioned the health infrastructure of a modern centralized state and documents and life histories of a group of physicians who had graduated from the former Eastern block who visualized de-centralized, equitable, free of charge health services. Some people have geo-political births to ensure Jerusalem birth documents or U.S. nationality. Narratives about birth bring to light women's worries about checkpoints in their lives: occupation, poverty, demanding family duties, lack of family support, longing for love and care in their marriages. They describe how they construct a space for themselves to live with the anxieties and difficulties of caring for their families and relationships. By bringing together these various themes, I present an ethnography of health, politics and family in Palestine. It describes how checkpoints, closures and waiting have come to characterize the terrain of Palestine, literally its hills and coast, but also its politics, its families and its births.

The lens through which I studied Palestinian society was birth; mothers, midwives, dayat, obstetricians, public health officials, leaders, statesmen, everyone wanted to tell a story about birth. The first question that I was confronted with, then, was about the nature of and the reason for this wanting. Why did people want to tell stories of giving birth, waiting and the everyday? Was it a particular means of talking politics? The questions go to the heart of the opposition between 'politics' and the 'everyday', the division between the 'public' and 'private' spheres. The everyday political experiences of Palestinians demonstrates with simple eloquence the arguments that some critics, in particular in the domain of feminist theory, have been painstakingly attempting to engrain: the division between public and private, political and personal is a product of a particular moment in history that reflects and enforces social hierarchies rather than explains social realities. Especially at this particular moment in Palestine, in times of heightened crisis and closure, the distinction between politics and the everyday misses the crux of the current situation. From the political emerging in your kitchen in the form of soldiers to the leadership operating from a kitchen in Arafat's destroyed compound, politics and the everyday are entangled and inseparable. It is a space where impossible politics operate amidst an impossible everyday; it is quite simply nonsensical to separate politics from the everyday. And this is evident to all the actors involved. Checkpoints are meant to disrupt the everyday precisely because it is politics. The fragmented topography of Palestine undoes the distinction between politics and the everyday.

I found my own ethnography, field notes, travels, life and perhaps my writing to be similarly disrupted and fragmented. My intellectual challenge was to bridge the fragmentation of my material and experiences and the seemingly unified and systemic

epistemologies. It is here that my work met Begona Aretxaga's (1997) observations on Northern Ireland, echoing de Certeau in affirming that "narrative is indissociable from any theory of practice." And it is for this reason that other people's stories fade in and out of the story I am trying to write.

While Foucault brought to light the workings of knowledge/power through an exploration of dominant discourses and their institutional histories, de Certeau seeks to find the gaps and interstices within the dominant discourses, institutions and technologies in order to account for a space where subjectivities can maneuver and social change takes place. The "oppositional practices of everyday life" (de Certeau 1984) are the sites of de Certeau's inquiries and a privileged site for ethnographies of resistance.

Chapter Layout: The whisper of stories and the silences of those untold

The introduction of the dissertation is both a subjective story of the fieldwork and a layout of the chapters. It describes the flow of experiences, questions and sites as I worked the field. It traces the way I first read my material and the way I reread it as I listened to the tapes and read my field notes as the material sunk in and after my own birth experience in August 2004. I have structured the dissertation chronologically to follow the time on the field and epistemologically to follow my re-reading of narratives and experiences of birth.

My fieldwork lasted 15 months. I lived in Ramallah and traveled to Jerusalem and neighboring villages regularly. The 61 taped interviews I conducted lasted between a half hour to three hours long. I conducted hundreds of informal interviews and discussions

which I would try to recapitulate in my notebook in the evening. Some took place at the hospital, a clinic or in an office. Others took place either in people's homes or in my family's house. I did participant observation in two hospitals: in the labor unit of Makassed hospital and at the Red Crescent Maternity Hospital in El-Bireh. I met doctors and midwives at the hospitals but also in clinics, and at the midwifery, nursing and medical schools. Mothers who had given birth, I met through friends, in hospitals or through the medical professionals I was working with. All the names of interviewees in this thesis are pseudonyms except for three founding members of the Union of Palestinian Medical Relief Committees, who are known figures. Inherent to my fieldwork was a tracking of birth and medicine in the two daily newspapers *Al-Quds* and *Al-Ayyam*. I cut out and saved at least an article a day for this purpose. This introduction presents, as does the thesis, interviews that marked some of the turning points in the course of my fieldwork.

In the summer of 2002, as I was sitting in our house in Ramallah watching television, I decided to take up birth as an academic research topic. The town was under curfew, empty, silent. Television takes on an important role when we can not leave our homes. It becomes the way to see the outside world, to see the streets we are not allowed to walk down. On the evening news that night, *Al-Jazeera* aired a story about a woman in labor who was barred from getting to the hospital in Ramallah, who waited and waited and finally delivered her baby at the checkpoint. I was moved by her story of a birth that could not be stopped. I decided to take up the topic of childbirth.

I started out by mapping the infrastructure of medicine and birthing in Palestine, to understand how health workers changed the infrastructures, routines and practices of birth in order to cope with the new challenges of occupation, the closure.

My first interview was on the 4th of July, the curfew is lifted for a few hours. The city is bustling. Every person who can walk is in the streets. Vegetable sellers, sandal and shoe sellers, shoppers and strollers mingle in the middle of town. Political leaders and prisoners and martyrs look down from posters on the walls. There is not a soldier in sight. Cell phones are ringing everywhere. Horns are honking. Radios are blasting. I ran through town to the office of a well known obstetrician to interview her about her work under curfew.

In an office building at the center of town, "Dr. Siham" shares a private clinic with a few other health professionals. The building is empty, the door barely open. Dr. Siham is alone in her clinic, on the phone: "you'll be fine. The curfew is lifted until 2 p.m. You can stop by the clinic, if you want before then. But I don't think it necessary. Call me at home if you feel pain". Dr. Siham turns to me and says: "I would never have imagined that I would practice medicine by phone (...) I never thought I would wake up at 2 a.m. to phone calls from women in labor and instruct the husband how to assist his wife in childbirth. I have never heard of a time in history when even health providers were restricted in their movements. But the thing is, life goes on. Women still become sick. Women still become pregnant. They can impose a curfew, restrict mobility, but it does not stop labor from starting. This is dangerous. This is frightening..." The phone rings again. It is another patient.

In between giving medical advice by phone to her patients, Dr. Siham told me stories about assisting birth by phone during curfew nights. She explained that the phone had become a crucial medium of medical assistance. Since the 29th of March, 2002, when the Israeli Army re-entered the city and imposed prolonged curfews, the obstetricians and midwives she knew, did much of their assistance by phone. And since many women thought it better to give birth at home than to brave the curfew, they would telephone health professionals to get counseling during labor.

Dr. Siham talked about a movement of health professionals who had mobilized to provide services to women who are in labor during curfews. They created a hotline to which people under siege can call and get guidance through labor and delivery by an expert. They trained at least one person- doctor, nurse, health worker or lay person- to assist births in each neighborhood or village. There was excitement in her voice when she talked about the network. And she conveyed the enthusiasm to me as a listener and to local journalists whose interviews I read in the press. It seemed that along with the stories of armed resistance and bombings, the Second Intifada had stories of mass participation and mobilization. Maybe it was not as we talked of it, an Intifada that mobilized the armed few and failed to mobilize shopkeepers, school teachers, student. Dr. Siham with the childbirth network produced energy and longing for past uprisings and movements.

However, embedded in her enthusiasm for a participatory movement centered around women's health and birth, was a political and long-term plan. She spoke as a strategic planner for the public health system in Palestine in which each neighborhood and village would be self-sufficient. "With this hotline and network", Dr. Siham explains, "we are also trying to convince women to have a natural childbirth at home or close to

the woman's home. That way, we can avoid the fear, humiliation and danger of the road (...) So, I try to convince women to forget about the hospital. That it is safer for them to give birth close to where they live (...) If we create a system where women can give birth close to their homes, that is what I mean by natural childbirth, then we would have succeeded in something extraordinary for our political aspirations." The ideas behind this network, she explained, stemmed from the ideas of the popular health movement of the 1980s of mass-mobilization, decentralization, popular heath, primary health care and equality. Popular health, she said, could not be understood unless it was set in juxtaposition to the infrastructure of sumud.

I left this first interview with a sense of enchantment about the grass-root efforts in the medical field and with a sense of fascination with the image she conveyed of doctors as fighters, saviors and leaders. She directed me to two infrastructures of health that formed the direction of the current childbirth network: sumud and popular health.

The first chapter works with oral histories of the building of the Palestinian health infrastructure. Palestine had started to develop its national infrastructure of health care in 1967 with the *sumud* movement. Sumud funded and constructed hospitals in major cities and prided itself on the complicated, specialized and high-tech procedures the hospitals offered. The sumud policy of the Palestine Liberation Organization consisted in promoting a type of non-violent resistance through which the occupied Palestinians endured difficult military and political measures and a harsh economic situation for the sake of their national future. The PLO and Arab governments had a policy of sending funds to promote living conditions in the Occupied Territories. It was a response and

challenge to the poor government services offered by the Israeli military-controlled "Civil Administration."

The sumud approach was rooted in Arab and Palestinian nationalism and understood colonialism and military rule to be the major causes of poverty and the major obstacle to improving the developmental level of the population, including in the health sphere. Sumud-linked donations were supposed to alleviate poverty and encourage Palestinians to stay in the occupied territories. The official sumud fund was established in 1978 at the Arab Summit in Baghdad. Many Arab governments contributed.

Dr. Rami is a well-known doctor working in Makassed hospital, in one of the most prestigious Palestinian hospitals. He operates on the most dangerous and high-risk pregnancies in the country, those with diabetes, previous Cesareans, twins, and tumors. He and his colleagues treated injured people during the First Intifada who came from all over Palestine, "from Gaza in the South to Jenin in the North, the injured flocked to Makassed. There were no checkpoints at that time. The roads were easy. Intifada injuries were treated free of change. Through its work in high-tech, complicated, emergency surgery, Makassed became the most prominent Palestinian hospital."

But this idealistic clear-cut world of sterile operating rooms, high tech interventions and highly specialized physicians was overwhelmed by the political and social issues of everyday life facing the country. Women foreseeing a planned Cesarean could not make it to the operation date and would come in a few days later needing a high-risk emergency operation. Women who are tired of going back and forth from the hospital back to their homes beg the doctors and midwives to induce their labor or just send them to the operating room to get it over with. Doctors sometimes can not make it to

their appointments. The doctors felt vulnerable in this unsystematic, confusing practice. No one taught them what to do when the patient can't show up for her operation but needs medical intervention a few days later, a young gynecologist told me. But managing the fragmentation of the everyday was also part of the politics of sumud.

Outside the hospital, I tried to map the beginnings of the popular health movement. I interviewed the founders of the Union of Palestinian Medical Relief Committees, the umbrella organization for the popular health movement (founded in 1979). Dr. Khammash was one of the doctors who lead the popular health movement. Like him, most of the doctors involved in the movement had just finished medical school in the Eastern Bloc and had been impressed by certain local public health programs in provinces of the Soviet Union. Upon their return to the Occupied Territories, Dr. Khammash said that the ideology of the popular health movement was still very malleable and not very stable yet. The leading ideas that held the group together were very popular and not very original. They shared "a nationalist objective and a belief in justice". "We had energy", he said, "we wanted to do something for our country. But also, we had all studied in the USSR or in other socialist countries, and during that period, we saw that health was free of charge in the USSR, whereas back home, people had to pay for it, and many people could not afford health care. This was unjust. So justice was our goal". The popular health movement was spontaneous and popular and not yet tied up with the work of political parties. Over the years, it constructed the most important primary health care infrastructure in Palestine.

Thus, the first chapter explores the intersection between the professional politics of medicine and national politics during the second Palestinian uprising which erupted in

2000. Through an analysis of interviews with health professionals and participant observation in hospitals, it examines the oral histories of two overlapping movements that contributed to building the public health infrastructure; the movement of *sumud* (steadfastness) (1967-1987) and the popular health movement (1978-1994). The oral histories illustrate contrasting visions of a nation struggling with restrictions on mobility and a ground chopped up by checkpoints.

I felt drawn to the world Dr. Khammash was describing of resisting the Israeli legal system and the Palestinian medical tradition, a world that created new moral and social standards. But these were memories and longings of a time past. Today, Dr. Khammash said, what is popular in health care is the provision of care for births in makeshift clinics in villages during the closure.

The first people I met who ran makeshift clinics were midwives who also worked in hospitals. They assisted all "normal" births in hospitals. It is with the midwives that I observed the practices of hospital births, learnt of the labor disputes in the institution and started hearing of midwives opening clinics in their homes and aspiring for this to change the legal framework of birthing in Palestine.

What struck me was that in their rank and file work of an exploited hospital worker, they were proud of their profession, of the philosophy and soul of their work. It was hard, exhausting work but they were deeply tied to it. Tahani for example explained how her work as a midwife along with praying kept her out of depression. With its routines and physical movements, midwifery and prayers kept her mind away from her marital problems and from missing her children. Furthermore, the way midwifery care touched women and the way praying touched her gave her spiritual strength. There was

something about midwifery that seemed close to humanity in contrast to the mechanistic and detached practice of medicine. Another midwife, Salma explained how comforting it was to walk down the street and for a woman to be running after you saying: you birthed me, you birthed me, I remember you, now I have the peace of mind to say thank you. Their relation to their work and profession was ambiguous however. While they viewed it as giving them a psychological space that helped them cope with their day to day troubles, they also viewed it as a burden on their lives. The work was exhausting. Many were rural women and had to travel to the cities everyday. Some had to live in the cities for the week and separate from their families. They had to struggle with prejudice against women who travel, work at night and sleep elsewhere than in their homes. But fundamentally, midwifery work, with its schedule and efforts strained their marital and family lives.

Some of the midwives had home-practices of their own in villages to assist births during the closure. Their everyday practices were shaped by the regulations of the closure and by the legal framework within which they were or were not allowed to work. I wanted to get a closer, micro- look at these practices and new clinics. My fieldwork in these clinics focused on how they were linked to the grass-roots childbirth network Dr. Siham had described on our first interview, or whether they were more linked to the top-down NGO boom that social scientists have been generally criticizing as counter-productive for Palestinian development.

The second chapter is about the topography of birthing clinics. It is an exploration of the practices and challenges that emerge in this space at the intersection of economies of solidarity and conflict during the Second Intifada. It analyzes local forms of

humanitarian assistance, international funding, new business ventures and quests for justice, all under the rubric of Non-Governmental Organizations (NGOs). It shows how there has been a change in the discourse around NGOs. The older generation of NGOs, the charitable religious and/or nationalist NGOs like Makassed and the grass-roots NGOs like the Union of Palestinian Medical Relief committees talked about their work in terms of social justice, the new NGOs use discourses of humanitarian aid. While the new birthing clinics are market-oriented, requesting birth fees and seeking financial aid where and when they can, and work within the context of an economy dominated by external aid, I do not understand them as simply donor-driven, subjected to higher authorities located far away from local dynamics. On the contrary, their emergence has a striking resemblance to the beginnings of the "grass-roots" NGOs of times passed.

Doctors too had opened birthing clinics in villages. I first heard serious critique of doctors from women who had given birth in such makeshift clinics run by a doctor. I had set out to understand how mothers/patients/clients were experiencing the reshuffling of health structures and practices during the closure.

One place where rumors were circulating about medical malpractice was in a village near Ramallah. The village doctor, Dr. T, was assisting births in an immunization clinic turned birthing clinic and a newborn died during delivery. It was a complicated delivery. The baby was stuck and Dr. T cracked the newborns skull as she was pulling it out.

Women from the village explained how after the incident, the villagers scared Dr. T out of the village. First, the director of the clinic closed the clinic and then Dr. T. had left the village and even the country. When I spoke to the director about the work of the

clinic, she said that the villagers were speaking and complaining so much about this case of infant death that they would not be able to assist births in the clinic anymore. If there were another closure, the villagers would have to look for assistance somewhere else.

As I interviewed more and more people in this village it seemed that while there are no enforced malpractice laws, there is a rather inconsistent system of accountability, one that gives voice to people's concerns about the medical care they receive and which in some cases the doctors must respond to. There was a similar case of maternal death in a Ramallah hospital while I was on the field. The doctor in question stopped working in that hospital. And the Ministry of Health held a few press conferences addressing the complaints and concerns people had voiced regarding this case. There was a general atmosphere of complaints, rumors of malpractice and criticism of doctors.

Two years after the incident of infant death in this village, I went back to do more work and I found that Dr. T had returned to the village and reopened the birthing clinic. I interviewed her and got her perspective on the events that changed her life. She was the only health professional assisting births in her village and among a few in her area. She had a high caseload. Ambulances could not reach her to assist with complicated cases. She had very little technologies and assistance at hand. She was under so much pressure from villagers to assist all the births that came to her door. She almost had no choice but to assist all these births. She was working long hours on her own in very strenuous conditions. It is hard to blame a doctor working in these circumstances.

On the other hand, Dr. T was benefiting from her practice. She became a public figure through her work in the birthing clinic. The clinic did close temporarily but by 2002, she had secured funding for a clinic that she would be heading. She talked about

writing a book because her story was so important. A year after the interview, she was given a post in the Palestinian Authority. There was a blurry line between the sacrificing national doctor and the self-promoting national doctor.

Chapter Four is an analysis of the site of vilification stories and scandals in which I pose questions about the overlap between doctors and political authority. This world of vilifying doctors yet needing them, mirrored a debate that was taking place in the Palestinian and Arab media. It was a time period where there were vehement critiques of the mismanagement of the Intifada and corruption by the Palestinian Authority. Like the critique of the Palestinian Authority, people used phrases such as: "he is a robber," "he is selfish," "all he wants is money." In this picture of vilifying doctors yet needing them, it seemed to me that medicine and prominent doctors were representations of political authority. Of course, association of power with the profession of medicine is common in many countries, however here it appeared to be more than simply association or symbolism. In Palestine, many doctors were in positions of political authority. Thus, they did not simply represent political authority by working for the government for example, but they were political authority. The examples are multiple: Fathi Arafat, George Habash, Haidar Abd-El-Shafi, Mustafa Barghouti, Abdel-Aziz al-Rantisi, Mahmoud al-Zahhar.

Much has been written about the participation of lawyers in the Indian Independence movement. One of the ideas of the movement was to fight the British liberal democratic state on its own grounds, through laws. Historians have also written about the predominance of engineers in the first generation of the PLO. This is certainly true of the external leadership that built the PLO, many of whom were engineers who

worked and began organizing in the oil-rich economies of the Gulf, but within the Occupied Territories, very few leaders are engineers. Several are doctors, however. I started to wonder about what that meant with regards to the identity of a Palestinian state and leadership. Was the idea of saving life itself, deployed through the humanitarian aid apparatus and through Palestinian survival and resistance discourse, being articulated in the overlapping of medicine and statesmen?

Contrasting the vilification stories, many women's narratives about birth were told as a very ordinary story. Rawya for example was from a village near Ramallah. She had to cross checkpoints in the middle of the night to get to the Ramallah hospital. She was in labor prematurely, in the eighth month of her pregnancy. All this was told in a tone of the ordinary: "that night the roads were closed off but the ambulance could get to the checkpoint. It was the middle of the night during the time when Arafat's compound was under siege. I walked a bit. I walked to the ambulance. I had no choice but to walk. I rested on my husband and mother in law's shoulders every so often (...) the problem was that I was in my eighth month. I walked into the room in the hospital. There was a bed. Around it was a curtain (...)" Most women told birth as a story of the travel between the home and the hospital and back home again. What they remember most is the space of the hospital which signals differences of class and origin.

In the Fourth chapter, I juxtapose these narratives of the ordinary with birth stories from the press. Part of my fieldwork was to track birth and medicine in the two local newspapers, *Al-Quds* and *Al-Ayyam.* While the narratives of mothers are in the register of the ordinary, the narratives of birth in newspapers, co-constructed by journalists and mothers are sensational. They have redeeming endings. On the one hand,

the space of the hospital in women's narratives of the ordinary is a socio-economic space characterized by an immemorial privilege for the rich. I can hear a haunting silence of stories untold in these narratives. The space of birth in the papers on the other hand is a space of miraculous redemption, a familiar space in the rituals of reading the daily paper. Both characterize the ecologies of anxiety of Palestine today.

I have always considered that my interest in medicine, political violence and resistance is as much an existential as it is an intellectual project. I was born to a historian and a midwife both with diverse cultural and political experiences (in the U.S, France, Switzerland and Nicaragua) who were activists in feminist, leftist and internationalist movements. I grew up in Ramallah during the period of the First Intifada, a place which was constantly inventing new modes of resistance and trying to grapple with the violence and silence of military occupation. Perhaps I was attuned to hearing politics in the whisper of stories of the ordinary and in the silences of those untold. Could I claim that the stories I collected for my fieldwork construct the narrative of my dissertation?

After 15 months of fieldwork, I gave birth in Beirut. It brought the stories of birth I collected close to home in an unprecedented way. The Lebanese infrastructures of health, birth and mobility differed from the Palestinian. I neither went to a hospital nor did I wait at a checkpoint. I gave birth at home with a midwife, my family and my husband's family around me. The apartment where we lived became a space for the creation of new bonds as well as a space for cultural and familial misunderstandings and disputes in this packed moment of a new birth, new family roles and the preparation for a move to the U.S. My husband and I spent three weeks going from embassies, to government offices to the general security services to procure our daughter the

documentation she needed to travel. However, all these interactions with institutions- of medicine, the state, the army, the family- were as important as the transformations that I was feeling inside of me as I maneuvered through intense inner worlds. It was a moment of making sense of the reality to which I was orienting myself, a moment of wanting and remaking identities, nations, places, families, motherhood and affects. Thus, my task of reading my material became an attempt at listening to the inner worlds of the mothers I had interviewed under the impress of political, economic and domestic pressures. Ethnography was after all a dialogical interchange, as Rabinow (1977), Fischer and Abedi (1990) and Clifford (1988) have reminded us. This dissertation is a product of this dialogue, however fragmented but sometimes perceptive it may be.

In chapter five, through a re-reading of the narratives as affect, as the point at which emotion feeds into an attitude, an orientation to the world, I identified the post-partum narrative as different from the birth narrative. The birth narrative takes place right after the first birth. The moment of the post-partum is a lonely moment when some women are trying to make sense of their lives, that starts a few months after birth and can last a year, or maybe more, before the child can speak. It is an introspective moment of loneliness when the mothers long for love and family support from their husbands but also from family members who are unable to reach them because of the closure. Some women feel enclosed by checkpoints as well as by family members within their homes. Some feel that the closure is intensifying a process by which the village is turning into a refugee camp (i.e. an enclosed space with displaced people) and the family is turning into fragmented bits of nuclear families, where the social support of relatives is lacking because of the new topography of the closure and emigration to other cities and countries.

Many build a bond with one family member (often a sister in law) with whom they can share their stories of loneliness and longing and make sense of their fragmented families and lives.

The narratives of enclosure sometimes remind me of the words of the poet of Palestinian nationalism and resistance, Fadwa Tuqan. Her poem describes her life experience, born in 1917 in an upper-class Nablus family, where she like most of the women of her social class were supposed to stay at home, a place where she found little comfort and love. Its words echoed some of the enclosed mothers that I came to know:

"A Life"

My life is tears

And a fond heart

Longing, a book of poetry and a lute

My life, my totally sorrowful life

If its silhouette should vanish tomorrow,

an echo would remain on earth,

my voice repeating:

My life is tears

And a fond heart

Longing, a book of poetry and a lute.

...

Now I bow my head, desolate.

A lost horizon thunders inside.

Poems alone are my refuge.

In them I describe

My longings

Only then can this soul

Find calm.

(Excerpts from "A Life" by Fadwa Tuqan 1990)

Chapter One

Building the Infrastructure, Modeling the Nation

This chapter explores the intersection between the professional politics of medicine and national politics during the second Palestinian uprising which erupted in 2000. Through an analysis of interviews with health professionals and participant observation in hospitals, it examines the oral histories of two overlapping movements that contributed to building the public health infrastructure; the movement of *sumud* (steadfastness) (1967-1987) and the popular health movement (1978-1994). The oral histories illustrate contrasting visions of a nation struggling with restrictions on mobility and a ground chopped up by checkpoints. In order to show how these two perspectives became possible, I shall first of all provide the necessary historical background against which health politics have been conceived in the modern and contemporary era.

One of the main themes in this dissertation concerns the overlap between the medical profession and the Palestinian political authority. This historical chapter will explore how it was possible for doctors to mobilize in service of political authority. How is it that the figure of the doctor converged with that of the sovereign?

Some of the answers to these questions lead us through the history of governance. In studies of medicine and society, Michel Foucault has probably had the greatest influence in shaping the ways in which notions of biology and medicine enter into governance. Foucault's concept of governmentality, elaborated in his lectures at the

Collège de France, describes a distinctly modern form of rule that aims to govern more efficiently by rendering individuals capable of augmenting their own welfare. It has three interrelated elements: government, which concerns the management of population; discipline, which concerns practices and techniques of rule; and sovereignty, which concerns territory and laws. Building on Foucault's formulation of biopower and focusing on the third of the three elements, Giorgio Agamben (1998) links the amalgamation of sovereign and medical power in Europe to the biologized notion of rights that emerged at the time of the French revolution. Agamben argues that with the body becoming the site of rights from the moment of birth—that is, when the body became the ground of sovereign subjects—the sovereign becomes displaced by another figure, the doctor, that is to say the one responsible for the care of the body (Agamben 1998).

In his dissertation on doctors and sovereignty in Syria from the mid-nineteenth to the early twentieth century, Robert Blecher (2002) shows that in the Middle East, the notion of individual rights has a different genealogy specific to the region's history. Firstly, he shows that Ottoman governmentality differed from its European equivalent insofar as it departed from the fixation on the individual. Where the European state appeared to retract itself from certain realms to create seemingly "emeancipated zones" (Blecher 2002) where "individual rights" were articulated through "civil society"; in the Ottoman Levant, Blecher identifies the new "social networks" of the early twentieth century as a crucial unit with historical importance. These urban, civic, national and professional *groups* of social actors may have been tied to the state but remained autonomous. Yet, despite its difference in focus, European governmentality, like its

Ottoman variety, was mainly designed to protect the interest of the population. In the colonial context, however, European states used techniques of governmentality as tools of coercion in ways that violated metropolitan norms.

Ever since Ernest Renan ([1882] 1998:32) and more recently with Benedict Anderson (1991), the relationship which establishes the national entity is seen as one between the individual and the state, passing through the workings of print capitalism. While this triangle is relevant, it would seem that in post-Ottoman societies, there are other dimensions to be taken into consideration.

In this context, the professional corporations and notably the medical one emerged out of a social context in which, historically, nation-building was not on the agenda. The historiography points overwhelmingly in the direction of continued Ottoman loyalism in the Arab East until a date that may be is as late as the outbreak of World War I and certainly not much before. Although we are dealing with a simultaneously colonial and post-colonial context in Palestine, its historical roots are thus seen to be mixed with deeply entrenched, unique political elements.

Arguably the most important body of work on colonial and post-colonial subjects has been carried out by the Subaltern Studies Collective, who have sought to recover subaltern subjectivity from the various epistemologies that have erased it. Influenced by and building on Foucault's concepts, they have paid close attention to the relationship between the state and the subaltern focusing on India but in the process establishing a model which has reverberated throughout academia. Blecher's analysis shows that in the Middle East, networks and groups of individuals having similar characteristics

(professional, charitable, civic, gender-based) need to be understood as an additional actor and therefore unit of analysis endowed with historical agency.

It is with this specific analytical configuration in mind (neither metropolitan nor colonial) that the present chapter explores not only the vector that links the colonial or postcolonial state to the colonial subject but the slow process whereby deeply rooted affinity groups and networks gradually became an essential element of the state and nation-building process, still on-going. I will analyze how a particular facet of the state and nation-building process evolved out of the constitution and development of two overlapping medical movements in Palestine, sumud and popular health.

To this effect it will be useful first of all to present a historical overview of state practices beginning in the Ottoman period and relating to practices of civil and health management of populations. These form a backdrop whose development is contemporaneous with the rise of various networks beginning in the late Ottoman period. It is against this bureaucratic and legal backdrop that the two movements in this chapter had to grapple.

I. Historical Background

Historically, the evolution of the birth infrastructure in Palestine has gone hand in hand with developments within the practice of birth registration and the management of population. In this respect as in so many others, the period of Israeli occupation is largely continuous (although presenting unique characteristics) with practices going back through the British mandate to the late Ottoman period.

Prior to the 19th century, the Ottoman empire adopted a decentralized approach to population related activities, with each *millet* or community held responsible for collecting required central taxes and, where applicable, providing men for military service. From the 1820s on, and more particularly beginning in 1839 with the series of reforms known collectively as the *tanzimat*, these activities became more systematic and transparent. During that period, interest in counting Muslims was greater, because the other religious communities did not by and large serve as conscripts. But since the other immediate purpose was to estimate at what level to levy taxes on each one of the non-Muslim millets, they were by the middle of the 19th century being included in registration drives, although not as systematically (many tried to evade registration). In the 19th century, the criteria of "wealth and religion" (Ismaoglu 2006) were always the two operative categories, and not the dominant European categorizations of "race" in the colonies. This distinguishes the Ottoman imperial case from the colonial ones described by Benedict Anderson (1991). Anderson is quite right, in the second edition of his landmark work, to revise his original "short-sighted assumption" (1991:164-169) that the model for colonial nationalism is to be found in the European dynastic states, finding it rather in "the imaginings of the colonial state" (163). In contrast to the inhabitants of colonial states Anderson describes, most Ottoman subjects did not consider themselves part of a nation building venture. This consciousness was until the end limited to "a small, mostly Muslim, elite" (Zürcher 1998:446). Nonetheless, they were indeed subjects of and thus monitored by the Ottoman empire.

Until 1878, only men were included, and so the recording of births and deaths remained a rather decentralized and haphazard practice. Thereafter, a new reform called

for the inclusion of women and infants in all population registries, which became permanent fixtures in villages, towns and the various quarters of the cities. Muslims and the various recognized millets had separate registers, and with the issuance of receipts for registration, a combined birth certificate/identity card was being issued for the first time in the later part of the century, in principle to all Ottoman subjects, so that at this stage, births and deaths were increasingly recorded right away (Shaw 1978).

The procedure for registering births emerged from these developments, likewise in the late 19th century. "For each newly born child, the *imam* or other local religious chief, or *muhtar*, had to set down its name, place and date of birth, and name of mother and father when available..."(Shaw 1978:331). This information was sent to the central authorities. There were particular procedures for people born abroad or at sea, and in hospitals, an unusual event at the time.

In short, the last half century of the Ottoman empire saw the birth and evolution of a rather systematic framework of census taking (the last Ottoman census was in 1914), and more specifically, of birth registration.

The British, who were in occupation from the end of the First World War until 1948, did not invest heavily in health, and where they did, their prime focus was on questions of interest to their nationals and to Jewish settlers, rather than Palestinians (Sufian 2002). Indeed, they steered clear of matters regarding birth and population, because for both the Palestinians and the settlers, they were explosive. Between the end of World War one and the end of the British mandate, the budget for health in Palestine actually declined from between 6.5% and 9.6% on the eve of the Mandate to 3% in its latter part (Sufian 2002:14).

Births continued to be registered by local professionals, in the urban hospitals or clinics, and in the villages (that is to say, for the vast majority of the population) by dayat (the Mandate authorities called them the "unqualified women"). Government and Christian missionary hospitals, maternity wards and clinics established in the cities (especially Jerusalem and Haifa), most of which had been in existence in Ottoman times, continued to operate, while villages continued to make do with the services of dayat and increasing numbers of Palestinian doctors and midwives (Sufian 2002:18).[3]

The period of Jordanian rule was characterized by continuity, and the marginalization of the West Bank (which perfectly matched the situation in Gaza during Egyptian rule). This was the time of the ascent of Amman and the East Bank. Among Palestinian urban centers, only Jerusalem was accorded any attention, particularly in the religious field; in the medical arena, the UN and particularly UNRWA was the central actor.

From 1967 to the Oslo Accords and the establishment of the MOH in 1994, the Israeli Civil Administration under the Ministry of Defense was responsible for the health of the Palestinians under occupation in the West Bank and Gaza Strip. They directed the hospitals, allocated the budget, hired and fired the staff, and were responsible for overall management and policies. The actual health providers were Palestinians, but they had no power to make decisions or take initiatives. Tax revenues from Palestinians financed the Israeli infrastructure of hospitals and clinics in the occupied territories. With minimal allocation of funds and poor systems of accountability, the government health system remained a neglected part of the infrastructure.

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[3] As for the Jewish hospitals during the Mandate period, essentially the Hadassah and Kupat Holim organizations, they were willing within the limits of their possibilities to accept Palestinian patients. The few who made use of them came from the urban upper classes (Sufian 2002)

Most tax revenues that went into health during the Israeli occupation were spent on building and developing large urban government hospitals. Israel systematically promoted them as venues for birth. It encouraged this shift from the home to the hospital by lowering hospital delivery fees, first in 1983 and then in 1991 to around $43 (Acker 2002). The justification for promoting hospital births was the high infant mortality rate, perceived to be a result of the considerable number of home births that were assisted by dayat. In 1993 the World Bank estimated that one-third of the births in the occupied territories took place at home without proper medical supervision (World Bank 1993). It is difficult, however, to imagine how the understaffed and overcrowded government hospitals could provide "proper medical supervision." But this did not seem to be a concern for the policy-makers. The strong motivation of the Israeli Civil Administration to hospitalize births was no doubt due in part to the desire to enumerate, register, track and control individuals and population growth more accurately.

Michel Foucault's concept of biopolitics provides explanations regarding the drive of modern states to regulate and control populations and individuals and its effects on the building of infrastructures and the shaping of individuals' lives. Biopower refers to "what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life" (Foucault 1980a:143). He points to a particular moment in eighteenth century France when the consolidation of centralized state administrative power went hand in hand with a new concern for the health of populations (Foucault 1980b). Health became a matter of state. Statistics, births, deaths, life expectancy, marriage, procreation and the categorization of bodies were new types of knowledge contributing to new experiences of control in modern life. In

addition, in the context of contemporary Palestine, as Rhoda Kanaaneh (2002) has shown, the demographic battle is an integral part of Israeli and Palestinian political discourse and controlling the information on numbers, people and places is and has been part of these projects.

It is hard to grasp the extent to which modernization has influenced the life of Palestinians. People can feel strongly against or for it but it is a topic they feel they must address. Medical institutions have been one of the central symbols and carriers of modernization. The past 30 years of Palestinian history have witnessed a rapid penetration of modern medical services in the West Bank and Gaza Strip. The location of birth provides one of the most telling statistics with regard to medicalization: the rate of births in health institutions went up from 67% in 1993 (World Bank 1998) to 96 % in 2004[4] (Palestinian Central Bureau of Statisitics 2005). Many of the births in the latter statistic take place in doctors' or midwives' clinics or in new health facilities constructed to assist births during the closure. These statistics do not register the differences in the types of medical institutions used. However, they show quite clearly that practically all births are thought of as taking place in an institution, whether a historic hospital of the state or of a Church or a makeshift clinic intended to deal with the context of closure.

The history of birth as a moment of contact with medical and state institutions in Palestine accelerated in the 1960s, and again in the 1990s. One of the areas where the Palestinian Authority was proud of its work before the outbreak of the second intifada in 2000 was the health sector. After the Authority took over in 1994, it continued to

[4] This is the rate of births with "proper medical assistance." It does not differentiate between a hospital and a clinic birth. However, what the statistic means is that there are only about 4% of births that take place in homes (or on the roads) assisted by dayat and family members. Many babies born on the roads or at checkpoints reach the hospital or clinic sooner or later and thus are considered hospital births (conversation with public health analyst).

centralize the system and to build and develop hospitals in urban areas. With regard to childbirth, it campaigned to have women give birth in hospitals, especially since now government hospitals were run by a Palestinian national entity and no longer the Israeli government. The Palestinian Ministry of Health (MOH) again lowered the fees for giving birth in government hospitals.

This strategy aimed to promote the on-going process of institutionalization of births, a continuation of the previous Israeli policy for the occupied territories. From 1994, Palestinian policy-makers thus encouraged all women, whether their pregnancy was considered normal or high-risk, to give birth in the hospital. Promoting a physician-based system for low-risk maternity care was a logical position for these policy-makers, who were virtually all male medical doctors. These policies benefited the professional interests of the over one hundred and fifty Palestinian obstetricians (of whom less than one-fifth were females). According to the Medical Association Register of 2003, obstetricians/gynecologists received their degrees from Eastern Europe (43% including the former Eastern bloc and post-Soviet republics, with 15% from Russia), Arab countries (39%, primarily Egypt and Jordan), and Western Europe and Turkey (13%), with only a few from unspecified countries. Their training in these countries took place in large urban maternity hospitals. As they returned to Palestine, the Ministry was under pressure to provide employment for physicians. During the period of the second Gulf War in the early 1990s, Palestinians who had settled and made their livelihood in Kuwait and other Gulf States were forced to depart. Many came back to Gaza and the West Bank, in search of employment. Some new positions were created in hospitals. This coincided with a policy decision in Gaza's largest governmental establishment, Shifa Hospital

(where 12,500 births take place annually) that normal births, previously the domain of the midwives, would be attended routinely by physicians to the exclusion of midwives. The decision relegated these midwives to the role of cleaning and assisting the physician, and it gave women no choice for a birth attendant except for male physicians.

In the West Bank during the 1990s, any place of birth other than the hospital became marginal and for all practical purposes outside of the law. The only legal and trained birth assistant who delivered at home was the daya. It was not illegal for doctors to assist home births, but most of them had no skill or experience outside of the hospital environment, and did not feel at ease in this role. In Gaza, physicians frequently did deliveries in their clinics. In the West Bank some midwives in the Jenin and Hebron districts had "midwifery homes" where women came to have a normal birth with few interventions. These semi-undercover establishments, primarily intended for women who could not afford a private hospital, were tolerated as the political situation became unstable and the Ministry of Health found itself incapable of regulating maternity facilities. But during the flurry of the Oslo period, which witnessed the establishment of new private hospitals, midwives who had maternity homes felt threatened by the pressure of the obstetricians and the Ministry. When the Ministry sent documents asking for the midwives to report how many births they assisted in a particular year, many said they underreported the numbers of births they attended. The Ministry never cross-checked the reported information from hospitals, clinics, doctors and midwives and the information on birth documents. In the Hebron district, where the birthing market was quite prosperous (30% of the approximately 53,000 annual births in the West Bank occurred in this district – Palestinian Ministry of Health 2003), some of the obstetricians said they

paid dayat a small amount of money for bringing pregnant women to them for antenatal care and birth attendance. This illustrates both that the dayat in this region continued to be close to their communities and that the obstetricians there needed business.

The paradox of the new Ministry's policies on the scope of practice for different types of health providers was that the trained midwives who had university degrees or a two-year practical midwifery school certificate were only allowed to attend births in maternity hospitals and were prohibited from doing home births. On the other hand, the dayat who had no formal medical education would continue to be licensed to do home births, but only as a stop-gap measure until they became obsolete. No new dayat would be licensed, and they would rapidly die out (as most were in their sixties), along with their profession and with home births. Only a few members of the new Ministry of Health were not totally in agreement with this policy. The medical director in the Jenin district, the northernmost region of the West Bank which is frequently isolated and cut off from other areas, expressed his anxiety that in the current unpredictable political situation, women might not always have access to urban hospitals. The dayat were still needed in the community in case of emergencies and closures, particularly where the threat of women being exposed to Israeli soldiers was always present.

The other supporter of maintaining and training was Wijdan Siam, known as Imm al-Walid, in the Women's Health and Development Directorate (WHDD), which was created in 1994 at the same time as the other ministerial departments and totally funded by one of the UN donors. It was run by a woman, Imm al-Walid, who was not a health professional but a social worker and had played an important role in Lebanon and in Tunis with the PLO. She did not have the same professional loyalties or biomedical

background which shaped the physicians' positions in favor of institutional births. She decided to organize training for the existing dayat, with the idea that they were influential among women in the community and could be advocates for women's health promotion in addition to attending home births when solicited. She recognized the importance of access, community-based services and sustainability. She was also supported by the outside funding she managed to bring to the ministry. However, she had less influence than the physicians in decision-making, and after the death of Arafat, was soon squeezed out of her ministerial position and forced to retire.

This course of action intended to phase out the dayat was also in line with WHO's policy of "Safe Motherhood." After several decades of supporting the training of "traditional birth attendants" in developing countries, it appeared that the strategy had little impact on reducing the maternal mortality rate, which remained very high. WHO thus adopted the strategy of promoting "skilled birth attendants" (midwife, nurse or doctor) in all cases, and traditional birth attendants were not included in this category. As screening pregnant women for high risk was not effective in predicting which women might have serious complications during labor and delivery, all birthing women required skilled attendance and access to emergency care. However, research teams from individual countries have been criticizing the turn in the WHO's safe motherhood program. In Egypt for example, researchers have called into question the emergency-centered policies (and funding) by showing that most maternal deaths were due to negligence or poor treatment in the hospital and not to the care of the daya (Egypt Ministry of Health and Population 2001). The Palestinian history of centralization and

medicalization of birth is to be understood in the wider context of post-colonial modernization projects as well as the global flows of policies and funding.

In the Palestinian context, where mobility and access to hospitals continues to be sporadic and unpredictable, there is a general double discourse about dayat and their work in villages. Some doctors talk of the daya as "an illiterate woman who arrives at the hospital in her bare feet with a woman in labor with complications" (conversation with an UNRWA obstetrician). However, contrary to this stereotype, the 179 dayat licensed in the West Bank in 1999 were quite a diverse group, with about one-third of them having formal training as a midwife or a nurse. They provided different components of primary health care in their communities, in addition to attending births. Many of them also described their social functions in the community. For example, the daya would help the mother after childbirth with the household chores and taking care of the other children. She played two roles, the midwife and the mother's helper (Institute for Community and Public Health 1999). Alongside the stereotype of the barefoot dayat, other doctors such as one from the Jenin district thought the dayat were needed. Palestine was a place that would go in and out of occupations and closures and these women with birth assistance skills were going to save Palestinian lives in such times of crisis.

As previously stated, hospital births went up to 92% in 1999 right before the Intifada.[5] The 1990s marked the takeoff of the Palestinian neo-liberal wave. In towns such as Ramallah, stores and restaurants were opening at every corner. Businessmen returned from the U.S. or the Gulf to invest in all Palestinian towns and cities. Consumer goods flooded the markets. Gradually, these investments as well as donor money

[5] During the Intifada in 2004, the rate of births "with proper medical assistance" rose to 96%. See footnote # 3 about this rate. This rate does not signal the rise of births in clinics and makeshift clinics.

funneled mainly through the Authority, created a rich, consuming class. Alongside these wealthy people there existed a petty market of arms, drugs and stolen cars as well as a class of poor people. This is the typical story of the rise of a neo-liberal economy compressed in a life of ten years. The important point in our context is that, by the end of the 1990s, the cities had developed a new and different social pyramid, including new groupings with modernist political, cultural, and consumerist characteristics.

The hospital infrastructure was, as noted above, limited to the cities, even as modern urban ways were increasingly attractive (although at the same time feared and resisted). The moment of birth had also become one of those when women drove or were driven to the city, a moment of direct and intense contact with its institutions. From the point of view of the hospitals and infrastructure, it was the moment of contact with villagers, assisting their births and registering their daughters and sons.

When the 2000 Intifada started, the rate of births outside of hospitals went up, although many still took place in the hospital after tedious and circuitous car rides. The Ministry announced the start of "Intifada insurances" which made birth assistance in government hospitals free of charge. For reasons cited above, public health analysts estimated that the statistics collected since 2000 do not accurately reflect the location of births or the significant changes in the infrastructure. The Ministry of Health collected reported locations of birth. Many births that take place on the road or at home are reported as hospital births if the newborn is brought to the hospital for a check-up thereafter. Midwives who assist births in their makeshift clinics manage to report the birth as a hospital birth in order not to be reprimanded by the ministry. While the statistics are blurry, ethnographic research provides a picture of a growing decentralized

birth infrastructure, with makeshift clinics in villages opening, closing and reopening as the conditions of the closure change.

This partly decentralized and unstable situation likewise reflected a recent shift in the development of the medical infrastructure. I will describe various aspects of it in chapter 2. In this chapter however, I will focus on two historically rooted phenomena: the infrastructure of sumud and the infrastructure of the popular health movement.

II. Two Contrasting Models of the Nation

The interviews in this chapter identify some sites of the health infrastructure and some turning points in the history of the health system.[6] Most of the data for the present chapter was gathered in a major hospital in East Jerusalem and a clinic and homes in the Ramallah area. The two overlapping movements in the contemporary history of the Palestinian medical infrastructure discussed in this chapter, sumud and the popular health movement are remembered as important moments in the history of the resistance against occupation and the process of building a nation. While the interviewees were describing moments in history, it is impossible to neglect the situation on the ground at the time of their telling: meetings, interviews and stories all were overwhelmed by the daily encounters with the closure.

The stories of people's gendered lives are intimately intertwined with the birth and development of the nation-state (Good 2001, Das 1997). Accounts of children's births and the development of the nation-state are both mediated through institutional

[6] I have used pseudonyms for all the doctors and midwives I interviewed except for the three oral histories of founding members of the Union of Palestinian Medical Relief Committees Dr. Mustafa Barghouthi (a well known politician), Dr. Salwa Najjab and Dr. Omayya Khammash whose identities and activities are known.

structures, involving expertise, power struggles, conflicts and negotiations. There is an overlap between the role of physicians in the Palestinian struggle for self-determination and in the building of medical and birthing facilities. This suggests that the stories of birth cannot be told as divorced from the (highly political) history of building infrastructures and shaping political imaginaries. The quasi post-colonial condition of Palestine as an "imagined community" (Anderson 1983), as an institutional state structure, and as a setting for the lived experience in the lives of its experts and of its (gendered) subjects underlies these ethnographic accounts.

The two movements in the history of Palestinian public health recounted here, sumud and popular health, were the focus of many of the oral histories. Stories from Jerusalem, the capital, the hospital, focused on the concept of sumud. Those from Ramallah, other parts of Palestine, the clinic, related more closely to the popular health movement. Looming in the background are two contrasting but related projections of the nation.

It is important to note here that Palestinians have not had full control over state mechanisms usually considered essential for "imposing uniform 'national' criteria of identity" (Khalidi 1997:10). Palestinian nationalism has therefore expressed itself in the form of a liberation movement often produced *in opposition to* state mechanisms (Sharoni 1995, Kanaaneh 2002). However, Palestinians have acquired a very strong sense of national identity, and their national movement has resorted to the construction of state-like mechanisms against or on the margins of the Israeli state.

The first model of the nation is embedded in stories about the medical infrastructure and birth, as represented by Makassed hospital in Jerusalem, the Palestinian

hospital *par excellence*. The hospital is an example of the successful national microcosm, with its competent leader and spokesperson/the doctor, its hard working, sacrificing citizens/the nurse, midwife and technician, its modern organization/sophisticated technology, successful operation, clean building, transparent financing and finally its naïve society/the patients.

The envisioned nation is here a classical one in its Jacobin roots as defined by the French Revolution: a centralized, republican nation in which the elites are chosen by the people and reflect the general will. It is also a positivist vision of the nation in the Comtian sense where technology provides the means for the solution to all social problems within the national context. This technocratic construct is based on a Westernizing ideology with science at the apex of the system.

The second series of interviews, those concerned with the Union of Palestinian Medical Relief Committees (UPMRC) presents an alternate microcosm of the Palestinian nation, based on a social-formations concept where it cannot be divorced from society and its components. Proponents of this model integrate all of the contradictions - notably those of class - in striving to extend the benefits of primary health care from the single institution of the hospital to the villages, camps and towns of Palestine in the form of clinics. This socially based vision of the nation incorporates the lessons of the socialist model, not as it was, but as it "should" have been practiced in the Soviet Union for example. Implicit in this articulation of the nation through an alternative health system is the effort to save the socialist model by radically restructuring it.

As will be seen, both of these visions engendered internal dissent, which is also described here. In the end, both adopt vertical and paternalistic forms of operation. And

implicitly the stories call for continuous thinking on and considerable restructuring of the two visions of the nation.

II. 1. The Embodiment of Sumud: Makassed Hospital, Jerusalem

a. Genealogies of Sumud

Makassed sits on the Mount of Olives in Jerusalem. It has a capacity of 250 beds, about 45% of the hospital beds in East Jerusalem, and is staffed by 560 employees. It has 9 medical departments of medicine. The department of obstetrics and gynecology is known throughout Palestine. It provides gynecological and laparoscopic surgeries and has a well-known infertility and perinatology clinic. It is affiliated with the new school of medicine of Al-Quds University and is the main university hospital. In addition it has its own school of nursing and offers additional training to nurses from many schools across the country. It receives patients from all over the occupied territories. Many members of the professional elite obtain treatment there, as do poorer people. Since it is a non-governmental, charitable hospital, the cost of treatment is considerably higher than in government hospitals but much cheaper than in the private sector. Furthermore, it grants financial support according to household income. With its impressive technologies, its interest in medical education, its diverse clientele, and its universalist aspirations, it is a working symbol of the Palestinian national movement's aspirations.

In the early days of my research, I went to speak with a prominent obstetrician at Makassed, Dr. Rami. When I asked him what Makassed hospital was like, he described its history as being intimately linked with the politics of sumud. The sumud policy of the Palestine Liberation Organization consisted in promoting a type of non-violent resistance

through which the occupied Palestinians endured difficult military and political measures and a harsh economic situation for the sake of their national future. The PLO and Arab governments had a policy of sending funds to promote living conditions in the Occupied Territories. It was a response and challenge to the poor government services offered by the Israeli military-controlled "Civil Administration."

The sumud approach was rooted in Arab and Palestinian nationalism and understood colonialism and military rule to be the major causes of poverty and the major obstacle to improving the developmental level of the population, including in the health sphere. Sumud-linked donations were supposed to alleviate poverty and encourage Palestinians to stay in the occupied territories. The official sumud fund was established in 1978 at the Arab Summit in Baghdad. Many Arab governments contributed. Physicians like Dr. Rami, when discussing the presentation of a specific genealogy of funding sources (well-known but regarding which there are very few records due to the illegal status of the PLO at the time) are indicating to someone in Palestine the institution's connection to sumud, a source of prestige. Like the PLO itself, the hospital has seen a succession of donors in keeping with the ebb and flow of international politics.

Makassed is one of the Palestinian hospitals known to be stable financially. Dr. Rami explains that it has large debts but manages to receive donations every month to cover salaries. When we talked that initial time in 2002, employees of the hospital had not received salaries for a few months. According to Dr. Rami, it was a problem of liquidity. Everyone seemed to be sure that they would receive their salaries soon. Sometimes, as he explained, it takes time for Israel and the Palestinian Authority to clear the donations and pass them on to the hospital. The limited resources of the hospital

suggest that it is not as stable financially as the employees portrayed it. However, it has always kept up with paying salaries even if late, something very few institutions, especially large ones, could claim. Furthermore, the symbolic and historical importance of the hospital in Palestinian national thinking made it seem difficult to imagine that it may be in financial crisis or teetering on the edge of bankruptcy. It does not work like the private hospitals that started to sprout in the mid-1990s and were then subject to the whims of economic and political changes. Makassed, it appeared, had the stability of a national state infrastructure.

While Makassed has remained afloat financially over the years, the multiple changes in sources of funding illustrate the unstable political conditions and practices of institutions in Palestine: "It has been funded regularly since its beginnings in 1968.[7] Before the Gulf War, most of the funding came from Kuwait and Saudi Arabia. After 1991, it had to depend more on other Gulf countries like the United Arab Emirates and Qatar. Since the Palestinian leadership sided against the U.S. and its allies during the Gulf War, Kuwait and Saudi Arabia took away their funding. But other Gulf countries replaced them." Makassed, unlike many other institutions, managed to remain afloat financially despite the political instability especially during the period of the Gulf War.

The majority of nationalists espoused the politics of sumud. According to the ideology of the time, real and lasting solutions to health problems could only be achieved with a just and durable resolution of the political crisis. In the meantime, however, the development of a Palestinian infrastructure within the limits imposed by Israeli military laws and practices was the aim. The administrations of these institutions thus agreed to

[7] Makassed Foundation started building the hospital on this site in 1964. It was not inaugurated however until 1968 after the sit-in of 1967 through which the hospital's opening took on foundational dimensions.

fight for permits and licenses in the offices of the Israeli military governor, for the renewal or inception of each project. Some applications were denied, others granted. But, an inherent principle of the politics of sumud was to act in the open.

The leaders and activists working in the context of sumud created the basic infrastructure of Palestinian curative services in the Occupied Territories. They bought medical technologies and developed expertise. Like Makassed, hospitals were usually large, bureaucratic and located in urban areas; they offered sophisticated technologies and specialized services. It is "as good and advanced as Israeli hospitals" (communication with Dr. Rami 2002).

b. Practices of Sumud

In 1978 Arab leaders officially started the pan-Arab fund, *Amwal al-Sumud*, and called on Palestinians in the occupied territories to be *samidin* [steadfast]. But Palestinians in the territories and in Israel have talked about sumud as a form of daily politics intended to challenge Israeli occupation which existed for a much longer time and whose purpose was simply by staying put, clinging to their homes. In his published journal *The Third Way*, Raja Shehadeh, a prominent human rights lawyer, writes of the everyday practices of sumud: "long before Arab politicians outside defined sumud as a pan-Arab objective, it had been practiced by every man, woman and child here struggling on his or her own to learn to cope with, and resist, the pressures of living as a member of a conquered people. Sumud is watching your home turned into a prison. You, *Samid,* choose to stay in that prison, because it is your home, and because you fear that if you leave, your jailer will not allow you to return. Living like this, you must constantly resist the twin temptations of either acquiescing in the jailer's plan in numb despair, or

becoming crazed by consuming hatred for your jailer and yourself, the prisoner. It is from this personal basis that sumud for us, in contrast with politicians outside, is developing from an all-encompassing form of life into a form of resistance that unites the Palestinians living under Israeli occupation." (Shehadeh 1982:viii)

Arab leaders took the concept of sumud, giving it a prominent place in political discourse regarding Palestine, even as Palestinians in the occupied territories were reading new meanings into it, thus carving a niche for themselves in official politics. Having shared in the history of sumud, as envisaged by Dr. Rami, thus meant not only being a supporter of the PLO but also helped to describe practices of everyday life under occupation.[8]

Dealing with the daily obstacles on the road and at work, are all part of living by the politics of sumud. The hospital partakes of sumud in the multiple meanings of its politics whether with regard to its links, roots and funding or in terms of the everyday practices of doctors and employees.

The difficulties of getting to work and the difficulties of the discontinuity of care due to the closure exemplify practices of sumud. While Makassed always has patients, the confusing part for doctors is where the patients will be coming from. Since the beginning of the contemporary period of closure in the early 1990s, patients from the Gaza Strip are extremely rare because they are not given permits to travel. But even from the West Bank, the numbers have fluctuated. Since the first phase of closure targeted Jerusalem, patients started going to hospitals in other towns. After Ramallah was reoccupied by the Israeli military in 2002, people started returning to Jerusalem. People

[8] For a discussion of the use of the concept of sumud among Palestinians in Lebanon, see Julie Peteet's book, *Gender in Crisis*. She describes how Palestinian women in Lebanon used the discourse of sumud of the PLO to describe and give political value to their daily work of house-work and child-rearing.

living in villages such as Hizma, Anata, Abu Dis, or those of the Ramallah and Bethlehem area, then found it easier to get to Jerusalem than to the nearest town. And with the completion of the wall around and within Jerusalem, the lines of communication have shifted once again. Everything seems to depend on the constellation of the closure. "We always have patients but the question is from where and how many?" And I would add to Dr. Rami's question: what does this repeated reshuffling of patient populations do to the continuity of care?

"My patient from Ras Karkar [a village close to Ramallah], she comes here like many because she has high-risk pregnancies. She had two previous cesareans and diabetes. She thought it would be easier to drive 40 km to Jerusalem than to get to Ramallah. We set up an appointment for the C-section. She was unable to cross the checkpoint that day. She arrived knocking at my door four days later. I had to stop everything, because her case was getting dangerous." This is the way, based on my observations, in which much of medical care was dispensed and many births assisted and given in Palestinian hospitals. The medical practices usually learned as routines had become unpredictable. Only rarely had medical providers seen a particular woman before she arrived, in labor already. They rarely had the time to get background information about the mother. Working in these conditions is practicing sumud.

The closure reshuffled the patient population and disrupted the work of employees. A resident in the anesthesia department whom Dr. Rami drove to and from Ramallah first had to take a five-hour drive from Tulkarem. "For two weeks I could not come to work," Dr. Rami tells me, "There is a doctor here who took my place for the time being. But it is still a mess. And can you imagine the road every day?"

I could imagine it. During this phase of my fieldwork, I often traveled the road that Dr. Rami takes every day, and could have collected many of my own stories of waiting, standing in line, delays, frustration and not understanding the logic. Passing Qalandia, the main checkpoint between Ramallah and Jerusalem, has been a strenuous and lengthy affair since the spring of 2001. Pedestrians – whether peasants, workers, doctors, lawyers or butchers – all lined up in the dust of a run-down road to get their IDs checked by the soldier. The alternative was to take a roundabout road. It was long and people, especially men, ran the risk of being arrested. Most therefore went through Qalandia. Things changed somewhat with the wall, when unofficial roads (*al-turuq al-sha'biah* or the roads of the people, as they are known) have been largely choked off, and the turn-styles modernized. But the waiting is the same, the frustration perhaps greater (because of dwindling options) and the noise- and dust pollution levels still very high.

Closure stories have become a communal account which refugees, returnees,[9] urban and rural people, men and women, poor and wealthy all share. This is not to say that there is only one story or that the effects of the closure are the same for all Palestinians regardless of class. However, the politics of the closure, the delays, standing in line, waiting, surveillance, being refused entry, being under curfew in your home as well as breaking the closure regulation, bypassing the checkpoint on winding dirt roads, or slipping out after sunset during curfew days are lived, told and remembered as communal, as the story of a whole people.

The practices of medicine are unpredictable at Makassed, but it is one of the more stable health institutions in the country. It may be difficult to predict who will come to

[9] The term 'returnees' designates Palestinians from the diaspora (usually designating a political class from the PLO in exile) who came to the Occupied Territories with Yasser Arafat in 1994.

work and who won't, which patient will arrive and which one won't, but the hospital's funding and prominence remains. Managing a hospital with the daily obstacles on the road and at work part of living by the politics of sumud.

c. Beginnings

Makassed hospital represented a victory for the Palestinian national movement over the Israeli occupation from the beginning. "There are two events in the hospital's history that single it out as the most important hospital in the Occupied Territories," Dr. Rami remarks. "In 1964, the Al-Makassed Foundation started building a hospital on the Mount of Olives in Jerusalem. (...) In 1967, when Israel occupied the West Bank and Gaza, the hospital was being built on land owned by the Islamic *Awqaf* (religious endowment fund). Right after the occupation of Jerusalem, the Israeli army decided to expropriate the still empty hospital building and transform it into a police station. Hundreds of doctors and nurses mobilized. They moved beds, equipment and even patients from private clinics and homes into Makassed premises. The Israeli authorities gave up control of the building." [10] Thus, the Makassed Foundation had just finished building the hospital at the time of the occupation. The building was still empty. By moving the beds and equipment, doctors and nurses unofficially inaugurated the hospital with the beginning of occupation in 1967, and this unofficial inauguration takes on foundational importance. The official inauguration was not until 1968. Its initial movement against occupation, according to Dr. Rami, made a name for Makassed right from the start.

The 1987 intifada secured its position as an emblem of Palestinian nationalism. "By early 1988, government hospitals were inundated with injured persons. These were

[10] For another account of this event see Barghouthi and Giacaman 1990.

controlled by the Israeli so-called "Civil Administration," under the aegis of the Ministry of Defense. Their services were not sufficient. So the injured from all over the occupied territories, from Gaza in the south to Jenin in the north flocked to Makassed. There were no checkpoints at that time. The roads were easy. Furthermore, the hospital specializes in high-tech, complicated, emergency surgery. And, like many other hospitals, intifada injuries were treated free of charge. Makassed became the most prominent Palestinian hospital."

The hospital's foundation story in 1967 resembles popular stories about what happened to the entire country when it came under occupation. It is a story about waking up to the necessity of joining the struggle, an impulsive awakening. It is the year the PLO opted for Fatah's historical insistence on steering clear of Arab nationalism of any stripe and concentrating on the Palestinian project. The decisive victory of the Palestinian over the Arab nationalist program resulted from battle of Karameh of March 1968 in which Israeli forces withdrew after an onslaught onto a Fatah military camp in Jordan, suffering relatively heavy casualties. Yasir Arafat had personally, and against the advice of many of his peers, insisted on standing firm rather than opting for a tactical withdrawal. Thanks to the bravery of his *fedayeen* and to the support received from Jordanian artillery, the line emphasizing the primacy of Palestinian liberation prevailed, and he and his organization, Fatah, gained control over the PLO. For the Palestinians and the Arabs, the battle of Karameh was the beginning of a comeback after the humiliating defeat of the Six-Day War of June 1967.

1967 is usually narrated as the quintessential story of loss followed by an awakening and then by civil disobedience. Makassed's successful sit-in is the non-violent

Karameh. It is part of the history of the everyday practices of sumud. The late Palestinian author Ghassan Kanafani wrote his novel *Returning to Haifa* (1969) about the events and psychological/political effects of 1967. It is about Said S., originally from Haifa, who is a refugee in Ramallah. He lives comfortably in a nice house, forbids his children to become fighters and waits for the day he can return to the house he was expelled from in 1948. In the rush to flee Haifa in 1948, this man and his wife had been unable to take their first child with them. Suddenly, nineteen years later, when Israel occupied the West Bank, Said S. had the opportunity travel to Israel, visit the house and inquire about his first born, Khaled. In the house, he found an Israeli couple living with their twenty year old son, Dov. The couple had found Khaled/Dov and adopted him. Said realized that his son was an Israeli, served in the army and did not want to have anything to do with his Arab or Palestinian identity. On his car drive back to Ramallah, he realizes that he must renounce even blood ties for the sake of the struggle and wishes his other son had joined the struggle. Kanafani's novel is about a middle-aged man's awakening to the need to struggle.[11]

Makassed's foundation story of 1967 is also about an awakening and the impulse to join the struggle against occupation. The doctors and nurses joined the resistance impulsively, by bringing their equipment and sitting in on the hospital grounds. Makassed is here seen as a microcosm of Palestine. The hospital is the land; the doctor is the fighter. He is the leader and spokesperson for this little nation. For him, the story about childbirth in Palestine starts with the history of the medical system and the medical system conveys his worldview. As will be seen later, the midwives and nurses, on the other hand, rarely recount this history without being asked about it specifically. They

[11] For a discussion of Kanafani in the culture of Palestinian resistance see Harlow 1996

usually start by talking about issues of work, labor relations and everyday life.

d. The Midwife: Rebellious intermediary

As I am chatting with the midwives in the nurses' room, a young midwife walks in singing and waving her purse. She takes off her veil, ties her hair up, wipes the sweat off her face and says: "The service taxi took the Tora Bora road but we have our salaries!" Tora Bora designates a mountainous, winding dirt road people take to avoid checkpoints. It is of course a reference to the Tora Bora caves in Afghanistan, where the American army was searching for Bin Laden. Seven Makassed midwives had sent Ruba to the Bank of Palestine in Ramallah to pick up their salaries. "The heat, the sweat and the wait at Qalandia checkpoint on the way to Ramallah! That was something," Ruba said. "And the return was through the stone quarries."

In my interviews with midwives,[12] they wanted to make sure that their working conditions would be part of the story I would write concerning Makassed hospital. The discussion of hospital practices seems to shift from a discussion of histories and practices of sumud to one of sumud and inter-professional struggle. From their perspective, the hospital is far from being the ideal nation and the doctor far from being the competent leader and spokesperson. One midwife told me that if I wanted to learn about childbirth in this hospital, I needed to know how many hours they worked per week, how much money they made and how often they got to see their families. Through telling their own version of the childbirth story, they re-adjusted the version they supposed I had gotten from the doctor a few days earlier.

Samia explained to me: "Makassed is late in paying its employees. It has happened before. But this time we have not been paid for three months. It is the longest

[12] I conducted 23 formal interviews with midwives/dayat/labor unit nurses.

time without pay I can remember. Today, they paid us. We get paid more or less 1000 NIS (about $250) per month. So they should not do this to us. We cannot afford to wait three months for our pay. We have bills to pay and children to raise. This makes it impossible for us to live regular and stable lives.

According to Samia and Ruba, the reason midwives at Makassed have been overworked since the beginning of the Second Intifada is that there has been an increase in the number of births there. Midwives assist all "normal" vaginal births in most hospitals of the occupied territories. Hence, more births in their hospital mean more work for them. "We midwives [at Makassed] usually deliver 200 babies per month. But since the closure we have been delivering 300. Since the tough closure on Ramallah and Bethlehem, it has become easier to come all the way to Jerusalem from neighboring villages than to go to the nearby city."

Samia gave an additional explanation for the rise in births at Makassed: "Palestinians from Jerusalem are now afraid to go to Jewish hospitals. Many people with blue [Jerusalem] IDs[13] used to deliver in Hadassah or other Israeli hospitals. But many women now tell me they don't want to go there. There are rumors that Arabs receive different treatment than Jews." Ruba, the midwife, talked about the same suspicions: "Because of the political situation, [Palestinian] women from Jerusalem are now afraid to go to Israeli hospitals. They say, 'you don't know what they will do to me. Will they take revenge on me or my newborn? We don't know how we'll be treated'." These stories are clearly specific to the residents of Jerusalem where women can choose to go to hospitals

[13] Palestinians from Jerusalem have blue identification cards, like Israelis and Palestinians who live in the 1948 borders of Israel. Palestinians from the Occupied Territories (excluding Jerusalem) hold orange or green IDs. The difference in the color of the Israeli ID cards is in itself a statement about which future nation Jerusalem (and its blue ID holding Palestinians) should belong to.

across the "Green Line," in Israel. In fact, the increase in hospital births during that period in 2002 is specific to the city of Jerusalem. In other West Bank cities, such as Ramallah, hospital staff spoke of a radical decrease in the number of births in their hospital, even of empty labor rooms during the curfews (conversation with midwives at Ramallah and Hebron hospital).

In addition to a larger case load, the labor room is now understaffed. There usually are 16 midwives. Two had recently resigned. "With so few midwives and so many births we can no longer work the way we used to. Now many of the important things of midwifery care, we can not assist with." Sometimes, they don't have time to shower women after delivery or to show them how to breastfeed. They go in rounds from one woman to the next and no longer have time to do more than the basic medical check-up and care.

Their stories about the closure intersect with those of the doctors. However, unlike the doctor, midwives see working conditions as the most important features of their professional existence. Actually to be *doing* the work of birth assistance is part of the identity of the profession of midwifery. They take pride in assisting births and contrast this with the doctor who "walks in the delivery room when the work is all over" (communication with a midwife in another hospital). It is important for them to emphasize that the hospital is not the ideal entity it presents itself to be. All is not organized, rational and smoothly productive. The doctor has here been identified as the privileged member of an elite whose self-ascribed role is based on the labor of others.

Another way midwives point to the difference between their profession and that of doctors is in their closeness to a Palestinian social base. Describing her previous job in

Ramallah, Samia explained how birth mothers demanded the care of midwives rather than doctors. Opening in the mid-1990s, the hospital in question was part of the expanding private sector that emerged amidst the hopes of looming peace and a rising economy. It vaunted its specialized, personalized and luxurious services, targeting mainly wealthy women, who could afford the fees. The novelty of this maternity hospital was that obstetricians assisted normal births instead of midwives.

According to Samia,[14] midwives were dissatisfied with their secondary role in spite of the good salary, as they could not provide midwifery care according to their vision of the profession. She thus decided to leave and go to Makassed. However, this Ramallah hospital was soon thereafter forced to change its policy due to lack of clientele, and permitted midwives to attend normal births upon a woman's request. Her story points to one of the main arguments midwives make to the Ministry of Health: unlike the work of doctors on normal births, their work is grounded in popular demand.

These stories reflect an increasingly visible tension between obstetricians and midwives in Palestine. As is the case in many other parts of the world, the professions of midwifery and obstetrics compete for the control of childbirth. However, in contrast to other countries in the Middle East (Israel, Egypt, Lebanon and Jordan for example), midwives in the West Bank assist almost all 'normal' hospital births.[15] While they do not have their own union (they usually belong to the nurses' union) and are relatively low in the hierarchy of the hospital staff, they exercise a certain power because of the shortage of midwives in Palestine.

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[14] This story was repeated to me by a few midwives including the head midwife at the hospital .
[15] For a comparative description of policies and practices in Egypt, Palestine, Lebanon and Syria see Choices and Challenges in Changing Childbirth Network 2005.

The intifada and closure have damaged the previous medical routine and organization of childbirth. This has opened a space for different groups to try to change and restructure childbirth assistance and health care provision in general. Thus, it is not surprising to hear discussions about the intensified rivalry between midwives and obstetricians. A midwife in a government hospital said that I could witness "the age-old fight between midwives and obstetricians here" as she drew an obstetrician who was walking by into the conversation. "They blame us for everything that goes wrong," she said, "and we tell them: 'you can start talking when you start doing the work.' We do all the births. Even with complicated births, we stay with the woman until she is fully dilated. Then, at the very end, the doctor comes in." The obstetrician retorted that doctors have other responsibilities such as operative deliveries, outpatient and gynecology cases.

In another interview, an obstetrician exclaimed while he was explaining the division of labor there: "midwives are mutinous! It is not like Europe and America.[16] Here, midwives fight to get what they want. But the biggest problem for us is that in the end, we are responsible for everything that goes on in the labor room. If there is a problem or a mistake, the obstetricians are held accountable for it."

The doctor talks of mutiny, of fighting, of responsibility and accountability. While it has been noted by many that the language of medicine and birth is full of metaphors from state and economic terminology, the wording in this simple exchange on the workings of the labor room is very strong and reflects an exacerbation of relations.

e. The phone as a birthing technology

[16] This doctor thought that in European and American hospitals, midwives did the nurses' work and did not have much say in the assistance of childbirth.

In the most technologically advanced Palestinian hospital, Samia is not shy to say that half of her work of birthing assistance is done on the phone. She tells stories that resonate with experiences of health professionals throughout the occupied territories. Samia recalled a woman telephoning from a village under curfew:

"'Hello, I have contractions. I am afraid. I can't go to a hospital. We are under curfew' the woman said. 'How many contractions per minute?' I asked. 'OK, take a shower and an Acamol [Ibuprofen] and try to sleep until morning, maybe you can find a way to come in the morning in daylight. But don't worry. Just don't be afraid. If worst comes to worst I'll guide you and your family through delivery'. In another conversation the birthing woman says: 'I have pain. I feel contractions. I can't wait anymore. The closure...I can't come. Help us!' So I got the birthing woman's mother on the phone and tried to take them through delivery. I explained how to clamp the umbilical cord, to tie a string, to boil a pair of scissors and then cut the cord." The phone birth is unexpected in a hospital in Jerusalem. It became relatively common in areas under prolonged curfew. Samia's account shows the close link between Jerusalem and the West Bank through a phone line and medical assistance. In her story, assisting phone-births challenges the closure,[17] connects her work to the resistance, and connects her and her profession to the people they are so proud of being close to.

These stories illuminate a tension between, on the one hand, the institutional, imposed and to a certain extent lived separation of Jerusalem from the rest of Palestine and on the other hand its unity and oneness with it that is imagined but, like the separation, also lived. The administrative separation of Jerusalem from the West Bank

[17] It is interesting to note that other health professionals argue that these coping mechanisms such as birth assistance by phone serve the closure policies as they make them possible to exist with fewer casualties.

affects one of the centers of their lives, their families. Except for the few midwives who are residents of Jerusalem, they now live in the nurses' quarters. In this way they avoid the difficult roads. But they are unable to live with their families. Midwives go back to their homes about once a month. They get one day off a week. And in order to accumulate a few days' leave, they work for four weeks without a break. They then go back to their hometown for four or five days.

Samia is 33, divorced and has a daughter who lives in her village in the Ramallah district. Samia must stay in the nurses' dorms at Makassed in order to work. At the beginning of the intifada, she traveled to Jerusalem from her village every morning. But that proved impossible to continue. She had night shifts and sometimes two in a row. Then she moved to the nurses' dorms and would go back to see her daughter every two days. But the road was crazy. Then she started going back every week. But even that was impossible during the long invasions of Ramallah. So now she cannot even go back every week. She no longer gets permits to come to Jerusalem. She is in Jerusalem illegally. "Maybe the army thinks that because I am divorced and can't see my daughter very often, I am angry and may do something [violent]!" She feels guilty that she is not able to see and take care of her daughter. Samia calls her as soon as she gets off work, sometimes wanting to quit her job. "But at least we bring money home. You know, I am always laughing. My daughter gives me motivation to stand strong on earth."

In the above discussion I have illustrated the articulation of the nation through the institution and the functioning of a Palestinian hospital, Makassed in Jerusalem. The nation is projected as a territorially unified entity despite all measures taken to remove an essential portion of it, its appointed capital. As it can be seen, this articulation is the first

type of a nation as I described it, the unified, Jacobin, technocratic one as projected by the doctor and contested by the midwife in the name of the people. What the midwives contest is the assertion by the doctor that this particular national paradigm functions smoothly and without major contradictions. These are stories of unpaid/unrespected labor. We are still within the first paradigm of the centralized nation.

II. 2. The Popular Health Movement: A de-centralizing vision

In the following section, I will present oral histories of three out of the four founding members of the Union of Palestinian Medical Relief Committees (UPMRC). I have kept long quotes and oral histories because very few works have been written about the history of this movement. While the three were founding members, they give different perspectives on what happened to the organization. Dr. Mustafa Barghouti got his medical degree in 1978 at the Patrice Lumumba Institute in Moscow, was the director of Medical Relief, remains on the board of the organization. He is now a public figure, politician and elected member of parliament, which is called the Palestinian Legislative Council. He ran for the election as an independent on a platform called *al-Mubadara al-wataniya* (the National Initiative) which I write about in the following chapter. Medical Relief is important to his work and campaigning, since the clinics are one of the links he has to the people who supported him most, people in villages and isolated areas.

Dr. Salwa Najjab is also a founding member of Medical Relief. She, like Barghouti, comes from a village in the Ramallah area. Her late uncle was a Communist Party and village leader. Her husband is still a leader and public figure in the People's Party, successor to the Communist Party. She is the only woman in the team which

founded the organization, and she led the Women's Health Unit in the 1980s. Since the mid-1990s, she has left Medical Relief, unhappy with the administration and decision making processes of the organization. She now has a private clinic in Ramallah, works for an NGO and has been involved in the childbirth networks during the second intifada.

Dr. Omayya Khammash is a founding member who was less involved in party politics than his two colleagues. He gives a different version of the involvement of political parties in their work. He too has left Medical Relief to work in an NGO.

a. Beginnings

The beginnings of the "popular health movement" take place at Makassed hospital. A group of newly trained physicians started volunteering once a week. They would pack their cars with a few medical supplies and drive from Makassed to under-served rural and refugee areas under curfew. Soon the group of physicians built the umbrella organization of the Union of Palestinian Medical Relief Committees. Physicians and other health professionals worked in various hospitals of the occupied territories and volunteered time with Medical Relief.

Dr. Mustafa Barghouti

"Medical Relief was our university," Barghouti said referring to the founding group of physicians. For him professional politicians and educated individuals like him could not fully grasp the deep-seated problems of the society because they lacked contact with the daily lives of its marginalized sectors. Through their work as doctors in underserved areas they started "to listen and understand their society." A movement such as Medical Relief quickly realized that they had a lot to gain by "knowing their society." For Dr. Barghouti, he and his colleagues had an additional unique qualification which

was their knowledge of other societies, giving them a comparative perspective on their own dilemma which placed them in closer touch with the realm of the possible. He called this a process of "cross-fertilization" which, combined with the dynamism of the organization's members, equipped them exceptionally well to deal with medical, psychological, social and ultimately political issues dear to the population.

This particular formula also endowed the team with the kind of flexibility that enabled them to act and react promptly and effectively in the rapidly changing Palestinian context. The foremost example was perhaps that of the mobile clinics which were conceived as an ad-hoc palliative to the centralization of the medical infrastructure permitting outreach to the remotest areas and introducing the very notion of primary health care to the occupied territories. These clinics, after having been elaborated and utilized for a while tended to fade away with the proliferation of fixed centers. The outbreak of the December 1987 intifada created a new situation and the mobile clinics were once again dispatched. During the Oslo period they were again put aside in favor of a decentralized infrastructure of clinics. At the beginning of the 2000 intifada the mobile clinics were deployed and reconceived to cope with the closure. In the process, Dr. Barghouti noted, the very concept of the mobile clinic was transformed from its halting beginnings in 1979 to its chopped up, de-centralized and yet highly professional make-up in the recent period. The basic idea however remains the same: "reaching out to communities by providing health at their doorsteps."

In all of this, the basic concept was that of the Community Based Rehabilitation Program whose models were found in places as distant as Mexico, India, Egypt and Britain. Such a model had been implemented under the auspices of WHO in Africa. But

according to Dr. Barghouti, Medical Relief had taken the model further and optimized it. The idea of the village health worker was likewise developed and rendered efficacious in this context. The organization trained village health workers as part of their women's health unit and sent them out to the field. But what was new here was the maintenance of the organizational tie between the village health workers and Medical Relief, thus eliminating the isolation which had so often plagued village health workers around the world and in earlier experiences in Palestine itself. In this new experience, the village health worker worked in the village health center with the doctor and staff.

Mustafa Barghouti emphasized what he thought were the exceptional qualifications of Palestinian doctors in creating these original types of networks at this particular time. Professionally, they had the necessary skills. Politically, they had acquired a broad socialist vision. Socio-economically, they came from previously deprived rural and refugee classes and were in the process of replacing the existing medical elite composed of urban notables (see Chapter 3). The founding members all noted that practicing medicine in underserved areas put them back in touch with Palestinian society, from which their long years of academic training and social ascension had somewhat alienated them. In addition, when Dr. Barghouti says that they come from rural classes he is speaking of their roots, in opposition to the long established urban elites. He, for example never lived in his village of Deir Ghassaneh (he grew up in neighboring El-Bireh and now lives in Ramallah) but maintained constant family, political and professional ties to his village. It is in this sense that he identifies the group of physicians as having more organic ties to the communities they served.

The decisive point for Dr. Barghouti however is the fact that in his view medical relief was from the start, and never ceased to be, a movement rather than a simple institution. Through thick and thin and even with the arrival of sums offered by funders UPMRC was able to maintain the integrity of its agenda and to dictate rather than simply accepting or refusing the terms of the needed financial assistance which it received.

He also noted the importance of the shift from the slogan "health for all" to "quality health for all" saying that it was the natural consequence of their protracted growth and of their increasing policy oriented strategies. He justified the move towards grand policy as a preemptive means of avoiding the pitfalls so often found in other developing countries, of imposing the acceptance of primary health care but then finding it isolated by the official health infrastructure. "In a way, Medical Relief is more of a social movement than a health organization. There are times when we get overwhelmed with the emergency needs, with lots of activities like during the invasions and so on and when we just do our routine mechanical work. But I think MR has been able to sustain a good combination of emergency and development work and a good ability to jump back to policy issues."

I suggested to Dr. Barghouti that the vision of health they projected was linked to socialist ideals and buttressed by the experiences of the Soviet bloc, but that in this different world without the USSR, it may no longer correspond to realistic expectations within the medical field and the society at large. He vehemently rejected this hypothesis, stating that their vision of social health equality was stronger than ever and that they had simply discarded dogma. For him retrospectively, the Soviet model was incorrect and the disappearance of the USSR by and large a relief, because even though they were not

happy when it happened, they then found themselves entirely freed in their ability to imagine and work towards a better world. In fact, they had always behaved in an independent and original manner and not felt bound by their party and political ties. Since many of the founding members had lived in the Soviet Union, they had always been highly critical of it and thus remarkably free of dogmatic thinking. This is something he felt was lacking among other groups and notably the Palestinian People's Party (formerly the Communist Party) which never discarded its political procedures and ties and thus ended up following Fatah and joining the Palestinian Authority. Medical Relief had avoided this trap and maintained its critical stance, always promoting the social agenda of the poor, the marginalized and the forgotten elements of society.

Barghouti insisted that even though many of its original members were in the party, the UPMRC itself had always maintained its independence unlike so many other factionally based health organizations which had for this reason and unsurprisingly all disappeared. The continued existence and development of UPMRC was proof of its political independence.

Dr. Salwa Najjab

Dr. Najjab is the only woman among the four founding members. She is from a village neighboring Ramallah and is the niece of a now deceased leader of the Communist Party, Suleiman Najjab. She talked about the philosophical and experiential influence which the popular health movement had on her current work in Ramallah. She had started in the movement by offering a few hours a week of voluntary work in mobile clinics, treating patients for free. She and a group of physicians would drive around in their cars to villages with equipment and medication donated by local pharmacies and

companies. Later, villagers offered them a room in the village to set up a permanent clinic. And the physicians would rotate, offering one day a week of voluntary service. Very soon, more and more young doctors joined their group.

When Dr. Najjab graduated from medical school in 1978, like any other doctor in Palestine she thought that the best thing for her would be to work and train in a hospital. It is through her work at Makassed that she started noticing that people came to get cured and then left and then would come back soon suffering from exactly the same problem. One case she remembers very well. It was a 23 year old woman. She came to her with a heart problem. When she gave birth, Dr. Najjab barely saved her life and she warned her that she should use contraception because all her births would be very dangerous. She lived close to Jerusalem where Dr. Najjab practiced but she would not come back to her because she was under pressure from her community to keep giving birth. She came back to her, pregnant, in her ninth month. Her heart was very weak. She died giving birth. She was an orphan herself. Her daughter survived the birth. Dr. Najjab and the other medical personnel called her Ratiba like her mother. Ratiba still comes to see her. She is about 20 now.

That case she will remember all her life. It was a turning point in her personal itinerary. She started thinking that if she was not close to her patients, it would be very difficult to help them. That was at about the same time an unclear idea was flourishing in the minds of young doctors (most working at Makassed hospital). The idea was that they had to go to the people, to try to get close to them, and not the other way around.

The first group event she remembers was in the late 1970s when Daheishe refugee camp, near Bethlehem, was under a prolonged curfew. She and a group of young doctors

from Makassed took food and medication that a pharmacy had donated and they smuggled themselves and their bags into the camp. They went from house to house through backdoors and alleyways seeing patients and visiting with their families. Then, after the curfew was lifted, people in the camp started asking for house visits. The same scenario took place in a village near Bethlehem and then in places farther away, in Jalazoun refugee camp near Ramallah for example.

It became clearer and clearer to them that the health infrastructure was lacking a preventive system. The Israeli public health system in the occupied territories had a very weak vision of prevention and the few Palestinian hospitals focused on curative care.

It is at that time that many of these doctors who worked at Makassed and others formed the Union of Palestinian Medical Relief Committees (UPMRC). Their initial idea and what they are still known for is the mobile clinic. The doctors would take their cars and go to the Jordan valley, to the village of Deir Ghassaneh, to Bethlehem. Everyone would go together.

But in the early to mid-1980s, party politics started playing itself out in the movement. Each political party wanted to create its "Medical Relief." Many UPMRC members, as Dr. Najjab explained, while not affiliated with the Communist Party, were close to it.

By the mid-1980s, UPMRC started opening clinics in villages (after the villagers asked for them) and developed the concept of "permanent care" in addition to having mobile clinics. "In 1985, we started thinking about women's health. We started having clinics specifically for the prevention of cancer and promotion of women's health." The first village where they opened this kind of clinic was Deir Ghassaneh. "In 1987, we

started our training for 'village health workers' and women doctors who had recently graduated. We did not have a clear idea of the training but we wanted it to be centered on women's health. Many of the ideas came from the women who had enrolled in the program. Then they started reading and hearing about experiences with this kind of training elsewhere."

She, like many other doctors, did not know what life was like in the villages. She is originally from a village and has kept ties there but her work with UPMRC exposed her to daily village life, to poorer villages and to poorer classes within villages. She learned a lot from the women in self-training. And then, when she would go to the clinics in the villages, she would look for what the young women had talked about. They had told her that the physical illnesses of women often had a basis in psychological health, things they could not talk about to their doctor because he or she would not understand or because customs say that the good woman is the woman who is silent and does not speak of pain. With experience, Dr. Najjab and her colleagues at the women's health clinics started getting more and more women who just wanted to talk. It is at this point that they decided that what women needed were not birthing clinics but regular contact, consciousness raising and psychological care. That is what they tried to train the village health workers and female doctors in. She trained about 10 doctors. What they now called the women's health program grew and was very successful. They had about 23 clinics and saw thousands of patients. She thinks it was the most successful program at Medical Relief. They did prenatal care and contraception counseling, topics that many organizations in Palestine had been reluctant to approach. Actually, many organizations such as Planned

Parenthood started applying their model. And there was an increasing understanding and thinking about the concept of women's health.

Along with the program of training village health workers, the program had grown so much and had become so important in Medical Relief that it was something all the founding members wanted to be a part of. "But at the same time, there was resistance to our understanding of women's health from the central machinery of Medical Relief, a machinery that in the end is quite sexist (masculinist, *dhoukouri*). For example, we wanted to start a campaign in our clinics to promote communication skills and sensitivity in the way the doctor speaks and listens to the patients. We wanted our doctors to be giving special care to the communities and be sensitive to rural and women's needs. The doctors were not interested. The administration was not interested. We had a problem in decision making at Medical Relief. Only one body could take decisions and that was the secretariat. Actually, only one man could take a decision and that is Mustafa Barghouti [the director at the time]. That is where in-fighting began. We wanted to de-centralize the health infrastructure but we had a centralized structure!"

"Actually," she continued, "during the founding years, there was much more team work. There was space for people and there was space for decisions. Everything was clear. We were still working on a small scale. We could take decisions as a group. We would meet and take decisions together sometimes fighting and then voting but still, we took decisions together. When the organization grew and started getting funding, things changed. Actually the funders bear a great responsibility in our group becoming autocratic. They want the responsibility for using the funds to be in the hands of one man and that gave the authority to only one man and he started taking decisions on his own.

He started to decide to what projects the funding would go. He was the one who knew about the funding. It became a very centralized organization. We had become this big organization, with big clinics and lots of employees and any micro-decision had to be taken by one person. In the 1990s, it started to develop into a power struggle among the founders. By the mid to late 90s many of us left. I felt like I was being pushed out. I was part of the steering committee which could take no decisions. We felt like we had become service providers and no longer had that impetus to change things in our country. We had moved from working as volunteers with communities to working far away from communities. I remember villagers complaining that we had come to their, village built a clinic with their help and now were not willing to listen to their demands! When I would bring it up at headquarters, I felt there was resistance. I felt they wanted me out. So I left in 1996. It was very difficult for me to take the decision to resign, because this was a project that I had helped in starting. I told them that I was like the woman that has a divorce and laws make her leave her children. I'm leaving my children with you and leaving. After me, a number of doctors who founded Medical Relief left. I did not leave because I was interested in working in the private sector. I had been working as a physician for 14 years and I never thought of opening a private clinic. But I wanted an alternative. I wanted a source of income and satisfying work. I opened a clinic not alone but with a group and we decided to focus on providing quality holistic family care. I think we are doing something new here."

Dr. Omayya Khammash

"In the beginning there was the national question. We felt we were young. We had just come back and wanted to do something for our country." Thus started Dr.

Khammash's interview. Even though they were strongly influenced by their experiences in the Soviet Union, they did not have a political agenda; rather they "wanted to help people," that is to say, their motivations were social. The Soviet experience had shown to them that health was a right and that people should be encouraged to exercise agency in the pursuit of this right. In Palestine, that right came with a heavy price tag, "and then came the occupation." Israel gathered the personnel, the organization and the practices of health into its hands and therefore for these young medical militants the struggle for the right to health was a direct challenge to the occupation. The remarkable fact about the adventure of activism in healthcare is that they succeeded in this challenge notably through the activities of UPMRC (as opposed to the political, military and economic sector). Israel, he pointed out maintained a system which lacked any services in rural areas. By 1994, right before the handover, the Israeli medical services had gone so far in their silent emulation UPMRC that they had established clinics throughout the occupied territories.

What their group brought to Palestine was primary health care not in the restrictive sense of the Israeli model based essentially on immunization programs. "We wanted health and social justice. We wanted total primary health care."

In explaining the mobile health clinics and their development, Dr. Khammash placed the women's movement at the forefront, explaining that it had opened avenues of contact to the most marginalized regions in particular in the Jordan valley and that services to women and to farmers as well as medical services all evolved in tandem. The women's committees were well established with their members and contacts and detailed

knowledge of villages and camps. "They did all the relationship building for us, all the coordination until Medical Relief constructed its own organizational body."

At this time in the early eighties entire infrastructures were thus built (schools, clinics, agricultural cooperatives). During the entire formative period which lasted over a decade UPMRC had no donors, they volunteered and used their own funds to collect the material they required. They also had fundraising parties in which they collected sums which at the time they considered considerable, at one party as much as $15 000. "Today, nothing works except with a donor. Even for a newspaper advertisement, you need a donor." And for Dr. Khammash the massive arrival of external funding led ineluctably to the development of an organizational bureaucracy. For him therefore, the movement thus became an organization: "it brought with it infighting between people in the administration and people who were working in the field." The other element in the development of the bureaucratic syndrome was the interference of political parties, in particular the Communist Party. As the membership increasingly tilted towards Communists, others and notably PFLP and Fatah left Medical Relief and created their own imitative and unsuccessful versions (the PFLP created the *lijan al-'amal al-sahhi* "Health Work Committees" and Fatah the *lijan al-khadamat al-sahhiyya* or "Health Services Committees").

Fatah in particular was anxious, through the Health Services Committees, to assert its political hegemony at the grass-roots level and it invested considerable money to that end. In other words, the political parties had understood the intimate relationship between health and power. In the short run, Fatah created over 120 clinics but given lack

of resources these were soon reduced to 20 and finally they were all closed down as Fatah placed its resources in other areas, such as unions and youth groups.

There was a new political surge in the health field coinciding with the 1987 intifada when the governmental infrastructure broke down, each party individually and all of them together stepping in to fill the breech. The UPMRC was in every respect the model and source of what then became a generalized interest in public health.

The three co-founders of the UPMRC, although differing on details and conclusions, together define the contours of the second image of the nation introduced in this chapter, where it cannot be divorced from the society as whole. In this image the interests of the marginalized must be included in a totalizing national vision. However, in ways resembling the fate of the Soviet Union itself, this image is found lacking when one looks closely at the critique of Dr. Najjab and Dr. Khammash: the nation as social formation is found to have developed its own bureaucratic and pyramidal structure characterized by the notorious system of "democratic centralism." Dr. Najjab's critique is gender-based. Dr. Khammash's is oriented towards the party political penetration of the organization. Even though the critique comes from members of the leading group within this national microcosm (former members of the "secretariat" of Medical Relief) the reading of their oral histories reveals the weakness and the inherent contradictions of this vision as well.

Conclusion:

As the stories surrounding Makassed hospital and the Union of Palestinian Medical Relief Committees shows, both the sumud-based, unitary vision and the one

grounded in a social project engendered dissident voices from within. In both cases the critique comes from disaffected former leaders, and even more, from the marginalized, the subaltern elements within each ideational system: midwives, birth mothers, alienated doctors, nurses. Both systems, despite their differences, have commonalities. They became elitist, bureaucratic, top-down, center-periphery in their operation. And implicitly the stories call for continuous thinking on and considerable restructuring of the two visions before they can be taken as viable alternatives or microcosmic medical models of the nation. As always and everywhere, the national project is constantly being reconfigured, re-projected and perhaps re-invented as a function of the rise and fall of paradigms and the ultimate test of reality.

What I also show in the Palestinian case is the inexorable rise of the medical profession to decisive political prominence during the period of occupation and resistance to it. Within these medical/national projects, the doctor acquires political stature, power and sovereign authority.

Chapter 2

Birthing Clinics at the Intersection of Economies of Solidarity and Conflict

This chapter lays out the topography of birthing clinics. It examines the rationale and processes behind the construction of a variety of small birthing clinics in the West Bank. These are linked to an overarching development in the ideology, movement and structures of international and local non-governmental organizations more generally. This chapter explores practices and challenges that emerge at the intersection of economies of solidarity and conflict during the second intifada (started in 2000): local forms of humanitarian assistance, international funding, new business ventures and quests for justice.

In Palestine, there are three generations of Non Governmental Organizations. The oldest are charitable institutions, mainly affiliated with religious and/or nationalist organizations. Makassed hospital for example is such an institution. In the late 1970s emerged the generation of grass-roots organizations such as the Union of Palestinian Medical Relief Committees. In the '70s and '80s these were mainly secular movements, recently there are also Islamist grass-roots organizations. The most recent generation of NGOs emerged after the Oslo Accords with the arrival of the Authority and larger amounts of foreign funding for the development of "civil society," seen by the donor community as a vital component of processes of "good governance."

This chapter will explore the everyday practices of the newest kind of NGOs that were constructed to assist births during the closure. It will show how the emergence and work of such organizations are not simply donor-driven enterprises. The birthing clinics in this chapter emerge to fill gaps in the infrastructure during the period of the closure and thereafter try to keep afloat financially, either with birth assistance fees, with international funding or with private bank loans—all part of the economic landscape of the intifada. While there are important ideological and structural differences between newer NGOs and the NGOs that emerged in the 1970s, the rupture is not as all-encompassing as political analyses present them (Barghouti 2005; Craissati 2005). All the NGOs hinge on the contemporary reconfigurations of the politics, economies and ethics of solidarity and humanitarian aid.

The "fall of the Berlin wall" has come to symbolize a world-historical turning-point. In fact, this purely geopolitical reference does not do justice to the magnitude of the transformation of the international ideological and political landscape, which resulted from the collapse of the Soviet system. The NGO landscape was likewise transformed at this precise time.

One of the changes at the non-governmental level is ideological. The implosion of the Soviet Union was not just a political event which helped to redraw the map of Europe and Asia. More than that, for large portions of the Third World and broad sectors of progressive opinion in the West, it meant the sudden death of a model: socialism. True, Soviet-style 'socialism' had already undergone a steady process of deligitimization and had proven its failures, but this was especially true where its own subjects and many people in the West were concerned. In other parts of the world, the picture was quite

different, and Soviet support for liberation struggles continued to legitimize the social experiment for which it claimed to stand.

After the fall of the Berlin Wall and the World Bank's report on poverty in 1990 governments identified a cluster of policies which are now held as a model for good economic and political management. The "Washington Consensus" also referred to as "good governance" is based on three elements: a competitive market economy, a well-managed state, and a democratic civil society. It is a version of the neo-liberal economy which recognizes the importance of the state and attempts at promoting human rights and democracy.

Virtually nobody foresaw the end of the Soviet Union and the socialist model. The first reaction in Palestine was bitter despair, because it had for decades been considered a supporter of the Palestinian cause. It had constant relations with PLO factions including Fatah and all those of the left (PFLP, Communist Party, DFLP) although few relations with grassroots movements inside the occupied territories.

Whereas the NGO's worldview and motivation had until 1991 been tinged with the dream of socialism, in one form or another, that is to say, of equality as the goal of popular action, the shock of the demise of the USSR caused this dream to collapse as well. Whether church- or party based, Western solidarity had sought to strengthen those segments of Palestinian society, and those Palestinian organizations, which advocated a social agenda alongside the national one, and refused to postpone equality until after the achievement of national liberation. Fatah, while not ignored by international NGOs (it was always recognized as the motor of the national liberation struggle) was at a disadvantage as compared with left groups. In addition, in the occupied territories, Fatah

activists tended to be less internationalist than certain other groups (particularly the DFLP and PCP – the PFLP also tended towards secretiveness and a certain degree of national exclusivism).

Since 1994, the U.S. has been the largest donor country to Palestinian NGOs with $44 million disbursed between 1995-98 (Hanafi 2005) Germany has been the second largest donor with $32 million dollars disbursed during the same time period. Norway, Switzerland and the Netherlands come next (Norway has been the most generous relative to the size of its economy probably initiated by their involvement in the Oslo Accords). Most donor contributions have gone into health and education (Hanafi 2005), leaving agricultural, economic, and cultural projects lagging behind.

NGOs funded by international aid only represent 20% of all the NGOs. These NGOs tend to have leftist leaning roots. Islamic NGOs tend to use local and diaspora charity networks to collect funds. Pro-Fatah organizations often have PNA support in addition to small amounts of international funding. However, the NGOs that do receive international funding are clearly the largest and richest.

Along with the Gulf War, the death of the USSR meant the end of a long era of NGO work based on the goals of equality and social justice. The international NGOs (now linked ever more closely to governments and to the World Bank, and together making up the donor community) discarded the goal of ideologically-driven social equity for that of market-driven social peace. New local NGOs also turned away from ideological and partisan mobilization to humanitarian and market oriented goals.

The end of the Gulf war with the expulsion of Iraqi troops from Kuwait was followed politically by the Madrid peace conference, and negotiations, first in

Washington, and then in Oslo, culminating in the Oslo accords of 1993 and the return of Arafat and the PLO in 1994. From a self-managed, internationally supported society owing largely theoretical allegiance to the Tunis-based PLO, Palestine became a new kind of heavily dependent proto-state just as socialist ideals had given way to market liberalism. Arm in arm, the Palestinian Authority and economic privatization marched forward. Many NGOs, both Palestinian and international, followed suit. Those sectors standing furthest from the center of power were least affected, including the Islamists (notably Hamas), but also a handful of individual organizations and social groups. Some of the birthing clinics I describe for example are too marginal to have the ambitions to look for foreign funding but they are part of the ideological and economic landscape of the post—Cold War era. It is in the light of this transformation of the NGO landscape in Palestine coinciding with the Oslo period, and outlasting it, that the following ethnographic examples can best be understood, marked as it is by the abandonment of the socialist model as well as the closely related phenomena of globalization, privatization, and the changing agendas of donors and recipients.

Maternity clinics have emerged as important service providers since the beginning of the tight closure in 2000, when access to the large urban hospitals became difficult. In the following chapter, I want to take a closer look at a variety of ethnographic examples of clinics that have developed independently of the main parts of the infrastructure. Discourses of birth during the closure are explicitly bio-political. They encode within them conceptions of populations and citizenship and imply practices of governmentality—rationalities of governance in both the governmental and non-governmental domains. Given the new ideological boundaries following the Soviet

Collapse, the discourse has shifted from a socialist one to one centered on the humanitarian paradigm. The birthing clinics have adopted some of the language and programs of the recent humanitarian-military interventions conducted by transnational formations such as the United Nations and state sponsored aid agencies (USAID, for example), which Mariella Pandolfi has described as "migrant sovereignties" (Pandolfi 2002). The health workers in the makeshift clinics make use of a series of categories that are applied to territories and human beings of "failed states" such as victim, refugee, trauma case, emergency clinic. These labels are the means by which sometimes it is possible to fund raise and tap into the business of humanitarianism. Erica James (2004) has analyzed how the humanitarian apparatus has routinized responses to the suffering of victims in Haiti. The consequence of this bureaucratized care mechanisms has been the development of what she calls "occult economies of trauma" for which victims prepare "trauma portfolios" thus changing experiences of victimization and reproducing social and political inequalities. In the makeshift clinics to assist births during the closure in Palestine, I see the use of the terminology of emergency, intervention and reproductive rights as attempts to access the occult economies of trauma. In addition, the makeshift clinics as responses to the closure are also part of a rooted history of local forms of solidarity which have adopted some form of the "spirit of development" (Pinto 2004) in their everyday encounters even though they are outside the range of formal structures.

Networks

On the 29th of March, 2002, the Israeli military imposed a prolonged curfew in Ramallah. For the first few months (April until mid-July), the curfew was extremely

strict. It was rare for an ambulance to get permission to drive through the city. For somebody to think of breaking it, there had to be an urgent reason. Every few days, the army lifted the curfew for a few hours for people to stock up on food.

On July 3rd, 2002, it was just another day of curfew. The streets were empty. The stores were closed. The people were indoors. The only sound of the city was the roar of patrolling tanks. From inside our home, I had decided to start doing work on childbirth during the closure. I was waiting for the curfew to be lifted to do my first interview.

On the morning of the 4th of July, I was awakened up by the sound of a car driving around; a few minutes later I heard honking; then I heard people talking; I heard more cars; now I could hear lots of people in the streets. I jumped into my clothes and flew out the door. The curfew had been lifted. Ramallah was bustling. The whole city was in the streets. Vegetable sellers, sandal and shoe sellers, shoppers and strollers mingled in the center of town. Cell phones were ringing everywhere. Cars were beeping. Radios were blasting. People were buying, selling, walking and just standing on the sidewalk to watch the passersby.

I walked straight to the office of Dr. Siham. She works with four other health professionals in a family health center. The office building is one of the multi-storey buildings in the center of town. The first two floors are stores and businesses; the third and fourth are doctors clinics. When I got there, the building was empty. The door was barely open. Dr. Siham was the only person in the clinic. She was on the phone: "you'll be fine. The curfew is lifted until 2 p.m. You can stop by the clinic, if you want before then. But I don't think it necessary. Call me at home if you feel pain." Dr. Siham turns to me and says: "We are facing a new challenge. The big problem is access to the patient. I

would never have imagined that I would practice medicine by phone...The thing is women will keep on getting pregnant. The army can impose a curfew or restrict mobility but they can not stop labor from starting. The situation has been very dangerous. Ambulances were not permitted to move. So I assisted births by phone. I never thought I would wake up at 2 a.m. to phone calls from women in labor and instruct the husband how to assist his wife in childbirth. This is frightening and creates unlivable psychological pressure." The phone rings again. It is another patient.

In between giving medical advice by phone to her patients, Dr. Siham explained that the phone had become a crucial medium of medical assistance. Since March 29th, 2002, when the Israeli Army re-entered the city and imposed prolonged curfews, the obstetricians and midwives she knew had done much of their assistance by phone. Because many women thought it better to give birth at home than to brave the curfew, they would telephone health professionals to get counseling during childbirth.

In response, she and other health professionals created "the emergency team." Doctors and community health workers would refer cases to her, for example, and she would give them specialized advice. In the villages, health workers did not have the appropriate equipment to assist births. The cities on the other hand were under total curfews during this period and could simply not leave their homes. For example, there is this generalist in Ramallah who had not done obstetric work for ten years. She called Dr. Siham every day for the first week of the closure with a woman in labor in her neighborhood. This network of health professionals was a very productive group. They gave medical advice to each other and to women. They also did some of the coordination

with hospitals. They supported each other and women in these times of psychological pressure.

They have not lost any mothers. But they have lost newborns. In the case of a woman from Atara, they were on the phone with her but no one could reach her. She needed a hospital as she had complications. But she could not get past the checkpoint. They lost the newborn. There was the very frightening case of a woman who had internal bleeding. She took so long to get to the hospital that when she arrived, she collapsed, unconscious. But she survived. Another frightening case was that of a blind woman who had had two Caesarians. She was afraid because the ambulance was not arriving to pick her up. By the time it did arrive, she had given birth in her house. In some cases it takes a lot of discussion on the phone to convince women that it is easier to give birth in their home than to risk the curfew. Dr. Siham would spend an hour on the phone with a woman in labor explaining to her that she will be fine. Finally, they agree it would be good if the nurse who lives nearby could come to the apartment. The nurse comes. But then Dr. Siham has to spend another hour convincing the nurse to assist them because she had never worked in a labor unit.

These experiences have shown her that the network needs to operate at three levels. First of all, there is the level of the society. Some births take place without skilled attendance. Therefore, they want to train "helpers" such as community health workers, nurses and other health professionals. They will train them to assist normal births and to encourage women to give birth naturally. Second, they need to distribute equipment and involve more and more people in the network. Their third plan is to develop maternity homes. They will need to raise awareness about them, train personnel,

get the hospitals to be the emergency and support line for back-up in case of complications. Doctors would be the key providers in the maternity homes, following the women in labor step-by-step. Medical decisions would be made by a team and not fall on only one health professional.

Dr. Siham has taken some of the ideas and strategies of the popular health movement which she helped to elaborate in the late 1970s, and has reworked them to fit the contemporary context of childbirth assistance. "With this hotline and network," she explains, "we are also trying to convince women to have a natural childbirth at home or close to the woman's home. That way, we can avoid the fear, humiliation and danger of the road...So I try to convince women to forget about the hospital. That it is safer for them to give birth close to where they live." And in a moment particularly reminiscent of the goals of the popular health movement she says: "If we create a system where women can give birth close to their homes, that is what I mean by natural childbirth, then we will have succeeded in something extraordinary for our political aspirations."

The meaning that she attributes to 'natural childbirth' is different from the connotations of this term in the US or Europe. 'Natural childbirth' in her context is more about locating the birth in women's neighborhoods rather than meaning a model of childbirth care alternative to the biomedical technological model (Henley-Einion 2003). The latter's natural, holistic, woman-centered model of childbirth has grown out of and in opposition to the medicalization of childbirth. It has developed along with the feminist movement, and has taken on different focuses according to the diversity within the movement. Some proponents emphasize the dehumanization of medicalizing the physiological life processes; some oppose the male obstetric pathological and ever-

expanding technological approach to pregnancy and birth, to the female midwifery physiological and relational approach (Walsh 2004). Some stress the issue of women's choice, control of her body and participation in decision-making. And others highlight the issue of equity and women's right to quality childbirth care. Whatever the emphasis, this debate has extended beyond the feminist movement and has entered the mainstream health care policy forum in many countries.

However, the use of 'natural childbirth' for Dr. Siham, and for the Middle East region in general, does not carry the same history of a feminist movement attached to the term as in other countries. The idea of the maternity homes for these health organizers was born out of the lack of access to the urban hospitals, which had been promoted by the Ministry of Health and had become the standard place for giving birth. As alternative locations for birth, the maternity homes were not born out of an anti-medicalization perspective or a grass-roots consumer advocacy group for better quality maternity care. The turf battle between the different professions of birth attendants (obstetricians, physicians, midwives and dayat) was also not a major force in this context, as the allied female health professionals (all caregivers other than physicians) are not organized and have low status and little power. Birth attendance is not a lucrative business although in the context of economic crisis, it is at least a source of income. Currently, most women cannot pay much for birth assistance.

Dr. Siham continued her reflections on the network and finding funds for their projects. It has been hard for her and the other members of the network, she explains, because they can not plan anything and execute it. Basic needs takes time. The people who have the time to plan are sitting comfortably in their homes. These are the same

people who get the funding. Even those living in Jerusalem don't know what it is like to live these conditions. While it was not clear who she was referring to, either the foreign donors or more established Palestinian health NGOs with a base in Jerusalem, the sentiment of injustice was clear, with some working in the field under difficult conditions with few resources, and others preparing funding proposals with relative tranquility at their desks and making successful contact with 'the donors', many of whom don't venture from Jerusalem into the confines of the West Bank.

During our conversation, the phone rang every few minutes. Two patients wandered into her clinic for a visit. All of us felt that the time was almost up. At this point, we heard the army's bullhorns calling out: "curfew, curfew. Go home."

One of the people with whom Dr. Siham was often in touch through the network was an obstetrician who worked in a neighboring village, Dr. T. She had turned an immunization clinic founded in 1970 by a women's charitable organization into a birthing clinic. She had delivered many babies during the closure. I went to the village that summer and interviewed women who had given birth in her clinic. Dr. T. was not there. The villagers told me she had left the village after a baby she delivered had died at birth. The event was the talk of the town and the rumors had chased her away.

The current director of the clinic was kind enough to talk to me over the phone and told me that the birthing clinic had closed down. It was out of the question for the clinic to continue assisting births because of the infant's death. The whole village was talking about it and it would be impossible to get around that problem.

Midwives and home-births

Dunia was a midwife who worked in one of the hospitals I spent time in. Every evening, when I walked into the labor room and she was not with a patient, Dunia was on the phone with her relatives in Kentucky. She talked to all the members of her family one after the other. Her sister-in-law (her brother's wife) worked as a nurse midwife in the U.S. In about four months she was going to travel to the U.S. to give birth with her sister-in-law and get a U.S. passport for her son.

Dunia is from a village near Ramallah. She studied nursing at the In'ash al-Usra ('Family Rehabilitation') society in Ramallah. In'ash al-Usra is a charitable society that was founded in 1965 by a dynamic Palestinian woman named Samiha Khalil ('Um Khalil'), who was also a member of the Palestinian National Council, the president of the General Union of Palestinian Women and ran against Yassir Arafat in the presidential elections of 1996. In'ash al-Usra was established to support the victims of war and occupation and the families of political prisoners. It also aimed to empower poor Palestinian women through vocational training, by teaching them skills and enabling them to make a living and to be active participants and decision-makers in their communities. 'Um Khalil', the backbone of the organization and an outspoken woman, tried to minimize the dependency of Palestinians on donor aid with political strings attached and to combat the "refugee mentality" of victimization, inculcated over the years by the hand-outs and free services of UNRWA for the refugees. In the mid-seventies, the organization had a pronatalist ideology and offered social benefits to Palestinian families with more than ten children.

'Um Khalil' died in 1999, but she left her mark on the organization and country. In'ash al-Usra continues to function and to carry out services which normally the government should be providing.

Training Dunia as a nurse and later a midwife gave her the possibility to make a living and support her extended peasant family and to serve her rural community which was near the Green Line, far from other villages and cut off by checkpoints from work and access to services in Ramallah. Men from her village were mainly unemployed, as they didn't have access to cities where jobs were available. As a woman and nurse, she could more easily find employment and get around the checkpoints on her days off to come and see her family, and to carry out home births in her community when she was present.

She began to work right after graduation in 1995 at the hospital in Ramallah. She worked in the labor room as a nurse for a few months, and was trained by the doctors in birth attendance. When her training was done, she received a scholarship from Al-Quds University (in East Jerusalem) to get a B.S. in midwifery. She graduated from that program in 2001.

Her village was under siege for two weeks. Not only could villagers not reach Ramallah but they were unable to leave their village. The village is surrounded by Israeli settlements and settler roads. The army needs only to close off two streets at two entry points into the village and it becomes impossible for the villagers to leave. During the two week siege, she assisted 10 births in her village. One of the births was a breech. There was another person assisting births in her village, a cardiologist. She did not want to work with him. "He makes women come to his home" she said, "I go to women's

homes. The women appreciated my work because I am a woman and because I went wherever they wanted me to go."

After the siege ended, she continued to assist births in her village. She said she was under a lot of pressure from her neighbors to assist their births. They did not want to take the tedious road to the hospital in Ramallah and they liked having their friend and neighbor assist them. She thought that because they were still very much attached to their village life, the women liked the model of the daya, all the more so because there were none left in the village.

Her village was different from those very close to Ramallah. It seemed very rural. Everyone worked the land and during this period of economic hardship also lived in part off of the land. The land was rich and red, planted with olive trees and apricot orchards. But the village was poor. Only the major streets were paved. The houses were one-storey structures, sometimes made out of stone, sometimes cement. Her parents wore the traditional village dress and spoke with their particular village dialect. We ate lunch on a straw carpet on the floor.

A few days after the siege had ended, someone filed a complaint to the MOH accusing her of assisting births in her home. She thinks the cardiologist filed the complaint. It is legal for him to assist births whenever and wherever he wants but not for her. She thinks he was upset because most women wanted her. The letter she received from the Ministry read: "You are not permitted to assist births in homes except in times of emergencies. You are not a daya."

This reprimand shows the irony of the MOH's regulation of who assists home births. Dunia had a university degree in midwifery, and yet she was licensed to assist

births only in the hospital and not in homes. Dayat, on the other hand, without any schooling were licensed for home birth attendance. This contradictory regulation of the MOH showed that political pressures and bureaucratic inflexibility had taken precedence over problem-solving to ensure access of birthing women to skilled attendance in a prolonged situation of instability. One might wonder what the MOH considered 'a state of emergency' in their warning letter, when Dunia's village had been cut off for over two weeks from any outside contact, and women had no choice but to give birth at home. Dunia contacted the head of the midwifery school at Al-Quds University where she had gotten her degree to see if they could intervene and talk to someone at the MOH to exempt her from this regulation, as her village, like many others, was very isolated even in times of normal closures. But it appeared that no one followed through on her request.

The problem is that women want her to assist births. "They beg me to assist them." She gave them due attention (*haqhum*, literally "their rights") much more than in the hospital. In the hospital, she is busy with many things. At these home births, she is only concerned with the birth. She and the birthing woman's mother massage and bathe the woman in labor. But "what can I do? I have no choice but to send them to the hospital unless there is a serious emergency."

Dunia contrasted the continual care that she can give the mother at a home birth to the busy routine of a crowded government hospital birth. Midwives in these hospitals frequently express their frustration at only being able "to catch the babies" and not having the chance to practice their vocation as they had learned it. These maternity wards are critically understaffed with midwives, who rarely have time to give any bedside care, sufficient monitoring or emotional support. In addition, family members (husband or

female relatives) are not allowed to stay with the birthing woman. The midwives at Dunia's hospital, after complaining to the nursing director for months on end that it was unsafe for them to continue working with so few midwives, finally closed down the labor room and went to the hospital director. He claimed that he knew nothing about the problem and promised them an additional staff member. A new midwife came to work there, but after six months of assistance still hadn't received a salary (communication with Sahar Hasan).

Dunia also expressed the tension between her and the cardiologist in the village, who she suspected of having denounced her to the MOH of attending home births without a license. These rural women preferred her assistance at birth to that of the specialist. She is a woman, she is closer to the village women's lifestyle, she goes to their home and she has experience in assisting home births along with the support of the female relatives. The physician makes the woman in labor come to his clinic. Most probably he 'manages' the birth as if he were in a hospital, does not use non-pharmacological methods of pain relief such as massage and taking a bath. Women preferred giving birth with Dunia.

The emergency situation and isolation accentuated the competition rather than the cooperation between the two health professionals of the village. The cardiologist was undoubtedly frustrated at not being able to reach his hospital practice in the city and being cut off from his source of income and therefore wanted the village women to give birth in his clinic. Dunia had no other recourse than to heed the warning and send the women to the hospital, with the possible risks that this entailed. She tried using the only connection that she could think of, her former university teacher, but apparently to no

avail. The professional relations of the physicians constitute a strong and influential network well connected to the decision-makers in the MOH. The midwives do not have the same kinds of representation and recourse.

Salma, the "legal midwife"

Salma comes from a Christian village in the Jenin district, the only one in the north of the West Bank. This village traditionally has a close link with other parts of the West Bank, as many members of this small village sought husbands or wives from the Christian communities of the central or southern regions. It is also an area where since the beginning of the Intifada, villagers are frequently cut off from access to health care in the city. The closure has been more severe in this region. Salma runs a birthing clinic from her home in the village, and two days a week she makes the journey to Bethlehem to work in a small clinic operated by a charitable society affiliated with a church. The clinic was founded as a charity to assist the births of the poor women in the Bethlehem region.

Deema Arafah, a student doing research about the history of the institution of mobile clinics in Palestine and I visited her in Bethlehem. We were in the neighborhood but no one knew where the clinic was located. We finally saw a sign in graffiti on the walls pointing us to her clinic.

The place looks empty. We ring the doorbell. No answer. We ring again. "What are you doing?" a woman's voice rudely responds. I say we were there to speak to her about her midwifery work and reminded her of our conversation on the phone. She changes her tone and opens the door.

The clinic was located in an old Arab house. There were two rooms with hospital beds, a kitchen and a bathroom. Everything was clean, well lit with a few plants placed at the windows. It felt empty, almost deserted. Salma was sitting on an old hospital bed playing solitaire. A woman with a little girl were sitting on a chair beside her and watching her. I wondered when someone had last given birth there.

Salma introduced us to Imm Hani, the cleaning woman who was sitting on the chair with her daughter. Neither Deema nor I were comfortable in that place and with the midwife. It seemed like life had been sucked out of it.

I asked Salma if there had been any births there recently. Since the intifada very few women came to give birth with her because the MOH had instituted the "Intifada Insurance," which guaranteed free birth assistance in government hospitals. Before, women came to give birth in her clinic because it was cheaper. Now, government hospitals were cheaper and provided all of the additional services, such as lab tests and pediatric consultations, in the same building. Changing locations was always one factor in women's decision-making about where to seek care.

She came to work in the clinic two days a week and the rest of the days a daya covered for her. Imm Ramez lived across the street. Some women came to give birth with her, a daya, in the hospital position, lying down on narrow, hard hospital beds, in a mini-'hospital' that looks like a house. Salma said that Imm Ramez sometimes has more work than she does because Muslim women who come to the clinic want a Muslim birth attendant. I had not heard those kinds of sectarian remarks concerning birth attendance in my work in the mixed Muslim and Christian communities in Ramallah and the neighboring villages. However, this midwife's situation was different than that of the

midwives and doctors whom I had met before and who ran clinics. She was not from Bethlehem nor did she live in Bethlehem. She commuted back and forth between her village near Jenin and Bethlehem. She therefore neither had the kinship ties nor the friendships that would create a busy practice. I suspected that her sectarian analysis of reluctance to give birth with her cloaked comments about her being an outsider and maybe simply the quality of her practice. 'Outsider' is a relative concept, and in this context belonging to a community has a narrow scope. She was from a different region. In addition, listening to her, Deema and I were both struck by the derogatory manner in which she talked about dayat and women who gave birth at the clinic. She seemed arrogant and cold.

She explained how here, everyone gave birth lying down. Except that one day, a Bedouin woman came to give birth in the clinic. She had a long labor. She kept on insisting that she wanted to give birth standing up. (*biddha tchokh al-walad chach*) Literally, "she wanted to pee the baby out." In other words, she wanted to give birth squatting. Salma refused a number of times, saying that that was not the way to do it in a hospital. But finally, she gave in because the labor had taken so long. And the Bedouin woman gave birth squatting in a few minutes.[18] (*shakhato shakh*). She peed him. Salma explained how this showed that labor pains were partly psychological. She would have given in earlier had it not been difficult for her to wait for the baby squatting down.

Unlike Dunia, who talked about her work as being similar to the work of dayat in the old days, Salma differentiated herself from dayat and talked in rather derogatory terms about them. She kept on saying: "I am not an Arab daya. I am a legal midwife."

[18] During the first half of the twentieth century, ethnographers documented that it was a common practice for Palestinian women to give birth in an upright position using a birthing stool (Granqvist 1947; Young 1997; Menicucci 1999).

Salma is from a poor family. She had received a scholarship to study nursing in Amman, Jordan. She then continued her studies, specializing in midwifery, specifically for home births. After her graduation she moved to Irbid (Jordan) where she worked in a military hospital for four years. Thereafter, she moved to the United Arab Emirates where she worked in one of the most high-tech hospitals in the world. In 1996, she moved back to her village. She found herself in a corner. Palestinian legislation forbade midwives to assist home births, but she had a degree in home birth midwifery.

So, she went to the office of the governor and told him that she was a legal (or certified) midwife and that he would have to give her a permit to assist births. "Our local government in the North only wants money" she said, "and the governor knows that such a permit would bring in 50 NIS per month for its renewal." So the governor changed the permit he usually gives to dayat. He changed the heading from 'Non-certified (literally illegal) midwife' to 'Certified (legal) midwife'. Every month, the governor crosses out the 'Non-certified midwife' heading and writes on top of it 'Certified midwife'. As soon as he had crossed out "Non-certified midwife" for the first time, Salma opened a birthing clinic in her village. "We have no state" she said, "since we have no state, we can follow Israeli law, British law, Jordanian law or follow no law at all." In fact, there were three other midwives with permits to assist home-births in her village who covered for her patients when Salma was in Bethlehem.

In stressing her legal status as a midwife, Salma was dissociating herself from the daya who has no formal training. A hospital midwife would not feel the necessity to emphasize this distinction in the same way. But Salma's practice was in the community, and she was thus in competition with the daya. Salma adopted this strategy of

differentiating herself from the dayat and putting them down as incompetent and archaic when she negotiated with the medical director of the district to write 'certified midwife' on her license for community practice.

The licensing of midwives in Palestine was first established during the British mandate period, which also brought with it the introduction of Western medicine. European colonial powers, vying for influence in the region, established health services for the Palestinians in the form of missionary institutions, particularly concerned with maternal-child health (Sufian 2002). This coincided with the administrative regulation of health practitioners. The ordinance of 1923 stipulated that all midwives who intended to practice had to be registered by the authorities and pay a fee to receive a license. Those who practiced but had no formal diploma in midwifery must put their names on a list of 'Registered Dayat'. Thus British administrators and their district medical officers established a system to define and control birth attendants. Limits to their scope of practice, indications for referral to a doctor, utilization of certain medications, a system of inspection, supervision and reporting, and provision for continuing education were specified in the revised Midwifery Ordinance of 1929. In the 1940s several hundred licensed midwives had been trained and were practicing (Sufian 2002:17) and ten government hospitals with maternity services (Reiss 1991:20), in addition to the European mission hospitals, existed. However, dayat were still widespread and continued to attend home births in the community. Under Jordanian rule (1948-1967), community midwives and dayat in the West Bank were licensed according to the Jordanian Public Health Law of 1966, which remains in effect to the present day, until the time when the Palestinian Legislative Council ratifies the new public health law.

While no new law regimenting midwives has been voted, the Ministry of Health decided not to allow certified midwives to assist birth in homes. They sometimes cracked down on those doing illegal birthing as in the case of Dunia. But they permitted exceptions, especially in the areas of the North near Nablus and Jenin and in the South near Bethlehem and Hebron where there are fewer hospitals, fewer doctors and stricter closure policies. Even after the establishment of the Ministry of Health in 1994, the Jenin district continued to function more autonomously. This approach of relative decentralization, due to the geographic position and frequent isolation, meant that certain government community health services continued to function after the Second Intifada in 2000, when they broke down in some other districts of the West Bank. The medical director of Jenin recognized the importance of maintaining the status of the dayat and of village health workers, apprehending closures that would cut off access of people in remote areas to physicians and the city hospital (Institute for Community and Public Health 1999).

Salma takes 200 NIS (about $45) for each birth, which is the price to give birth with a daya. However, if the birthing women need medication, they had to pay more. She often induced labor in order for the birth to be over by the time she needed to leave for her other jobs. In the cases of induction, the price often rose to 300 NIS. Induction of labor (using medication to bring on contractions rather than waiting for the woman to go into labor) without medical indications can be a harmful practice (Cochrane), particularly outside of a hospital. 'Midwifery', 'female gender', and 'community-based practice' do not necessarily mean a more holistic and less medicalized approach to childbirth, as illustrated in this case of induction of labor for convenience and economic incentives,

similar to many physicians' birthing practices. Palestinian midwives as others are not a homogeneous group, but have different backgrounds, approaches and world views as seen by these birth stories.

Tamima and the NGO boom

Tamima was another midwife who was assisting home births in her own home. She lived in a village south of Bethlehem close to a refugee camp. She graduated from Bethlehem University, a catholic run Palestinian university, and had worked in the Holy Family Hospital in Bethlehem for many years, a charitable hospital and orphanage belonging to the Knights of Malta. Tamima went to through the most prestigious training and practice for midwives. The midwifery school at Bethlehem University had been developed in close cooperation over several years with a Norwegian NGO who funded and provided midwifery tutors to work along with the young Palestinian teachers to build capacity in their program. The Holy Family Hospital had for many years a foreign head obstetrician, most recently from Ireland and then Belgium, and matrons who followed European midwifery model of care for normal birth, and who promoted independent high quality care from midwives for uncomplicated births.

Then she started working at Al-Daman Hospital where her husband still practices as a staff nurse and with an UNRWA clinic. She and her husband live on the second floor of a two-storey house, and run a birthing clinic on the bottom floor. On the clinic floor there is an entry way, two rooms and a bathroom. It too looks like a mini-hospital.

But unlike in many of these birthing clinics, she does not use oxytocin (a drug to stimulate contractions) to induce labor and almost never does episiotomies. She said that the reason for this is that she is happy with keeping "a simple practice," that is a low

profile, small practice. Midwives and doctors who use oxytocin in their home/clinics want to make labor go by faster and cram in more patients. She has a number of faithful birth mothers from her area and she is happy with the relatively small practice. Her husband's income as a nurse in the hospital and her income as a home-birth midwife charging 200 NIS per birth permits her to send her children to good schools. She would rather have a safe small practice with no problems than one that makes more money and has to close down after a while because of a dangerous birth. She is referring here to cases of complications during childbirth in clinics like her own.

She registered her clinic as an NGO a month before our meeting. The name of her NGO is 'The Mother and Child Care Association'. She gave me the brochure she had just had printed. It said that the clinic had opened on the 18th of November 2001 and was newly registered at the Ministry of Interior. "The beginnings of this project are humble but will continue." It has assisted 300 births, provided 200 families with family planning (the clinic provides the pill, condoms and IUDs) and dealt with 180 cases of emergency care. It plans on recruiting more employees, opening a daycare unit and teaching exercise classes for pregnant women. Tamima said that they were running the clinic on the income from births but that maybe one day they would get funding for their projects. She is looking to possibly profit on the NGO boom, that has created a veritable and ever growing 'NGO economy' in Palestine.

I met four of her patients in the waiting room. They said they came there because it was a cheap place to get good care and because they knew Tamima well.

Dr. Karima: a new business enterprise

I went to visit Dr. Karima and her husband in a village north of Jerusalem. I had to take three communal taxis to get to the village from Jerusalem. The first taxi took us to the Qalandia checkpoint. I got off and crossed the checkpoint on foot. The second took me and the rest of the passengers from the main road to Ramallah, and from there into a more rural area. About ten minutes into the ride, the driver dropped us off. I got off and followed the rest of the passengers. We climbed a mound the height of an S.U.V that was barring the road. From the top of the mound, I could see three taxis waiting for customers, further away on my left was the eight-meter high 'Separation Wall' zigzagging into the horizon. The Wall stops abruptly to the other side. "It is still under construction," the person walking up the mound behind me said. Straight ahead were villages. I got into another taxi telling the driver my destination. We were stopped by another checkpoint but did not need to get out of the car. We finally arrived. I stepped out in front of the clinic and looked over my left shoulder. I saw Jerusalem. It was so close I could almost imagine hopping onto the next hill where it stood.

These villages north of Jerusalem, west of the main road to Ramallah are situated in a surreal nexus of checkpoints and the solid cement Wall. Being in prison is hardly a metaphor here. There are barbed wire, earth mounds, checkpoints, more barbed wire and the Wall everywhere you look. They lie right outside the administrative border of annexed 'Greater Jerusalem'. The inhabitants therefore have a West Bank identity card and since 1991 have been barred from entering Jerusalem. This is where, in 1997, I had carried out research for my undergraduate thesis, and the process of encroachment and enclosure had gone on apace ever since.

Dr. Karima was from a village east of Jerusalem. She had studied medicine and then worked with the Medical Relief for many years. Her husband, also a physician, was from the village they worked in today. Together, they had opened a 'health center'. This clinic was a much larger enterprise than the birthing clinics I described above.

Dr. Karima and her husband got a $100 000 loan from a bank to build this health center. They need to return it in four years. With the loan they paid for the building, the medical appliances and monthly salaries. The center has an emergency room, a labor room, a delivery room, a nursery, a post partum room and an operation room. She and her husband have hired doctors, midwives and nurses from the area. They decided to build the center when they realized how isolated the people from the village were. The villagers cannot reach Jerusalem and it is difficult to reach Ramallah. The center serves seven villages, about 40 000 people. The seven villages have unusually high unemployment rates because of their isolation. For this reason, many women who give birth in the center can not pay the 400- 500 NIS fee. As in most other private health facilities there is a range of prices depending on the income of the family. If they cannot pay, they can give birth in the center for free. She explained that about 4 out of 15 births (almost one third) were free of charge. When the Wall is completed, the seven villages will lie in a sort of a fortress, with nowhere to go. Unemployment will rise further and it will be even more difficult for people to pay fees for births. Dr. Karima and her husband may find themselves in financial difficulty with the banks as their income mainly derives from births. The center also receives emergency patients. Recently, villagers have been demonstrating against the Wall. The army shoots at the demonstrators. I arrived in the center the day after a young demonstrator had been shot dead. The nurses and one doctor

on the site had not slept as they were trying to save the life of the demonstrator, operating his stomach. In the morning, they had joined the rest of the villagers in the young man's funeral march. They were now back at work.

Dr. Karima was exhausted too. She had slept only two hours. While the man was being operated on and dying in the center, two women were giving birth in the labor room. Dr. Karima had been with them during labor and delivery. She wished there were other doctors working in the health center with her, so that she would get a break from time to time. She has too much responsibility. Up until now she has assisted about 900 births. All were normal. Until there are other doctors working with her in the labor room, she receives no births with complications. They have a policy that for breech pregnancies for example, the woman may ask for the Center's ambulance to try to get to the hospital in Ramallah. During pre-natal care of breech pregnant women, she tells them time and again that they need to get to the hospital in Ramallah for their birth. But the women arrive at the hospital fully-dilated. She therefore is bound to assist breech births vaginally. She never learned how to assist breech births in her training except by doing a C-section. But she trained herself with practice and old books.

Dr. T's problem

I returned to the field a year after my initial research. Dr. Siham was still working with the networks of health professionals. She still had her private practice. She also had started working as director of the maternity homes project for Maram, an NGO that works in health and development and which is funded by international donors, notably the USAID. She is overseeing the development of four pilot maternity clinics, three in the

West Bank and one in Gaza. She told me that Dr. T, who had had the problem with the infant death, was back in her village and directing one of the pilot clinics.

I went to interview Dr. T. in her clinic with my friend Deema Arafah. She explained that originally the clinic had been a primitive primary health care center with limited resources and old equipment. It was founded in 1970 by women's committees from the village. It ran its projects on the modest profit they made from women's volunteer work in selling agricultural produce and *tatriz* (embroidery). It also received modest financial support from a local church. In the 1980s, it seems to have received small donations from development organizations. In 1994, when the Palestinian Authority arrived, it received no more funding, as most international aid went to the new government. NGOs suffered financially during that period, especially small ones.

Dr. T also had a private clinic in Ramallah. Before the start of the extensive closures on Ramallah, three pregnant women from her village came to her and asked her if she would be able to assist their births in the village if there were a closure on Ramallah. There had been sieges and long closures on Nablus and Hebron and most cities of the West Bank and so, it was not unreasonable to think that it might happen to Ramallah. When the first woman came to ask her if she would assist her birth in the village if there were a closure, she did not take her seriously. She was an obstetrician, trained do operations, to assist births with complications. She had only assisted births in hospitals, with their technologies, nursing staff, operating rooms and specialized physicians. When the second and third woman asked if she would assist their births if their labor started at a time when there was a closure, she decided to prepare herself. She

packed scissors, receivers, sterilizers, cotton, gauze and gloves – the needed equipment for a delivery – and put them in the immunization clinic in her village.

Neither Dr. T nor anyone else foresaw the scale of the closure. Her village, which has been dependent on the infrastructure of schools, markets and hospitals in Ramallah was now isolated from it for months on end. She delivered the first woman a few days after the beginning of the incursion with the help of a volunteer nurse. That first case was frightening for her. The woman was 38 years old. She had had many children. She was anemic. Dr.T was afraid that the something may happen during or after labor such as bleeding. She had called the Red Crescent and told them that this woman needed a hospital because it was a risky birth. They told her that the checkpoint was completely closed and they begged her to do the delivery herself. She assisted the birth. The baby needed to be resuscitated but all went well. She kept the woman in the clinic for a night, provided her with food. And the woman went home telling people that she had a better experience at the clinic than she ever did at any hospital. After that, the word went around and Dr. T assisted more and more births. A few days later, the village council called upon the key people in the neighboring villages and declared that this clinic was the emergency center for women in labor who managed to reach it. Then they printed pamphlets about the clinic, which they distributed in the neighboring villages.

Dr. T was the only obstetrician in the area and received practically all the patients. One night, she had four women in labor at the same time in her little clinic with the help of only one nurse. After that she went home exhausted. She took care of her ill mother. She barely had energy to do the basic house work. She delivered 80 births between March 29th and May 5th.

After three weeks of the closure, and no predictions that the road to Ramallah would open, she worried and decided to try to get donations for more expensive equipment. The four doctors with private clinics in the neighboring villages brought her all their basic material such as cotton and gloves. Two local pharmacies brought her sterilizers and other supplies. And she got donations from Palestinian organizations in Israel which permitted her to buy oxygen cylinders, IV drips and the drug oxytocin which brings on contractions. Ethnographies of medical services in poor settings show that this is central to their economies. Health workers and often patients walk in to the hospital room with their own supplies for an operation.

What needs to be noted here is that we are not in the setting of a hospital. Dr. T had just turned a clinic with the bare minimum in terms of supplies into one where women give birth. In the U.S, IVs and especially oxytocin are used only in hospital settings as the medical literature shows that the drug increases the chances for complications. In the words of a nurse who worked in the clinic for a few months, "Dr. T has turned the clinic into a mini-hospital, but we have nothing of a hospital other than a few hospital drugs. It is a dangerous place".

Actually, there were few cases of complications in her clinic, to my knowledge. But there were two notorious ones that traumatized Dr. T and the villagers. Out of the 80 births, two newborns died. The two stillbirths were those of two women from her area who were at the end of their first pregnancies. The first case took place March 30th. The woman was in labor for 18 hours. Her husband was a sheikh. He was well educated, she said. She made him stay with her and his wife during the whole process of labor and delivery.

Actually, she made all the husbands stay with their wives during labor and delivery. She thought they were supportive to the woman in labor and they were an important protection for the doctor. This way the husband sees what is going on and the efforts she puts into her work. He can see that she did her best. If a problem arises, he is a witness. She saw herself as setting a precedent in her country, as changing ways of life, as a modernizing force.

After six hours, labor was not progressing. She called Ramallah Hospital to ask to transfer the woman to the emergency room. But the ambulance service said that it was practically impossible for them to get anywhere. They got the emergency physician on the phone who begged her to try to find a way to manage the case. Even if she gets to the hospital, he told her, we have no place for her. The labor unit is full of injured. The emergency room is so busy there is barely space for the staff to walk through. She had no choice but to keep the patient.

After 12 hours of labor and no progress, she told the husband that there was no longer anything she could do except wait. It was dangerous for the baby and even dangerous for the mother. He listened to her with fear. Six hours later, in the eighteenth hour, he came to her and said: "Doctor, please do anything to save my wife. Do whatever you have to do with the infant, although I love him, but save my wife's life." It was very difficult for the couple. This pregnancy had come after two years of infertility.

The husband stayed next to the doctor and his wife every minute. He saw how she tried to save both the mother and infant. For 18 hours, she did not leave the woman in labor. But the baby was big. He would have needed an operation instantly. At that time, she had practically no medical supplies. She did not even have a monitor to check the

fetus's heart rate. It was such a difficult moment. When the head was down and visible, the woman could not deliver the baby. The baby could not come out. Dr. T had to fracture the skull and clavicle of the baby.

This happened on the March 30th. She went home that day, sat down to have a cup of coffee, and thought: "why am I putting myself under such stress." She felt terrible but there was nothing she could do. She called the sheikh and he came with other family members. She told them how sorry she felt. She told them that the sheikh had been there to witness how much she tried to save the life of both mother and baby. She told them she thought she should stop practicing in this clinic because it was too much pressure on her. She said she would close the clinic. The women should find other places to give birth. The ministry of health should find solutions. She can no longer bear this responsibility on her shoulders alone. But the family supported her and told her she could not stop. The sheikh said he had been with her and had witnessed all that had happened. These sad incidents happen. "*Qada qadr.*" ("It is destiny.") At that moment, two women in labor entered her clinic. The family told her to go continue her work. She left the discussion and assisted the two women.

She wanted to close the clinic but she could not do it. The closure got worse and more people started coming. Her colleagues heard about the incident and started calling her to give her support. They told her that these things happen even in hospitals. Her morale was very low. She was frustrated. The closure continued. People kept on coming for assistance. She delivered case after case. A woman with two previous caesarean sections came to her asking for assistance. Dr. T told her to leave because she could not take the responsibility of such a risky delivery. But the woman said: "where do you want

me to go? It is either here or on the street." There was still a complete closure on Ramallah. Her husband who was a journalist begged Dr. T to admit his wife: " Doctor, go ahead. Rely on God. Put your faith in God and deliver her."

She was so afraid. She went back to her old books. Fortunately, she had studied and practiced obstetrics with the old generation of obstetricians. Dr. Khammash Maa'touk had been her professor. He is a well-known physician who was director of the Red Crescent Hospital in Jerusalem. He started practicing during the 1950s? Hand skills and clinical judgment were the only way that he permitted his students to practice. He had studied in the UK and was part of the old school of obstetrics. She worked with him for a year and a half. During that time, she wished she also had training in the high-tech modern way of practicing obstetrics. She got that kind of training later when she did her specialization. But now she realizes how valuable had been the skills she learned with Dr. Maatouk. The squatting position for example was a skill she learned with him, which obstetricians no longer learn, and which is essential in an obstetrics practice with virtually no technologies.

In the long run, this practice is too exhausting. She is by herself. It is too much work and responsibility. Under the situation of emergency in which her village found itself, she was willing to give all she could. Some nights she did not sleep. Some nights, she slept on the couch in the clinic. It was too much pressure on a daily basis. She decided to close the clinic.

The activity of her clinic and others in the country made the staff of Maram, the NGO for which Dr. Siham was working, to start thinking about constructing a permanent infrastructure of birthing clinics. Dr. Siham contacted Dr. T explaining to her that they

were interested in re-opening the clinic with funding from various international donors including USAID.

Conceptually, these clinics would be modeled on American birth centers. They could be run by general practitioners, obstetricians or preferably, midwives. They also have the model of Gaza and South Africa. Gaza has relied on maternity homes because it is influenced by the Egyptian system. The difference is a cultural one, according to Dr. T. "In Gaza, they are more accepting of midwives. They appreciate having a woman assisting them. In the West Bank, we unfortunately think of ourselves as very sophisticated. Most people do not accept to be delivered by midwives unless it is in the context of a hospital where the doctor is supposed to be supervising and signs off the birth documents. The West Bank is influenced by the Jordanian system. In Gaza, they adopted the maternity homes model because they did not have enough obstetricians. They had one obstetrician in the whole Gaza Strip. Until this day, they rely more on dayat and midwives because they do not have enough physicians. This model is very useful for an underserved area." In her village, she thinks they should build a hospital with surgeons and nurses rather than a maternity home.

Maram came in 2002 wanting to develop her project as one of the pioneer maternity homes. It took long meetings and discussions and they wrote the proposal. When they had written it, they had to go through a whole new discussion about the anti-terrorism clause which was added to any organization working with funding from USAID. This was part of a larger national debate in Palestine about whether NGOs should sign the anti-terror clause. For 18 months they had to discuss this issue. They decided like most of the NGOs not to sign the bill and refuse USAID money. She said

that like the other NGOs, the board thought that the terminology of terrorism was slippery. They all considered themselves to be resisting occupation. Was that part of what the USAID clause considered terror? Would they have to give up their rights to resisting occupation? They refused to sign.

But months later, another international donor (also using U.S. funds) offered Maram and Dr. T's clinic funding with no anti-terror clause to sign. That is when the clinic started functioning again. The NGOs and the donor countries had found ways through a third organization to deliver funding without an anti-terror clause (the intermediary NGO signing the clause and taking responsibility for its implementation). While this financial assistance is visible to everyone and well-known, the issue of U.S. funding remains a delicate and complicated one. The anti-terror clause after September 11th raised the question of U.S. funding, given the foreign policies of that power, to the level of a public debate. But even after the debate itself had cooled off somewhat, most of the people I talked to who worked for USAID-funded projects were happy to discuss the issue of funding as long as I was willing not to name specific organizations, people and funding agencies.

Dr. Siham, who runs the "safe maternity homes" project has chosen Dr. T's clinic as one out of four pilot clinics. The aim of the project is to ameliorate women's health and relieve the pressure on hospitals. In such clinics, the medical staff deal with normal births that do not need advanced technologies and specialized doctors. These maternity homes should offer women an environment similar to their environments at home with

the assistance of midwives. The Safe Maternity Homes projects are modeled on the American woman-centered, midwifery run birth centers.

It would appear that the combination of NGO politics, and most importantly the funneling of large sums by governments through the non-governmental system, increasingly after Yasir Arafat was sequestered and declared not a partner in peace, and decisively since the electoral victory of Hamas, has had a powerful effect on official and professional orientations in the field of birthing. These have swept up so many of the previously grass-roots oriented medical practitioners, causing some, like Dr. Siham herself, to come full-circle, from their espousal of popular networking to mediating the globalized form of a technologically advanced and medicalized environment in the guise of a new and updated kind of village clinic, purporting to place the midwife at the nexus of operations.

Speaking of Dr. T's clinic, however, one midwife said: "This is a mini-hospital. It now has all the equipment of a hospital except for Fetal Heart Monitors. And they say it is a midwifery clinic. It has nothing to do with midwives. They pay their office staff better than the midwives. Why don't they just get a surgical ward and call it by its name, a hospital?"

In this chapter I have discussed some of the ways in which birthing clinics emerge and function during the Second Intifada. Health professionals open birthing clinics in their homes, construct networks of professionals linked by phones, invest and construct health centers in their villages and sometimes find international funding for their projects. Like the Sumud and Popular Health Movement these movements grow out of gaps in the

infrastructure and networking of professionals. However, they rely on a discourse of humanitarian assistance and market needs rather than on a socialist and nationalist program.

Chapter Three

Doctors and Deliverance

During my fieldwork, I was surprised by the number of rumors and discussions of medical malpractice that took place in my presence. Palestine does not have the same legal infrastructure and traditions as the U.S. for example, where lawsuits for malpractice are widespread in the medical field. But in Ramallah, in October and November 2003, everyone was talking about various cases of doctors "medical errors" (*akhta' tibbiyyeh*).

In her book, Kanaaneh identifies the clinical encounter as a site of contest. In the Galilee, part of the contest is a nationalist contestation, the institution being Israeli and the patient Palestinian. It is also the site of a contest over the reproduction of the proper modern family in a context of countervailing pressures. In this chapter I shall flesh out this idea of the clinical encounter as site of contest in West Bank clinics. Within the clinical setting, the first chapter has described a contest over planning and organizing the public health system and competing visions of the Palestinian nation. This chapter will present critiques of the encounter between doctor and patient.

This chapter will describe the contradictory place of physicians in the Palestinian political imaginary. First I shall describe the nature and implications of vilification stories, and then move on to the lofty stature of doctors in Palestinian politics, as well as the relationship of "organic intellectuals" to the traditional ones, that is to say, the PLO-formed intelligentsia which returned thanks to the Oslo accords, only to tumble in the

public esteem as a result of the quality of their administration of the Palestinian autonomy, from 1994 on.

With respect to the ways in which it becomes possible to mobilize the doctor as political authority, it is interesting to return to the problematic raised by Robert Blecher (Blecher 2002). The current president of Syria, Dr. Bashar Assad, labored to bolster his authority upon assuming power after the death of his father, Hafez Assad, in 2000. As he and his advisors presented him, the young president represented technology and science and thus a large step in the direction of modernity in its grandiose, imposing and untouchable form. In the Palestinian case, glorification comes through the popular identification of doctors as true representatives of the people, to whom they belong, and to whom they remain closely wedded. They enter Palestinian homes and bodies without shoes, barefoot as it were. Both the Syrian and Palestinian cases speak of healing the nation through its body, but they rely on two different imaginaries: one based on the hospital and modern technology, and a popular/populist one.

Vilification Stories

One revealing case concerns the village I have called 'Balad': a newborn baby died at a birth assisted by Dr. T. In the summer of 2002, I went to interview three women in Balad about their births during the siege, and casually discussed matters with an old man who was present as well. The death of the newborn had spawned numerous critiques: "We need another doctor and a hospital in the village," the old man told me, "the doctor is a failure. The baby died in her clinic. It is like the old days again. They talk about progress. Here, we are going backwards." There was public commotion in the

village, rumors blaming the doctor. According to Manal, there is an essential problem with doctors, namely that they don't tell you what they are doing and think they can get away with everything. Another woman explained quite plainly that even though she did not have a bad experience with Dr. T., she would never trust her again, and that what had happened was too much. Very soon thereafter, Dr. T. left the village. The villagers said they had forced her out.

When I went back to the village a year later, Dr. T had returned and reopened the birthing clinic. It had received funding and had many more medical supplies than previously. I interviewed six other women about their birth experiences during the siege. One of the interviewees told me when I asked about the clinic that the villagers were still terrified by the infant deaths. They still spoke of Dr. T's multiple cases of malpractice, seeing malpractice in everything she does.

In the last chapter, we discussed the conditions in which she was forced to work. While I felt close to the women who were expressing critiques about the care they received, it was difficult to blame Dr. T., who had to deal with such heavy pressures. She had had virtually no choice but to assist all the women who arrived at her clinic, working alone under very strenuous conditions.

On the other hand, the villagers considered that Dr. T. had benefited from her practice and was continuing to do so. Her medical activities in the village and her relations with the PA had propelled her to a novel status as a public figure. While the institution had indeed closed temporarily in the summer of 2002, she was now well funded and would again be heading the clinic. She was even talking about a book she wanted to write because of the importance of her story. In 2004, she assumed a position

in the Palestinian Authority. The line had clearly been blurred between dual roles, as sacrificing national doctor and ambitious politician. The complex of stories in the village provided a window into a world where the doctor made sacrifices for the nation, while steadily rising up the post-Oslo political, social and economic ladder; and where patients denounced the doctor while deeply needing her.

Developments in Balad had a particularly dramatic and poignant quality, but critiques of doctors, their lack of qualifications, their strategic errors and their high fees were not unusual in my interviews. Maha's birth narrative was typical in this particular respect.

It was April 2002. Maha, who lived in Ramallah, was in her ninth month of pregnancy and had felt contractions for short periods two days in a row. She worried about where she would give birth because Ramallah was under a tight curfew. She called the doctor whom she had been seeing during the pregnancy at the Red Crescent Hospital in El-Bireh. He told her that he was stuck in the hospital where he had been confined for five days, and that if the curfew were to be lifted for an hour or two, he would go back home to be with his family. He could not wait for her labor. He told her that if she could get to the hospital, he may be there or may not but that surely there would be someone who could assist her birth.

She thought about what to do. She worried that even if she got to the hospital, she may not be able to get back. She was afraid to leave her husband and children at home. What if the army came and rounded up all the men as they had done a few weeks earlier? Who would stay with her two young children?

She had heard of a doctor who was assisting births in her own house, a few blocks away from Maha's. She obtained her number through a neighbor and called her up. The doctor said that she was assisting births in her house and that she was welcome to come because it sounded like she was in labor. She walked over to the doctor's house, it was about 1 p.m. The doctor checked her and said that she should go home because she was only dilated 2cm. Maha insisted that she had to give birth, that she could not go back and forth between her house and the doctor's. There were tanks driving by every so often. There were sharpshooters posted at the end of her street. She was afraid to be walking in the streets. The doctor agreed to give her oxytocin to speed labor and told her that in about three hours she should be giving birth. Maha started having stronger contractions but wanted to get home until she was ready to give birth. She walked home and then started walking around the house with her husband and children. At 6:30 pm, she went back to the doctor's house. She was still only dilated 3 cm. So the doctor gave her more oxytocin. At 9:30 pm, she had given birth. The doctor cleaned her up quickly. The contractions had been so strong and painful that she had a tear. But the doctor did not stitch her up. She started telling her that she had another patient coming some time soon, that her husband was tired of having all these birthing women in his house, that their bedroom was right next to the room she had turned into a birthing clinic. She told her a hundred stories and made her feel that she could not stay even though she had just given birth. Plainly, she told her that she had to leave.

It was 11:30 p.m. by the time the doctor had cleaned her up and cleaned the baby up. Ten minutes later, once they had understood that the doctor did not want them in her house, they picked up the baby, wrapped her up and set out for the walk home.

In the middle of their walk home, they hear the roaring noise of a tank. So they ran to the closest house and started knocking at the door. "Let us in, we are women. Let us in!" The noise of the tank was getting closer and closer. Finally, someone opened the door and let them in. They sat down with their hosts to have tea and the host listened to their story. She started telling them that it is incredible that the doctor let them walk home right after a delivery when it is dangerous to walk because of the curfew. And Maha started thinking: "I did not have 10 minutes to recuperate after the delivery. I had a tear and the doctor did not stitch me up. Look at how lowly this doctor is. Just to get me out of her house, she did not stitch me up. I suffered because of her misconduct."

With the help of the young men in the neighborhood who called from house to house to make sure that the road was clear of soldiers, they were able to walk home safely. Maha decided to call her daughter Wa'd. It means promise, the name of the woman her favorite uncle had loved and protected all his life.

The plot of the narrative is familiar. She had no way to get to the hospital. She looked for an alternative in her neighborhood. She gave birth with a health professional accompanied by her neighbor. With the help of other neighbors, she was able to get home. Finally, she named her baby. What is striking in her narrative is the staunch critique of the doctor. She would not stitch her up after the delivery for selfish reasons. The doctor was not doing her a favor. She was not sacrificing anything. She was paid for her services and she did not return what she owed.

Maha's critique of doctors was a recurrent theme in my birth narrative interviews. Discussions with friends also would frequently turn to doctor's stories. I first heard about a notorious malpractice case which took place in late 2003 through close acquaintances, a

teacher and a restaurant owner in Ramallah. A woman had bled to death in a local hospital after a caesarean section at hospital X. Later on that week, during a public lecture he gave at the Institute for Community and Public Health of Birzeit University, Dr. Munthir Al-Sharif, Deputy Minister of Health, made a presentation about the state of the Ministry of Health (MOH) and its cooperation with the World Bank. A student asked him what policies and measures the MOH was implementing with regard to malpractice and how they were thinking of building a system that holds the doctor responsible for professional errors (*ghaltat mihaniyyeh*). Dr. Al-Sharif replied that they were now receiving hundreds of complaints (*shakawat*), more than ever before. They were studying each complaint individually, taking and executing the appropriate decision. Among measures open to them were warnings, firings and license revocation. Asked about the incident at hospital X, he said they were studying it, and the fact that everyone in town was speaking about it did not make it any easier to understand. After the lecture, the students continued the discussion, noting that the doctor responsible for the caesarean and the maternal death was no longer working at the hospital.

A few weeks after this event, the Palestinian Independent Commission for Citizens Rights PICCR), a legal and humanitarian NGO with official standing, which receives complaints about all kinds of legal and abuse issues within the PA, organized a televised panel discussion about medical malpractice cases (*al-akhta' al-tibbiyyeh*, literally 'medical errors'). The PICCR spokesperson talked about an increase in the number of medical complaints over the previous three years and called for more systematic legal procedures to deal with the problem (*Al-Ayyam*, 28 October 2003, p. 7).

The vocabulary of accusation and misconduct was part and parcel of the discussion on accountability and the PA. The vilification of doctors on whom people nonetheless depended mirrored a debate in the Palestinian and Arab media. This was a time of vehement critiques of the mismanagement of the intifada, and of corruption in the PA. In the case of both politicians and doctors, people were using phrases such as: "he is a robber," "he is selfish," "all he wants is money." Prominent doctors were seen as representations of medical but also political authority. Of course, association of power with the profession of medicine is common in many countries. Here, however, it went beyond the symbolic field. In Palestine, many doctors actually were in positions of political authority. They did not simply represent political authority by working for the government, in many cases they actually were the political authority. There are multiple examples of this phenomenon some of which I discuss below, for example Drs. Fathi Arafat (Fatah), George Habash (PFLP, who in popular parlance was for decades simply referred to as *al-Hakim,* [the doctor, literally means the wise man]), Haidar Abdel-Shafi (Independent), Mustafa Barghouti (Palestine Communist Party, later Palestinian People's Party, then *Al-Mubadara*), Mahmoud al-Zahhar (Hamas).

The participation of lawyers in the Indian independence movement is well known: following Gandhi, the ultimate lawyer-cum-anticolonial activist, many lawyers would confront the British liberal democratic state on its own grounds, using law as an anti-colonial weapon.[19] Historians have written about the first generation of Fatah and the PLO (1959-1967), many of whom were engineers who met, organized and financed their movement in the new oil economies of the Gulf. Among the leadership inside the

[19] For a discussion of Ghandi's reliance on British constitutionalism in the struggle for securing the rights of Indian subjects, see Wilson 1986.

Occupied Territories, very few leaders are engineers, whereas several are doctors. I started to wonder about what that meant with regard to the identity of a Palestinian proto-state and leadership. Was the idea of saving life itself, deployed through the humanitarian aid apparatus and through Palestinian survival discourse and resistance techniques being deployed in the overlapping of medicine and statesmanship?

The essential role of the medical profession and also its vulnerability were clearly delineated in the course of the 1987 intifada, in which a number of paradigms crystallized. Throughout the uprising, the United National Leadership of the Intifada (UNLU) directly addressed the medical profession in its constant stream of communiqués (one or two a month), and in particular, doctors and hospital administrations. They are addressed both in their traditional and modern embodiments of medical expertise, because of their capital importance in saving lives. From the outset, the leadership stressed the importance and ever greater need for the creation of new mobile clinics (communiqué 3: this text was drafted in January 18th, 1988 cf. Legrain 1991). The leadership welcomed the infrastructural assistance offered by internationalist supporters, in the form, for example, of rehabilitation clinics. It called for the training of specialists in various essential fields, if possible in partnership with foreign experts. It asked that, neighborhood by neighborhood, the people of the intifada take on the responsibility for health and medical care. Again and again, the leadership played up the role of doctors, praising them for the protection and care they were offering the citizenry, for example on the occasion of the World Health Day, April 7th, 1988 (communiqué 12). And they emphasized the role of anti-occupation Jewish doctors in offering care, as well as that of local, regional and international journalists (communiqué 23). But at the same time, they

demanded that this care be given for free or at cost, and that the cost of hospitalization be drastically cut (communiqués 24 and 27), thus betraying a critical (and class-based) stance towards the medical profession, already. Doubt sometimes crept into the discourse, not regarding the quality of medical care, but the perhaps overly materialistic motivations of the profession. Sometimes, the demands seemed to exceed what was humanly and professionally possible (but not only in relation to the medical profession) by asking that clinics remain open on a permanent basis (communiqué 9). And throughout, the UNLU's communiqués called on doctors to assume their role as public spokespeople vis-à-vis the domestic and international society (communiqué 31).

Before I start talking about some of these doctors who are also leaders, I want first to step back and describe the contexts and meanings of these vilification stories.

Medical, Historical and Bureaucratic Context

The vilification stories are symptomatic of a number of issues. First of all, women in conditions of closure go through very anxious pregnancies and deliveries as they are always waiting, waiting for the nine months to go by, waiting for the labor to start, waiting to know when this will happen, but also waiting to know if the checkpoint will be open on the day of the labor, waiting to know if they will manage transport to the hospital and all this waiting knowing that labor is uncontrollable. It comes when it comes and it is impossible to tell it to come at a certain time just because the roads are open. Under these conditions of anxious waiting, it is likely that the experience of birth will be stressful at best, dangerous at worst.

Secondly, the health institutions are under increased pressure due to understaffing and an increase in cases. Take the example of Dr. T. in Balad who assisted one to two

births a day, or the example of Ramallah government hospital, where there are "human traffic jams in the labor room" as one woman said, with dozens of women in labor one next to the other in a huge labor room. Everybody agrees that the quality of care has declined in all institutions and these vilification stories reflect *fear* of insufficient care and a demand for better care. "We need a hospital in the village," the old man had said.

One of the areas where the PA was proud of its work before the second intifada was the health sector. In the second and third chapter of my thesis, I write about the building of the Palestinian health system. The Israeli occupation had contributed to the centralization of a health care infrastructure of hospitals in the major towns and cities. After the Authority took over in 1994, it continued to centralize the system and to build and develop hospitals in urban areas. With regard to childbirth, the authority campaigned to have women give birth in hospitals, especially since now government hospitals were run by a Palestinian national entity, and no longer the Israeli government.

With the outbreak of the 2000 intifada, the percentage of births outside of hospitals increased (cf. chapter 2). Nonetheless, he Authority and doctors continued to consolidate a variety of regulatory mechanisms to make sure that only in times of emergency is it legal for midwives or anyone else, except doctors, to assist births. For bureaucratic reasons the PA was worried by the de-regulation of births. For medical reasons, it was worried (and justifiably so) about the quality of care of all these births with assistants who either were not trained at all or were trained to work in the context of a hospital with its technologies, drugs and an operating room across the hall. As for the doctors' unions, an influential entity, they were worried about the increased interest in

midwifery and in births outside of the hospital, both of which constituted a threat to their monopoly.

This is not simply a story about conflict between the state-producers and subaltern villagers-consumers. It is more complicated than that. Many villagers would have wanted to get to the state institutions but that was not always possible after the beginning of the closure. Even though many births were taking place at home during the intifada, the Palestinian context of the 1990s had created a situation where people wanted and needed births to take place in a hospital in the city and by virtue of this felt need and the frequent impossibility of its realization, they tended to take out their frustrations on their government, with all of its real and perceived shortcomings. The PA, in this context, was seen as compounding the problems posed by the Israeli occupation.

Returning now to the stories, accounts and rumors regarding medical and political malpractice during the second intifada, births were and continue to be an occasion when Palestinian women could see and experience directly the failure of those institutions from which they expected assistance.

The vilification stories were the mirror images of what people were saying at the same time about the Palestinian leadership. Rumors portrayed doctors as being dishonest, money grubbing and self-aggrandizing, the very same images evoked in the public critique of the mismanagement funds as well as of the society on the part of the leadership in this time of intifada-induced crisis.

By telling these stories as rumors, they are redirecting these stories to an author such as 'the people' or 'the public'. This further alludes to something that encompasses both a medico-legal critique and a political critique. They came to stand in for the failed

promise of Palestinian statehood – symbolized not only by the occupation with its numerous checkpoints and curfews but by Palestine's own political leaders, many of whom are themselves doctors.

These interconnected considerations point to the fact that medicine itself appears to have become a central element of Palestinian political identity. In Adriana Petryna's (2002) analysis of the aftermath of Chernobyl, she shows how being a Chernobyl sufferer becomes both the grounds for governing by an independent Ukrainian state as opposed to the Soviet state and the grounds for Ukrainians to stake citizenship claims. In the Palestinian context, the right to medicine and in particular to emergency medicine is practically the only right the Israeli military, the media and human rights organizations take notice of and, at least theoretically, concede. Although this right is frequently denied, it is a fact that when the Israeli military does give permits to cross checkpoints, it is for medical reasons, especially emergencies. Emergency medicine has thus in a real sense opened the road to mobility for Palestinians. This is why people of influence and those with means will sometimes pay to be transported from one city to another by an ambulance. The ambulance has become the VIP's taxi. The documentation of Israeli human rights violations by the media and human rights organizations often concerns the Israeli military's blocking the assistance of emergency medicine. "My son is ill, so let me cross," is what you hear so often at the checkpoint.

Doctors as carriers of the nation

The late Fathi Arafat, a Cairo-trained pediatrician and the brother of the Palestinian leader, headed the Palestinian Red Crescent Society (PRCS) after 1978, and

until he became ill in 2001 (he died in Cairo shortly after Yasir Arafat). While the PLO was headquartered in Beirut, until 1982, the PRCS functioned as the PLO's ministry of health. At the same time he directed the Gaza Maternity Hospital in Beirut known as the "Palestinian baby factory," in keeping with the heavily pro-natalist policies of the organization, until the PLO's expulsion from Beirut. After that date, he divided his time between Geneva (where he served as the Palestinian delegate to the World Health Organization) and Cairo, where he headed the Palestine hospital. He was the only physician from his generation of top PLO leaders in the diaspora to have returned with Yasir Arafat under the terms of the Oslo accords, and liked to be referred to as "the nation's doctor." Nonetheless he remained firmly embedded in administration for most of his career, whether at the level of the hospital, the PRCS or in the WHO. It is undeniable that he understood the importance of building a medical system as an integral part of the national project, both as a symbol of nation building, and for very practical reasons (he had witnessed the terrible suffering caused by Israeli bombing of Lebanon in general, Beirut in particular, and the attendant destruction of the refugee camps in June-July-August, 1982). In keeping with his Egyptian education however, and as the brother of the supreme Palestinian leader, his approach to building the medical infrastructure was heavily centralistic. In this respect he did not behave very differently from the medical establishment generally during the 1990s. Nonetheless there was some tension between him and the medical (and ministry-based) bureaucracy, heavily dominated by insiders, linked to a more general competition for power between locals and returnees (Heacock 1999). Health (along with education) was one of the only areas where the insiders were able to hold on to their positions of paramount influence. Despite his closeness to the

chairman of the PA or perhaps because of it, he did not have a strong impact on the political developments in the Oslo phase. And for health reasons, he did not have the opportunity to participate in policymaking during the Al-Aqsa intifada. At any rate, he never developed a popular following in Palestine.

He appears to have had a greater impact on people and events in the medical field prior to his return to the occupied territories, and in Beirut he surrounded himself with devoted assistants. The PRCS's vice president, in particular, Imm al-Walid, was highly respected throughout the Palestinian community in Lebanon, although not herself a doctor. She said that she had become "half a doctor" through her work in the administration of the PRCS, something which is true of a large number of Palestinian paramedics in different parts of Palestine and the diaspora.

"We considered our role at the Palestinian Red Crescent Society (PRCS) to take care of the nation. I was doing social work at the Red Crescent. Because social work was linked to the *fedayeen* [fighters], we would take them and we had to give them medical care. As it turned out, PRCS was responsible for the institutions we had for disabled people and for Gaza Maternity Hospital in Beirut, and then Ramallah Maternity Hospital in Beirut. We mainly had social workers and psychology specialists. We brought the women all kinds of foods. We were so conscious of women's health. We wanted more babies. So we took care of mothers so that they would get us other children. I became half a doctor. From 1970 to 1994, I was vice-president of the organization."

Imm al-Walid basically became a spokesperson for the PLO. After the Sabra and Shatila massacre, she was the first Palestinian official to go to site. "We [PRCS officials] were hidden in the Red Cross headquarters. Someone called and said 'we want someone

from the Palestinians to come'. So they said 'we'll send you the vice president of PRCS'. I went and was shocked. My hair was standing on end. I had to put my hand on my head to keep my hair from standing. The Red Cross representative gave orders, said 'you have to talk'. He hit me to get me out of shock. And I started to talk. 'Now, you have to give the order'. It had been 3 days since the people had been killed. Everything smelled of death."

"It was one week before I could take a shower. And I looked at myself in the mirror and started screaming, my hair had become white. I went to the doctor and he said 'thank God it came to your hair. There are dyes you can use'."

There are numerous physicians from the internal political leadership. Haydar Abdel Shafi belongs to an older generation of doctors from the notable class in Gaza. Both Mahmoud Al-Zahhar and Abdel Aziz Rantisi, doctors in the leadership of Hamas lived in Gaza during the year of my fieldwork (unfortunately, I do not have interviews with them. Rantisi was assassinated in the Spring of 2004 and I did not manage to do interviews in Gaza). Mustafa Barghouti is the leader who is the most visible as a doctor as well as politician.

The exemplary case of the fusion in occupied Palestine between medicine and political leadership is found in the example of Dr. Haidar Abdel Shafi, the Gaza surgeon. Haidar Abdel Shafi has always been media-shy and rather self-effacing, although he belongs to the class of notables, many of whom were displaced by the social revolution in the medical profession. As a result, there is no coherent, analytical biography (or autobiography) of this key personality on the medical and political firmament of Palestine, and the present sketch is drawn from a variety of fragmentary and disparate sources. Born in Gaza in 1919, Haydar Abdel-Shafi was exposed early on to the life and

significance of officialdom since his father was a high-ranking employee of the Islamic Waqf. In 1943 he obtained his degree in medicine from the American University of Beirut, and got hands-on experience with mandatory and Jordanian medical services. During the period of Egyptian administration in Gaza (1948-1967) he directed medical services, and also became a member of the so-called Gazan Executive Council, thus making his first personal connection between medicine and governance. In 1964, he was present at the creation of the PLO and a member of its very first executive committee, already in opposition to the chairman of the time, Arafat's predecessor, Ahmed Shuqayri. Israeli occupation meant time spent in jail and a brief period of deportation, after which, in 1972, he founded the Gaza Palestinian Red Crescent Society, whose dual function has been medical (free consultative services) and political (under the euphemistic designation of 'cultural') and which he has directed ever since. By this time he had become one of the most respected Palestinian figures on the 'inside', although, because of the relentless spotlight on the outside leadership around Yasir Arafat, he remained unknown to most of the world until appointed to head the Palestinian delegation to the 1991 Madrid peace talks. His gentle charisma, transparent honesty, impeccable medical reputation and unyielding principles, then revealed to the world, most certainly contributed to the precipitate signing of the Oslo accords by Arafat.

In the words of Hisham Sharabi, "[t]he Madrid peace process initiated in 1991 produced what Arafat had dreaded most: the emergence of an alternative Palestinian leadership. The distinguished Palestinian negotiating team headed by Dr. Haidar Abdel-Shafi projected an image of Palestinians as rational, practical, and articulate, in sharp contrast with the image of Arafat and his group. He had every reason to fear Abdel-Shafi,

a respected physician, who looked like Nelson Mandela, with an impeccable political record and a long history of struggle, and who would have probably played a leadership role in Palestine had he been allowed to remain in the public eye. But Arafat's secret Oslo agreement not only enabled him to pull the rug out from under Abdel-Shafi and his team, but to put himself firmly back in the saddle" (Sharabi 1998:3).

Despite his links to the Palestinian left, and to the Communist Party in particular, he always remained independent and was considered to be above the fray. As the secret Oslo talks and resultant agreement became known, he pulled back and finally resigned from the negotiating team. His critique of Oslo was immediate and unrelenting (Abdel Shafi 2002), since he considered that it represented acquiescence in the "Bantustanization" of rump-Palestine (Boyle 2002). He continued for awhile to attempt to play by the new rules, and was elected to the first Palestinian Legislative Council (PLC) in 1996 by the biggest margin of any candidate. Very quickly he became disenchanted by Arafat's sidelining of the PLC and concentration of legislative power into the hands of the executive (that is to say, his own), and in October 1997 he resigned his seat. A member of the Palestinian National Council (the parliament of all Palestinians whether residing on the inside or in the diaspora), he walked out of it when Arafat silenced his objections to the unconditional amendment of the Palestinian National Charter.

When the intifada broke out in September 2000, he considered it, as a belated recognition of the accuracy of his analysis of Oslo, and a spontaneous revolt against Israeli bad faith, repression and continued settlement-building. Nonetheless, he was much more critical of the apparent rudderless meanderings of the unorganized uprising, deeply

concerned with injuries and the loss of human life on both sides of the conflict. He always condemned attacks against Israeli civilians. He thought the uprising should be run by a government of national unity, involving all factions, including the Islamists (Abdel Shafi 2002), and not allowed to become an end in itself. "We are not interested in fighting per se. Unless we are prepared and ready to fight a reasonable and productive battle, then we have to look for another way... Respecting the message of the Intifada does not mean that we should continue to sacrifice without any result. But we should suspend the negotiating process and then get engaged in seeing how we can improve our situation by using whatever potentials we have" (Bahaa 2001).

The anarchic and unorganized quality of resistance activities, along with negotiations for their own sake could only benefit the stronger Israelis ("We cannot continue with hopeless talks. Israel exploits our sitting at the table to add a cover for continued aggression on the ground," (Bahaa 2001), while discrediting the Palestinians in the eyes of world opinion. His profound humanistic values included irreducible opposition to the death penalty under any conditions (discussion of the debate in Palestine). In his quest for a way out of the impasse, he joined Mustafa Barghouti, Ibrahim Daqqaq and Edward Said in creating the Palestinian National Initiative, a grouping devoted to grassroots organizing and resistance activities, combined with progressive opposition politics and preaching national unity government in face of the ongoing emergency.

The link between medicine and politics is explicit in the case of Haydar Abdel Shafi, since his Gaza political network and later constituency was built on the clinic system which he played a key role in setting up. As some researchers point out (West et

al 1999), the very cohesive professional group constituted by doctors gives them a strong power base in comparison with other corporations or professions. Above all, the combination of professional competence, political integrity and personal charisma made him the Palestinians' ideal representative, relentlessly opposed for that very reason by both his own leadership and that of the Israelis.

Hamas partly owes its slow but inexorable ascent to electoral sovereignty in Palestine to the historic and continued leadership of medical doctors. Dr. Abdelaziz Rantisi rose to prominence through the period of collective exile in Marj al-Zuhour, Lebanon, imposed on the Hamas leadership by decision of Israel's defense minister Yitzhak Rabin in 1992. His uncompromising line and his virtues as a spokesperson shone through as he addressed the peoples of the world from the snow-covered hills of the southern Lebanon.

Rantisi became a refugee at the age of one, moving from the village of Yibna in the Ashkelon area to the Gaza strip in 1948. He studied medicine at the University of Alexandria, and was soon attracted to the Muslim Brotherhood. After completing his specialty in pediatrics, he returned to Gaza, and became head of pediatrics at the Nasir hospital in Khan Younis, a post from which the Israeli military dismissed him in 1983. He also taught at the newly created Gaza Islamic University from the late 1970s. Perhaps most importantly in his formative years, he contributed strongly to the proliferation of grassroots charitable organizations (with Israeli support) linked to the Muslim Brotherhood. This provided the popular base for the later growth of Hamas in Gaza. At the same time, he ensured the political hegemony of the Brotherhood in the Gaza Islamic

University, thus accelerating the creation of a class of technocrats and political leaders who successfully competed in all fields and at all levels with the PLO.

Rantisi was a founding member of Hamas in December 1987, and he was one of those who fought for a more proactive stance with regard to the occupation. Nonetheless, Israel continued to favor Hamas over the factions of the intifada leadership (Fatah, PFLP, DFLP, communist Party) and even to allow funds to get through to it, until a political reversal in 1991, following the organization's increasing resort to armed struggle. The deportation of Hamas leaders to Marj al-Zuhur followed, and Hamas increasingly came to embody, and to be described as, the gravest threat to Israel. Within this framework, Dr. Abdelaziz Rantisi was always understood to side with the "hardliners" along with the outside leadership, and in contradistinction to Sheikh Ahmad Yasin, who was more prone to compromise. Nonetheless, the Israeli government assassinated Yasin first, in March 2004, and killed Rantisi one month later, perhaps because his authority, bolstered by his professional profile and accomplishments, was becoming greater by the day.

Another noteworthy doctor in the Hamas leadership is the foreign minister in the first Hamas-led administration (formed in April 2006). Mahmoud Zahhar was born in 1945, and in the summer of 2006 remains the last surviving founding member of Hamas. He too was trained in Egyptian medical schools (Cairo and Ain Shams), from which he graduated as a surgeon. He played a key role in founding the Palestinian Medical Society, and Gaza Islamic University. Even though he lacked the language skills and charisma of Dr. Rantisi, he always took a major part in leading the movement, and probably has been elected its top leader in the wake of the Rantisi assassination. For years, he was the personal physician of Sheikh Yasin.

The political leader who is most visible as a doctor is Mustafa Barghouti. In his biography edited by Eric Hazan, Barghouti talks of his childhood. Born in 1954, he grew up in Ramallah. His father, who hailed from the village of Deir Ghassaneh, was an engineer and worked as an urban planner for the municipality of Al-Bireh, Ramallah's sister city. Barghouti comes from a clan that has always been active politically, and as such had always heard of prisons. During the mandate period, his grandfather and great uncle were imprisoned in Acre. In the 1950s, his family members were active in their opposition to the Anglo-Jordanian accords and in the beginnings of the pan-Arab movement. A number of his family members were condemned to ten or fifteen years in prison under the Jordanians. He was told that the first time he went to a prison had been at age two, to visit one of his uncles.

In 1967, he was 13. It was a humiliating shock for him to see Israel defeat the Arab armies, as it was for many Arabs. "How to explain the gap between the grand speeches [of Gamal Abdel Nasser] and the reality? It was a lesson never to be cheated by propaganda again." (Barghouti 2005:118). On the other hand, it was no time to recognize defeat, he and his comrades had to find ways to resist injustices.

In 1971, he began studying medicine in Moscow. Upon his return to Palestine in 1978, he worked at Makassed hospital. It is there that he and some of his colleagues started realizing that the hospital system was not sufficient, and in some ways redundant. They would treat patients who would go home and return with the same symptoms two months later. "We were telling ourselves: what are we doing here (...)? All of our work stops at the door of the hospital. We are losing our time and energy. We must find

another approach since three-quarters of the population live in rural areas or refugee camps." (Interview with Dr. Barghouti)

As we have heard from other doctors in the popular health movement, it is at Makassed in 1979 that a voluntary movement of doctors began organizing mobile clinics to respond to medical needs of camps under curfew. The refugees, then the villagers, could not believe their eyes: doctors leaving their hospitals and coming to them? Their warm welcome gave them the determination to continue. Soon they devoted one day a week to voluntary mobile clinics. This was the origin of the Union of Palestinian Medical Relief Committees (UMPRC).

I interviewed him in June 2005. He talked about the motivation of his generation of doctors as being part of a class-based reformulation of medicine. In the 1970s, with remittances and scholarships from the oil economies of the Gulf, many people from poor families in villages and refugee camps suddenly had the opportunity to study. Those who obtained the highest scores in the high-school matriculation exam (*tawjihi*) would receive a scholarship to study medicine. And the best students were often lower or lower-middle class villagers. The new graduates in medicine were no longer part of the urban elite. This restructured the medical establishment and represented a form of social upheaval within the medical profession.

Physicians, in whom, as "organic intellectuals" so much hope was invested by Palestinians that they were in many cases raised to the pinnacle of popular political movements, were, during the difficult days of the 2000 intifada the subject of numerous vilification stories.

The first institution to stand against the voluntary mobile clinics and the foundation of UPMRC was in fact the Palestinian Medical Association. The old guard tried to prevent interns from taking part in the mobile clinics by threatening to make the hospital administration fire them. In his interview-based biography, Barghouti notes that the medical establishment called them "the barbarians" because they packed their bags and drove down to the villages instead of staying in hospitals. But there were too many active new graduates hired by hospitals and involved in the popular health movement, and the establishment was gradually forced to give in.

The other party closely following their activities and trying to stop them was the Israeli occupation. In a media-covered event, the military came and arrested the whole crew of a Medical Relief mobile clinic. The reason for the arrest, they said, was that they had violated the Ottoman law of 1911 making it illegal for more than one person to undertake a particular act of volunteer work. The affair was covered by so many medical journals and medical associations, in Israel and worldwide, that they dropped the case. They released the medical crew but never abandoned their accusations. The popular health movement was one that they used all the means they could to quench, but it was spreading like wildfire.

Medical Relief had a larger vision than simply to change the medical establishment. It was not an organization created *for* doctors but one that was created *by* many doctors. Since its inception, it began calling for political and social changes. Mustafa Barghouti saw two reasons doctors went into politics and were interested in leadership. First of all, the gradual change in the class makeup of the medical profession gave some doctors the hope and ambition, as well as the potential space to vie for

political leadership. Unlike lawyers, for example, doctors could not make a lot of money in Palestine. Previously, physicians had been able to make money and remain isolated from the difficulties of life. But with the democratization of the system of education and the arrival of new social groupings, as well as the occupation, less lucrative possibilities presented themselves to members of the medical professions. And because of their travels, studies and professional activities, they became part of the educated middle class, while the nature of their practice, families and villages of origin kept them in touch with people's daily problems. The institutions that could separate doctors from the public don't exist in the same way as he has seen them in the U.S. for example. The distance between the patient and the doctor is not an individual distance buttressed by divisions of class, origins and space. The doctor enters the clinic and feels he/she is in direct contact with her/his society and patients. A few weeks into their career, doctors are in immediate touch with people's daily problems, and from this they reconstruct their social understandings.

"Little by little, doctors realize that no matter how good they are in strictly medical terms, they cannot change the ocean. To do this, a doctor must transform the social and political situation."

"This is true for most Third World countries," Barghouti concludes. "But in Palestine it is more dramatic because we are under occupation. In Egypt, for example, the feeling must be less dramatic because the doctor feels that the country is there and life is there. Nobody is leaving. They have a bad system. There is injustice but that is where people live and will remain. Nobody is leaving; nobody is making them leave; their families' land is not being confiscated; nobody is taking their land. Here, in Palestine, we

have an existential problem, overwhelming every aspect of life. That is why you see doctors feeling the drama and urgency of our lives and participating in politics."

These and similar considerations led Mustafa Barghouti, after years spent in the Palestine Communist Party (after 1990, the Palestine People's Party – PPP) to play a key role in the creation in 2002 of the Palestinian National Initiative, *al-mubadara al-wataniyya al-filistiniyya*, or *Mubadara*. He had been prepared for such an evolution of his work during the years of organizing at the UPMRC. The idea behind the *Mubadara* was to conduct political activities at all levels simultaneously, by basing their national-level political platform on concrete grassroots actions in favor of social change and resistance to occupation, without the ideological baggage of the communist movement.

"Without Medical Relief, I personally would probably not have been able to develop, with others of course, the concepts of what became the basis for the *Mubadara*, it was one step further from being a social movement in health to being a political and social movement for the whole country and in all areas. So that is what distinguishes the *Mubadara* from every other political movement, having a social program. The others may have slogans but there is not a consistent, proactive, daily interaction of dealing with the social issues whether it is the strike of the lawyers I've just been to visit demanding the rule of law, or supporting women's right to have a quota [guaranteed minimal representation] in the parliament, or protesting acts of violence against women, or fighting in favor of the rights of disabled people, or the teacher's strike which has been ongoing since 1998..."

"*Mubadara* is working with doctors who are on strike in Gaza because of unemployment among doctors. But we don't want to replace other institutions. It is a

movement that tries to connect with other institutions. We don't want to be providing services for instance but we want to link to those institutions which provide services and defend rights and provide a political umbrella and platform that can help advance... because my belief is...why do we need political groups? You could have students doing a good job in their work and fighting for their rights, you can have women...but very frequently these groups end up on their own, without the solidarity of other groups in society. It is very difficult to achieve anything alone. That is where you need a political movement as a bridge to hold together these movements."

Most notably, in this explicit and increasing politicization of his public life, Barghouti has never discarded his medical activities. He appears at the scenes of Israeli destruction and killings in an ambulance, and helps with rescue and relief work. During the Israeli siege and attacks on Gaza in June-July 2006 he was in the Strip, launching an appeal for international assistance in reopening passageways to medical and other supplies. He is not media-shy, and belongs to a much younger generation than his mentor, Haydar Abdel Shafi. Dr. Barghouti went through two significant political tests after the death of President Yasir Arafat in November 2004. First of all, he ran in the presidential election that followed in early 2005, and managed to achieve a significant score of nearly 20% against Mahmoud Abbas – Abu Mazen, the officially invested PLO candidate and for years the heir apparent. With slightly over 60%, the new president could claim full political legitimacy as head of the executive branch. But Barghouti had managed to open a "third way" suitable to those in the society who were not willing to vote for the failed Fatah "official" party, or for the religiously inspired opposition under Hamas (which by calling for a boycott, had caused a nearly fifty percent abstention on the

part of a highly politicized electorate). The future seemed promising for the third way and for Dr. Mustapha Barghouti who had demonstrated its potential.

The second electoral test came in January 2006, when the Palestinian Legislative Council (PLC) was renewed ten years after it had first been elected under the terms of the Palestinian autonomy. In the meantime numerous other groups and individuals had identified with the secular "third way" and, under a variety of denominations they ran their candidates and lists. Because of a culture of political division, because of personality clashes and because of authentic political differences, they ran against each other more than against the heavyweights, Fatah and Hamas. And because of the vehemence of the competition, and because of the wish to vote "usefully," most people chose Fatah or Hamas, with the latter carrying the day.

The independent, secular candidates did rather poorly. Four lists squared off against one another for what at best still only represented twenty percent of the electorate (based on Barghouti's presidential score): they ended up with a total of about half that many votes in all (ten percent). The PFLP thus obtained three seats in the new PLC; the Palestinian People's Party-DFLP-Fida coalition, Hanan Ashrawi and Salam Fayyad's "Third Way" list, and Barghouti's coalition "Independent Palestine – *Filasteen al-mustaqilla*) two each. Barghouti was elected, along with Rawiya Shawa of Gaza. The *Mubadara* has thus not had a heavy electoral impact to date.

But this purely electoral account of the fortunes of Dr. Barghouti's political campaigns should not obscure the fact that he occupies a significant space in the Palestinian elite spectrum, as someone who relentlessly cleaves to the grassroots

mobilizing and organizing trail, and at the same time labors to bring about change at the society's helm.

Conclusion

As I have attempted to show in this chapter, the medical profession provides great social and political opportunities in Palestine, but it also contains many pitfalls. Although the doctors who were vilified in the stories I heard and read were not top political leaders, the latter do not escape the critical scrutiny of the people, and their position is never secure once and for all. They are, so to speak, subjected to repeated examinations, which they may pass or fail. So it is that Dr. Abdel Shafi, despite his belonging to the old caste of Palestinian notables, made a successful transition to political authority during the period of social change in the profession and the arrival of the Palestinian Authority, despite the latter's concerted efforts to marginalize him. Dr. Mustafa Barghouti's political fortunes have seen rises and falls. As for the doctors subject to vilification stories, they too can have a reversal of fortunes, and reappear in a position of responsibility, as shown in the case of Dr. T. in Balad. Doctors are simultaneously glorified and vilified.

CHAPTER 4

The Strangeness of the Ordinary and the Familiarity of Miracles

Introduction:

This chapter explores two sets of birthing stories. One revolves around the ideal of "natural births" (*wiladaat tabi'iyya*). The other focuses on birth under extreme conditions (at checkpoints, in prison), told often with redemptive overtones ("princesses of struggle"). "Natural birth" means normal vaginal delivery in sharp contrast to cesarean section, and sometimes also to the use of analgesia. "Natural birth" can sometimes mean birth at home with a midwife as opposed to the hospital. The desirable "natural birth" thus internalizes certain institutional, medical and technological routines, and rejects others. It is part of a discourse regarding imagined optimal conditions for birth as well as the existing centralizing and decentralizing medical system and the state pre-and post-Oslo (1994), and after the outbreak of the second intifada (2000).

The first set of stories about natural birth is told by mothers, midwives, dayat and the doctors of the childbirth networks. I will talk about seven of these women. I visited the women who gave birth in this chapter twice and interviewed each one individually in her home. As for the doctor and midwife who appear in this chapter, I met, interviewed and worked with them in their clinic and hospital over the course of the fieldwork. With the help of a transcriber, Mahmoud Al-Adawi, we transcribed all the interviews and typed them in a form of written Arabic dialect. Later, I translated the transcriptions,

trying to keep the register and tone of the interviews. Combining my field notes and transcriptions, I have reworked our interviews and encounters in the form of written stories about birth.

These women talked about their births with very little drama. There was something ordinary about the tone they talked in. Maryam, Rima, Rawya and Rama all frame their births within the context of travel from home to the institution and back home. The space of the institution is what they remember most, a place which can be difficult to get to because of checkpoints and a place which registers differences of class and origin. It is a socio-economic space organized by an increasingly stratified society. In this space, the services for the rich are couched in words to make you feel better. But in the end, it is a birth, what matters is getting back home with a healthy baby. At times, they remember something the nurse or midwife told them. Very little do these women talk about the routines of medical practices. These have been internalized as an inherent part of the experience of birthing not needing mention. These narratives show the ways in which birth has become one of the moments when women are in contact with institutions of medicine in the city.

The second set of birthing stories about checkpoints and prisons, illustrated with four cases, are co-constructed by reporters and interviewees and appeared in the local press. I read the two main local newspapers (*Al-Quds* and *Al-Ayyam*) everyday while in the field, collected articles about health, medicine and birth and have translated some of them (see Appendix). They are sensational, focus on oppression, suffering and outrage. They are about the intifada and struggle against occupation. They are redemptive, beginning with labor and ending with the naming of new life.

The juxtaposition of these two sets of stories brings forth the question of how everyday life is transformed in the engagement with violence, and by extension, what this notion of the everyday as a site of the ordinary is. What is the everyday in a context where daily existence is characterized by extra-ordinary events? What can we say of everyday life in a "violence prone zone," or in a "culture of violence," terms that give inhabitants of this place a specific form of (dangerous) subjectivity. At stake here are notions of the normal, the ordinary, the everyday, the pathological, the violent.

The global circulation of images and narratives from this war-torn zone forged through practices of nation-states and images that cascade through the global media form collective identities and shape everyday personal relations. Arjun Appadurai states it as follows: "Macroevents, or cascades, work their way into highly localized structures of feeling by being drawn into the discourse and narratives of the locality, in casual conversations and low-key editorializing of the sort that often accompanies the collective reading of newspapers in many neighborhoods and on many front stoops of the world. Concurrently, the local narratives and plots in terms of which ordinary life and its conflicts are read and interpreted become shot through with a subtext of interpretive possibilities that is the direct product of the workings of the *local* imagining of broader regional, national, and global events." (Appadurai 1996) This chapter proposes an analysis of the specific interrelations of the institutional productions of the Palestinian press and the local narratives of ordinary life.

The reporters and interviewees in the newspapers produce a story of heroes, ideology and nation-states in a tone of drama and outrage. They write of repetitive but

specific events. In their telling of the birth story, women talk of the quotidian quality of war in a tone of the ordinary. They write of a constant reality.

There is a notable parallel here to Miriam Cooke's discussion of the group of women writers she calls the Beirut Decentrists. In *War's Other Voices* (1996), Cooke describes how the writings of women during the civil war in Lebanon is different from that of men, how instead of writing of strategy, ideology, violence and existential angst, they wrote of their daily entanglements with moral and emotional matters of war-life and of their abandoned loneliness. There are important differences between the cohorts of young women I describe and the Beirut Decentrists. The narratives of birth are oral stories that I turned into writing. They are by women from a variety of social backgrounds (poor, middle class, rural and urban) whereas the writers in Lebanon were middle class urbanized women. They speak from different societies, in terms of both politics and bellicosity. However, Cooke's attention to local modes of thought, audiences and expressions provides a unique access to the experiences of women and men in Beirut during the war. I attempt in the dissertation to use the comparative tools she presents to shed light on experiences of women and men at different moments in family histories.

The relation between the local structures of feeling and the large events that work their way into local communities is not easy to describe. Commenting on the diachronic dimension of this linkage, Appadurai (1996) suggests that local readings of macro events or cascades become shot through with local imaginings of broader regional, national, or international events. He goes on to state, however, that "the trouble with such local readings is that they are often silent or literally unobservable, except in the smallest of passing comments...They are part of the incessant murmur of urban political discourse

and its constant undramatic cadences. But people and groups at this most local level generate those structures of feeling that over time provide the discursive field within which the explosive rumors, dramas, and speeches of the riot can take hold (153)."

The juxtaposition of the un-dramatic, ordinary stories of women's birth with the sensational birth stories from the press, evokes precisely this question—how do cascades of images and narratives in the press affect the structures of feeling and everyday life and how do local structures of feeling provide the discursive field within which the speech of political/nationalist/mass mobilization takes place?

In his work on the "oppositional practices of everyday life," Michel de Certeau analyzes everyday practices as spaces of social transformation. The workings of transformation, the openings and foreclosures of social space for political intervention, the subtle changes of meanings in dominant discourses is what concerns de Certeau, and what I find important for an ethnography of resistance. He talks of the everyday practice of reading as anything but passive. The reader changes the text as he turns the readable into the memorable. "He poaches on it, is transported into it, pluralizes himself in it like the internal rumblings of one's body (...) A different world (the reader's) slips into the author's place. This mutation makes the text habitable, like a rented apartment. It transforms another person's property into a space borrowed for a moment by a transient. Renters make comparable changes in an apartment they furnish with their acts and memories; as do speakers, in the language into which they insert both the messages of their native tongue and, through their accent, their own 'turns of phrases' etc... their own history" (de Certeau 1984). The practices of everyday life flourish in the interstices of institutional technologies and dominant discourses and are often accompanied by

disruptions and gaps in dominant discourses that open the space for subtle transformations in social and personal readings.

In the juxtaposition of women's birth stories and stories from the press, it is very hard to discern who is the speaker and which is the language, who the renter and which the apartment, who is the reader and which is the text. In the local context, it is hard to discern which is the dominant discourse and which the oppositional practice. They both are poaching from each other and transporting themselves into each other.

In their act of reading the birth stories in the local media and retelling their own to me, the women transform the birth story from one of ideology and nation-states to one of daily life; from a tone of drama and outrage to one of a register of the ordinary. By doing so, they form an oppositional discourse to the grand narratives. They render the outrageous, frightening text and experiences of births in Palestine "habitable," ordinary actions.

And yet part of the retellings of birth as the everyday and ordinary leave an eerie silence regarding anxiety, the fear of the birth experience in this context for example. The interviews are interspersed by rare but recurrent cadences pointing to the everyday ecology of fear and anxiety in which life is lived in this zone of violence and emergency: "I was afraid I would have to give birth under the eyes of the soldiers," "It was at the time when Arafat was under siege. The middle of the night. The roads were empty." With the addition of these rare phrases and so much silence, there is something of the uncanny in the ordinary. Tomorrow can not be taken for granted or trusted. The tone of the ordinary becomes a register of skepticism. There is something a bit off. When they went into labor

they were not safe even if they never left their home. They needed the medical assistance. They had to travel the streets of checkpoints. But this is the story of the ordinary.

The media coverage of checkpoint and prison births taps into this affect of fear and anxiety and are part of its ecology. They are dramatic and produce feelings of outrage and anger against the occupation. They have a redeeming quality to them. The jailed women can no longer fulfill their family responsibilities but are given the social and political roles of resistance fighters and political prisoners. The checkpoint births end with the naming of a new (Palestinian) life or in the mourning of a dead newborn who becomes a martyr. While outrageous and frightening, it is a utopian space in which there is almost a miraculous possibility: a new life in injustice, an order of things that seems immutable.

If the silences or ephemeral references regarding fear in the women's narratives are haunting, the dramatic representations of suffering in the media are almost unbearable. They are too close to us. Commenting on the global flows of photographs of suffering, Susan Sontag states that they "are a means of making 'real' (or, 'more real') matters that the privileged and the merely safe might prefer to ignore," (2003). But in this context, the viewer of the photographs feels very close to the sufferer. He/she identifies with the sufferer. No one really feels safe even at home watching the photographs. The women in labor seeing the images are waiting, expect to be stopped at a checkpoint. The birth stories in the media are not "Regarding the Pain of Others," Sontag's title for her book. They are potentially their story tomorrow.

The Strangeness of the Ordinary

In the following section, I will relate four birth stories. The ways that women of this generation use the infrastructures of birth vary. Some arrive at the hospital to push and deliver the baby. Others go to a private hospital and get analgesia and don't remember much of their births. Others give birth in the government hospital and wait for the end of the 24 hour admittance policy before they wash off their babies. All these are natural births. In general, having a natural birth points to a medical order of birth. It means the woman did not have a C-section and usually it means that she did not get analgesia. It is more or less equivalent to the "normal" births of medical manuals. The medical institution in the form of the hospital with its routine administration of IVs and oxytocin has become the natural way to give birth. It is the desired way to give birth. As the mother-in-law of a woman I was interviewing interjected at the beginning of an interview: "I am happy with all my daughters-in-law. They had natural births."

This section of the chapter tells stories of four Palestinian women I met in and around Ramallah, each of whom had given birth in Ramallah medical institutions. Their stories are informed by media accounts that I will present in the second section of this chapter. They are more complicated and told in an ordinary register. They do not repeat the sensational and heroic meanings of newspaper articles. The ordinariness of their discourse signals the internalization of the modern ways of giving birth in an institution as well as their repeated experiences with the system of occupation.

In the introduction of the dissertation, I showed that the recent history of the West Bank and its topography is replete with national, territorial and political events. It may

thus seem confusing to invoke a discourse which asserts the ordinary and every day nature of something like giving birth. Yet I introduce this discourse to show its very specificity, not to universalize from it. I present these four stories to bring forth two points. First, I draw attention to the entanglement of Palestinian women with medical institutions. For a birth, women cross checkpoints to get to an institution of medicine. What they remember most is the journey from home to hospital and back home as well as the inside of the hospital in which they give birth. The space inside the hospital, with its rooms and its cleanliness signifies class belonging, wealth and national histories. Second, I come back to the issue of the register of the ordinary in these stories of giving birth to show the difference between them and the birth stories in the local press. It is not to discard the stories in the press as untrue or even exaggerated but to explore the stories of these four women as situated social commentary. In these stories, these women disrupt the flow of legitimate knowledge regarding birth. They tell the story of birth as a story of institutions, checkpoints and nation-states as does the press. However, they tell of the dailiness of occupation and national struggles not of heroes, ideology and strategy. Furthermore, there is an uncanny silence regarding the ecology of anxiety during the second intifada. The references to fear of the birth journey and experience are practically muted. In some cases however, I designate a moment in the story where the figure of anxiety emerges.

Maryam-

Maryam gave birth in different types of hospitals. All were natural births. She comes from a large village near Ramallah. She had her first two children at Ramallah Government Hospital. Her third was in a private Ramallah hospital (*al-Mustaqbal*)

because they now had health insurance. At the governmental hospital, it was too crowded. The care at Mustaqbal was better. Here, she only had one woman sharing her labor room. The bathrooms and labor rooms were clean. There was a curtain between her bed and the bed of the other woman in labor. A midwife assisted her birth. She could not afford a doctor. She would have had to pay 500 NIS ($115) to have a doctor present. She knew that all was normal and that the baby's head was low. Why would she need a doctor? If there had been any kind of problem, the hospital would have sent the doctor on call.

Earlier that day, she had cleaned the house and cooked until around 2PM. She started feeling something in her sides that came and went. She thought that maybe she had walked around so much that she was just tired. Then she started feeling pains. She played with the children until around 11 PM, when she decided she should get checked at the hospital. Actually, she had never liked to go to the hospital early in the labor. They will speed things up or make her suffer somehow. She figures out herself when she is ready to go to the hospital.

This was a common feeling. Many women I spoke to and saw at the hospital had arrived when they thought their labor was quite advanced. They often would be walking in front of their homes or in front of the hospital before they entered the labor room. Arriving "just in time" was a way to continue the lay practice of walking during the first phase of labor. This is also proven to shorten labor in medical books although it is rarely practiced inside the hospital because it is cumbersome to have people walking around and because it is harder to use monitors. It was a way for women to give birth in the institution but labor outside of it.

The issue of not getting to the hospital "in time" for the birth was however raised by some women to deride women from another class. "She could not keep up with herself," "she did not know when to leave for the hospital," were statements intended to designate the more rural, less modern people.

Maryam arrived just in time. She gave birth a half hour after her arrival at the hospital. She stayed there for 24 hours. Her husband tried to get her out earlier but the doctor would not let her leave until the 24 hours had gone by. Those are the rules. The next day the doctor checked her and her newborn and discharged them.

This too is a common scenario. In almost all birth narratives, the husband tries to get his wife released before the minimum of a 24 hour stay after delivery. I witnessed arguments between husbands and personnel in the hallways of hospitals regarding the early release of women who had given birth. In some birth narratives, women said that their husbands were able to get them released earlier than the 24 hour minimum which showed influence. In addition to this personal aspect, these enactments of conflict between husbands and medical institutions told of the difficult situation on the roads. Everyone wants to get back home quickly. Furthermore, they were signs of discomfort on the part of husbands that institutions of medicine imposed protocols on the movement of their wives.

The timing of the arrival and the timing of the "release" is about a socio-economic space organized by a stratified society. The stratification pits an immemorial struggle between the rich and powerful and the poor, rural or Bedouin. It is presented as a space of constant victories by the rich. A villager waiting for his wife to be released from the government hospital and complaining that they will not let him take her home states it as

follows: "he who has money, shits on the world." The new economic order with a Palestinian Authority and a deeper gap between the rich and the poor is a cover for the immemorial class system. Being well connected with the ruling class/Authority has just come to be added to wealth as a source of capital and influence on the hospital.

The timing of the release is also a gendered space. The husband wants his wife released from the hospital because "he wants to take care of her" or "she does not speak Arabic and will not know what to do in the hospital." The wife wants to be released from the hospital because "she worries of the state of the roads and of checkpoints." Women tell of their husband's influence or lack thereof by referring to the time of their release. At other time periods, before the intifada, researchers observed that women wanted to give birth in hospitals because it would give them a 24 hour break from housework (communication with Rita Giacaman). While the stratification is talked about as immemorial, it seems that the current economic and political order has intensified the feeling of injustice.

The time of arrival at the hospital is stratified differently. It is field of equal opportunity where the hospital can not impose its protocols. Doctors and midwives complained of never being able to plan anything because women arrived fully dilated and the hospital personnel had to run to the delivery room to catch the baby. But the class system emerges nevertheless in a discourse which puts down the uncivilized who "does not get to the hospital in time" or who "could not keep up with themselves."

In the private hospitals, Maryam explained, the midwives study women's states of mind. It is as if they have studied how to take psychological care of birthing women. The midwife was very nice, asking how she was doing and speaking to her as if she herself

was feeling what she felt. Maryam had arrived at the hospital for a checkup because she was feeling contractions. Upon arrival, the midwife looked at her and said that it looked like she was going to give birth. She knew already. She could feel it. She checked her and sure enough she was dilated 7 cm. She was definitely well into labor. Maryam told her friend who accompanied her that she should scream before labor was over! They laughed. The midwife walked her over to the delivery room. Within a half hour she had given birth.

Maryam thinks that the private hospital needed to show her that they offered her something out of the ordinary. They came and asked about her. They checked her and the newborn in great detail. They even gave her something, vitamins. They made her feel important. On the other hand, at Ramallah hospital there were people coming in and out as she was giving birth. There were a lot of women giving birth at the same time.

The main difference was the psychological support she got at the private hospital. Next time she gives birth, and assuming everything is normal with her pregnancy, she will simply go to the governmental hospital because it is unlikely that they will have insurance again. And while the care at private hospitals is better, it is not worth paying for.

The hospital is a socio-economic space where the services for the rich are covered up with nice language. But in the end, it is only a birth, an ordinary, everyday event. What matters is getting back home.

Rhoda Kanaaneh (2002) has called the use of reproduction and family planning as a register of difference and modernity in the Galilee a "reproductive measure." As Maryam's story has shown, this measure of difference appears in the ways people

imagine, talk and use the space of the hospital. A recent public health paper analyzed the Palestinian Central Bureau of Statistics 2004 Demographic and Health Survey to explore a mother's satisfaction with places of birth (Giacaman et al. 2006). The authors found that the highest preference was given to private hospitals, followed by private doctors' clinics, followed by government hospitals, followed by home births (Giacaman et al. 2006). In part, this ladder of preferences reflects the values given to high technology, specialized medicine and expensive goods consumed by the wealthier classes. It also reflects the current situation where home births are usually unplanned or the result of not getting through to the closest hospital.

The preference for different kinds of medical practices and caretakers fluctuates with the political situation too. One hospital midwife remarked that during the Oslo period women requested specialists and high technology. After the outbreak of the intifada in 2000, birthing women put more importance on a close relationship with the midwife and emotional support to give birth normally.

The private hospitals like the one Maryam gave birth in have all the technologies and drugs available in the country, specialized doctors and private labor rooms. "They are as good as if not better than Israeli hospitals such as Hadassah," one doctor who worked in one of these hospitals told me. As Kanaaneh shows, Palestinians have reproduced the Israeli discourse of Arab backwardness and Israeli advancement. Technology and medicine have become the terms for the distinctions. These private hospitals are part of services that opened during the economic bubble of the 1990s when Palestinian businessmen were investing and opening businesses in Ramallah and other cities of the West Bank. New private hospitals were established with the latest equipment and

comfortable furnishings, with the expectation that Ramallah would become the Amman of the West Bank and appealing to the consumer class, which had formerly gone to Jordan for special treatment. New services were also offered, such as infertility treatment and in-vitro fertilization. Advertisements for such services were put up on the billboards along the roads. Driving from Ramallah to Birzeit, a nearby village with the oldest Palestinian university, one would notice a large sign advertising an in-vitro fertilization clinic in Ramallah and the following enormous billboard informing the passers-bye that USAID provided them with clean water. Goods for consumption such as Coca Cola, Levi's Jeans as well as private hospital care gradually flooded the market. With the closures and economic crisis during the Intifada, some of these hospitals had to shut down; others had to bring down their birthing fees; some had to institute birth attendance with a midwife, where formerly it had been only with a private obstetrician, in order to attract more women and charge less. Nonetheless, these private hospitals remain more expensive.

Political analyses of the eruption of the second intifada have interpreted it as both a reaction to the Israeli policies of closures and land seizures during the ten years of Oslo and as a movement of anger against the new economic and political order of the Palestinian Authority (Heacock 2005) The narratives of birth lay bare the intense ways people were living and perceiving the increasingly stratified socio-economic order.

There was not one reference to the order of occupation in the interview until the very end. She said: "next time I give birth...I will go back to the government hospital because it is unlikely that we will have insurance again. The care at private hospitals is better but not worth paying for. Of course, I always imagine that I could be stopped by a

checkpoint or something. I know myself to be courageous but I still have this feeling of fear. Who knows what will happen in the next moment. If I can't leave my village when I am in labor, there is a doctor who assists birth in the village. That is a bit reassuring."

The ecology of anxiety that Maryam is referring to only appears in the last few sentences of our interview. It is made up of checkpoints and a future that is unstable and unknowable. Checkpoints appear and then disappear but only to reappear. Hospitals close down for periods of time, then they reopen. The private hospital where she gave birth closed down for more than a year because it was located close to one of the checkpoints around the city of Ramallah where there were daily confrontations between young stone throwers and the army. Her reference to this world of instability and anxiety is so ephemeral that it appears as an uncanny specter at the end of our encounter.

Rima-

Rima is from Jerusalem but lives in Ramallah. She is employed by an NGO. Her husband is a civil servant for the Authority. She had a natural birth at a small private doctor's clinic near Ramallah. The labor room was small but agreeable. She was in the labor room with her mother and a midwife. Her mother had not wanted her son-in-law to be present in the labor room but next time Rima will make him be with her so that he knows what it is like to give birth, so that he sees from up close the pains of labor. Rima's sibling and father were all waiting in the adjacent room. The first midwife who cared for her actually did not care much about her. Then the shifts changed and she had a wonderful midwife, older and very supportive. The midwife and Rima's mother stayed with her for her whole birth. In the end, her doctor walked in for the delivery. She likes

him very much. He is gentle. She was given a drug, an anesthetic. She does not remember much of the delivery. She remembers that as she was pushing, feces came out, the room started smelling bad. She remembers saying "sorry, sorry, sorry". The doctor was supportive and said it was ok, that she should just push the baby out. Then, a blank. The next thing she remembers is her asking her sister who was now in the labor room with her if her baby had all her fingers.

The private clinic was strategically located for them. It was in an outskirt of Ramallah which is part of the administrative borders of annexed Jerusalem. She needed to give birth in annexed Jerusalem in order to pass on to her daughter a Jerusalem ID. She was well aware of the importance of Jerusalem IDs and of the efforts of the Israeli Authorities to make it difficult for Palestinians to receive and renew them. Her sister had to hire a lawyer and go to court because the Israeli authorities were questioning her right to a Jerusalem ID. She did not have enough proof of residence in Jerusalem (she is from Jerusalem but never resided there). Between the ages of 16 and 18, her sister had to manage without an ID while the courts were taking a decision about her case. She finally won the case and received her ID. Her sister's experience with the authorities made her ever so conscious that she had to do everything necessary to secure her daughter a Jerusalem ID. This clinic was exactly right. She would get the right papers and she did not have to drive down to the city of Jerusalem. She was afraid of the wait at the checkpoints and did not want to give birth in a place her husband could not reach. The clinic was ideally located: her daughter would receive a Jerusalem birth certificate, she would not need to cross checkpoints and her husband could be with her.

Rima gave birth with a form of analgesia. In many cases, women refused analgesia and in particular, the epidural (*ibrat il-dahr*). The accompanying mothers or mothers-in-law, in particular, often said that the epidural may cause harm to the newborn and makes it harder to push the baby out. Many times, the expression "I had a natural birth" is followed by an affirmation that they did not have an operation or an epidural. For Rima, having a natural birth simply means having a vaginal birth.

Rawya-

Rawya gave birth on the 10th of July 2002. It was a hot night. The roads were closed but the ambulance was permitted to cross the checkpoint. It was during the time when Arafat was under siege in his compound. It was the middle of the night. The streets were empty. Her husband went to get a taxi to take them to the checkpoint. She waited for a long time. The car arrived. They drove to the checkpoint. She got off with her husband and mother in law. The main road between her village and Ramallah was empty. Even the checkpoint was empty. There was only a barricade made of huge rocks. They walked across the checkpoint. There were no push-carts at that time of night (around checkpoints, one could hire a push-cart or a horse and carriage to be carried or to carry suitcases across the checkpoint). The ambulance could not pass the checkpoint. It waited for them right behind the checkpoint at the top of the hill. She was still in the eighth month of her pregnancy and she was in labor.

I remember as I was listening to her narrative, I thought for a minute that her story may have a disastrous ending even though she was holding a healthy baby while she was telling me the story. She was in labor prematurely. It was the middle of the night. The

emptiness is scary. The time when Arafat was under siege was a time when roads that lead to villages were feared during the night. Palestinian sharpshooters aimed at passing settler cars. But people said their weapons were not very effective and they missed their targets most of the time, making you a possible target of a lost bullet. People said they could not really tell who was a settler and who was not. They just assumed that a car driving the unsure roads were settler cars.

But the rest of her narrative was just ordinary. She went to the Red Crescent Maternity Hospital in Ramallah. She walked into a room. There were three beds in that room. But that night, she was alone. A nurse came and closed the curtain around her bed so if another woman arrived, she would have some privacy. There was a bathroom adjacent to the labor room. Everything was very clean. The midwife assisted her birth. She does not remember her name. She was a foreign woman. The three foreign nurses I had come across during my work in hospitals were two Russians and an American who were married to Palestinians. She does not remember what they said to each other. She barely remembers her presence. She just remembers that she would come to check her to see how dilated she was. At the end of the birth, the midwife came back with a doctor because it was a premature birth. The baby weighed 1.9 kg. They put him in an incubator for 13 days. Then, she took him home. They had thought of giving birth at a private hospital but they chose the Red Crescent because it is the only non-government hospital with incubators.

Since Israeli occupation, charitable NGO hospitals such as the Red Crescent Hospital and Makassed for example developed as the Palestinian national institutions because the governmental hospitals were controlled by the Israeli military. They are

much cheaper than private hospitals but more expensive than the governmental ones, where birth assistance is free of charge. The services and space of NGO hospitals vary. El-Bireh Red Crescent Maternity Hospital, as we have seen, has incubators. However, the labor rooms are much smaller and there are at least two hospital beds per labor room. At Makassed in Jerusalem, also a charitable NGO hospital, women have private labor rooms.

The setting for the scene of her birth story is frightening. The denouement is ordinary. The ordinary is strange in this scenery of anxiety.

Rama-

Rama is from the same village as Maryam. Her husband works in construction. She takes care of the children. She prayed during the pregnancy for the contractions to start during the day and not at night. She thought that if her labor came at night, she might not be able to get out of her village "Thank God, both girls came during the day. One in the morning and one mid-day." She went to her father's house and from there she went to the checkpoint. Her husband spoke with the soldiers. They said they would not let her through. Her husband begged saying that Rama was going to give birth. They said they wanted to see her. Rama went up to the soldier. He saw that she was tired and let them pass to get to the hospital.

She gave birth at Ramallah governmental hospital. The hospital was crowded and dirty but she liked it. She remembers that there were two rooms. One is huge where women stay during labor. And then there is a smaller room where the woman is taken to deliver. The door stays open between the two rooms. When she was taken from the labor

room to the delivery room, she was screaming. The other women in the labor room were waiting, waiting for their turn to deliver. They chanted words and prayers to support her. She felt so tired when she went into the delivery room, she cried out to the other women: "I want to die, come help me." All she could hear were the laboring women's words coming through the door. Then, after delivery, she was taken back to the labor room for recovery. She talked to these women whom she did not know but nevertheless felt close to.

The narratives about birth in government hospitals evoke the sense of community of the insurgent peasantry as described by Ranajit Guha, the founder of the Subaltern Studies Group. Commenting on Guha's notion of peasant consciousness, Partha Chatterjee writes that what "the principle of community as the characteristic unifying feature of peasant consciousness does is directly place it at the opposite pole to a bourgeois consciousness." (1993:163) Whereas the bourgeois consciousness operates on the basis of interests rationalized in the form of preferences, the peasant acts on the basis of "bonds of solidarity that tie them together [which] already exist." The primacy of community as a principle comes through very strongly in the interaction replete with solidarity between women in labor in the labor and delivery rooms of governmental hospital.

At the government hospital, they don't bathe the newborn. They don't have the facilities for that. They just wrapped the newborn with the cover that she had brought to the hospital. She has 24 hours to spend in the hospital before she is discharged. She took the baby in his cover and washed him at home.

The "Return" Home

Now that I have specified the contours of births as a journey across checkpoints between home and the institution of medicine and back home, I draw attention to the ways the discourse of the childbirth networks and neighborhood clinics that seek to relocate birth "back" into women's neighborhoods is present in all the narratives of institutional births. A close reading of the first four cases shows that the "return home" is implicit in the stories of the women who have chosen the institution: they want to return home immediately; they are concerned about the roads; it is as though they wished the institution were located in their home; they yearn for a hospital birth at home. This is clearly reflected in their interactions and those of their families with the hospital administration.

During the intifada which began in 2000, access to maternity facilities became even more difficult, with hundreds of checkpoints cutting up this small territory into pieces. There were 99 reported births that took place at checkpoints between September 2000 through 2003,[20] among them 54 reported stillbirths or neonatal deaths (National Report of the OPT, 2004). There were 368 reported cases of stillbirths overall, including in hospitals and at checkpoints and 104 000 live births.[21] Pregnant women frequently spoke of their anxiety about how they would get to the hospital to give birth and then

[20] A public health expert told me this number was underreported. Sooner or later after a birth at a checkpoint either the woman and her newborn get to a hospital or a health worker arrives at the scene. The birth is reported as either born in the hospital they reached or assisted by the health worker (i.e. in his or her clinic). This would be one explanation for the terrifyingly high rate of stillbirths at checkpoints (i.e. the total number of checkpoint births are underreported). Another explanation is that during curfews those women who do all they can to get to a hospital for their births are women who go into labor prematurely or have other types of complications. Of course, the stress and anxiety level is quite high during these births and that also affects birth outcomes.

[21] These figures are also based on reported cases of stillbirths. Some hospitals reported having no stillbirths at all during that same time period. According to the public health analyst, this is not possible. Hospitals must have some stillbirths every year. The hospitals are not required to submit paperwork regarding stillbirths and therefore underreport them. The hospitals overlook this reporting because they have too little staff and because they fear repercussions of a bad reputation.

how they would get back home to their families. Doctors and midwives were solicited by telephone during curfews and closures to guide and support family members who found themselves assisting an emergency home birth. Several innovative health providers, who had been active in the grassroots popular health movement years before, decided to form a network to provide isolated pregnant women and their families with medical advice, emotional support, and step-by-step do-it-yourself directions of how to assist women in childbirth and take care of the newborn (See chapter 3 for an analysis of the childbirth network and clinic as infrastructure, business, politics and scandal).

The birth networks became the lifeline. An essential instrument was the cellphone, first designated as the "biliphone." Most people now were never without their mobile phone. Land lines could be cut off, whereas it was more difficult to jam the mobile phone. It was also a useful tool when waiting at checkpoints to inform others of one's whereabouts. The first company to sell these phones in Israel was called Pelephone, which was adapted in the Arabic dialect to 'bili' and this new device has kept this terminology, in spite of rival companies with different names who later joined the lucrative market. Pelephone in Hebrew means "the magic phone". More recently, the Palestinian monopoly Jawwal which means "mobile," has entered the market aggressively, and so most people in the West Bank use the new designation. The jawwal or biliphone, in the case of unplanned home births, became the lifeline. This medical network responded to immediate emergency needs, and then developed different components of a system helping women to give birth near their home, such as mapping the location of midwives and back-up obstetricians and training them in emergency obstetric care (Juzoor report).

"With this hotline and network", Dr. Siham explains, "we are also trying to convince women to have a natural childbirth at home or close to home. That way, we can avoid the fear, humiliation and danger of the road (...) So, I try to convince women to forget about the hospital. That it is safer for them to give birth close to where they live." And in a moment particularly reminiscent of the spirit of the popular health movement of the nineteen-eighties she says: "If we create a system where women can give birth close to their homes, that is what I mean by natural childbirth, then we will have succeeded in something extraordinary for our [Palestinians'] political aspirations".

Dr. Siham and some of the midwives and doctors involved in assisting births in women's neighborhoods and villages, have borrowed the language of the natural to describe a historical "return" to a woman's home town for the birth and delivery. It builds on the popular health movement's ideology of health care coming to communities rather than communities seeking health care in the city or from the state. It is part of the ideology that called on Palestinians to decentralize health services in order to empower the rural and underserved. The birth networks described by Dr. Siham are marginal in comparison to the centralized medical institutions and governments in a number of ways. Nonetheless, doctor's and midwives' clinics have become a common feature of life in the occupied territories, and many individual health professionals assist births in facilities or homes in their village. In the 2004 PCBS demographic and health survey, births in doctor's and midwives clinics were considered births with proper medical assistance and hence the high rate of 96% of births assisted in medical facilities. Only the births at checkpoints, assisted by a family member or a daya were read as non-institutional and without proper medical assistance. The statistic 96% of births in medical facilities does

not leave room to signal the emergence of a new infrastructure, that of doctor's and midwives' clinics.

In another account of a natural birth in the woman's community, I interviewed Dunia and Fatima, two sisters, in their village. Dunia was a midwife who assisted births in her village during the siege. Fatima, Dunia's sister, said that she was happy to be able to have natural births with the assistance of her sister. She had given birth on a mattress in the house that her family had built. Although the house was almost ready to be lived in, they had not moved there yet. She just crossed the yard from the house they lived in to the newly constructed house. She did not have to face strangers. She could move around as she wanted. She could squat and sit and the most important thing was that she did not have to leave her village.

Dr. Siham and Dunia are from very different circles. Dr. Siham is an obstetrician. She is originally from a village but lives in Ramallah. Until the 1990s, she was a leader in the popular health movement and worked at the Union of Palestinian Medical Relief Committees (UPMRC). Now she has a private clinic, participates in running the hotline and network of births and works in an NGO. Dunia is a midwife who works in a Ramallah hospital and lives in her village. She assisted births in her village during the closure and had to stop when the Ministry of Health sent her a notice explaining to her that she could not legally assist home-births except in times of emergency. Both health practitioners talk of births being natural if they take place in their communities. The idea of assisting births in women's neighborhoods or villages brings together a much wider group of medical professionals than the network Dr. Siham talks about.

Giving birth in a "maternity clinic" or in the "midwifery clinics" in villages is far from entailing a de-medicalized birth. Many of these clinics are "mini-hospitals". Some routinely administer the same drugs as hospitals. What is "natural" about them is their location in the community of the birthing mother rather than the urban center. The meaning attached here to the expression 'natural birth' is different from its common significance. It opposes birth in women's communities to birth in an urban medical institution. The childbirth networks politics and language tap into the anxiety women live waiting for their labor and waiting to see if they will get to the hospital in the urban center.

In addition, Dr. Siham talks of a "return" to the home or of "bringing back" birth to the home referring to a system of medicine and childbirth of an older generation. It is located in women's villages in which the institutions of modern medicine play a marginal role. In many birth narratives, a segment is about "how our mothers gave birth," referring to a generation who gave birth in their villages with the daya. By drawing attention to these parts of the narratives and to Imm Issa's story, I want to show how the current contours of birth are opposed to that of their mother's, how the notion of a natural way of giving birth is embedded in notions of nationalism in more than one way. Whereas today births take place in institutions, some older women look nostalgically upon birth the old way, the "authentic Arab" way, "as in nature," although they say it is a situation which is impossible to return to.[22]

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[22] For Rousseau (and for the European 18th century generally) the pursuit of happiness ("l'amour du bien-être," as he calls it) is the sole motive of human actions, and thus in a sense the purpose of living (Rousseau 1987:61). In this regard, the state of nature was far more successful in obtaining the purpose at hand than the current state of life in 'civil society', that is to say, under the terms of the social contract. In the state of nature, families were united in a "little society" based on love ("conjugal and paternal", p.63). Problems began arising with the division of labor ("the socialization process," in Rousseau's terms), which kept women at home with the children. Gender differences (p.63) and, in particular, patriarchal families thus

Imm Issa[23]

As I was interviewing Mariam about her hospital births, her mother in law, Imm Issa was interested in our conversation and spoke about the rapid medicalization of birth in Palestine. She gave birth to all her children alone with the village daya. The daya was her aunt (her uncle's wife). She was a very kind and wise lady. Imm Issa used to give birth and barely know how it happened. After birth, she wished she had had ten other children. She would give birth, get dressed and go down to get water from the spring and clean everyone's clothes. She never had to be bedridden after birth. She would keep on with her daily chores. The special event was that she would put the baby on a tray with nuts underneath him or her. The guests would come and eat from underneath the baby. It was a very ordinary but beautiful event. Everything was like in nature, she said.

She is happy because all her daughters-in-law gave birth naturally. None of them had an operation and none had complications. All of them had easy births. They all gave birth in the hospital. Today, women have to give birth in the hospital because they now

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flowed from the existence of civil society, and not the other way around. Civil society was also coterminous with capitalist relations, in the sense that "[t]he first person who, having enclosed a plot of land, took it into his head to say *this is mine* and found people simple enough to believe him, was the true founder of civil society." (p.60)

The contrast is clear for him, between the state of nature and the existence of social formations, although there is a slow but certain progression within the natural state, making the emergence of competing civil societies necessary, through consensual social contracts (which he admits, two hundred years before Benedict Anderson, may historically speaking be imaginary: "it was or should have been thus"). 'Civil societies' are impregnated with the markers of reason and civilization, whereas the state of nature was one of ignorant bliss, based on the unfailing instincts of self-preservation and procreation.

The crux of the matter for Rousseau is: what are the contemporary implications of this progression from the state of nature to civil society? And here the important thing is not to strive to return to the primitive state, which is impossible and undesirable, but to be conscious of it as an ideal that once was (or should have been) lived reality, and that continues to be the most faithful mirror of human nature and aspirations.

The contrast between the actual and the ideal, which comes up in the successive stories of Maryam, Rima, Rawya and Rama, invariably evokes, in Rousseau's terms, the imagined state of nature and the actuality of 'civil society'. Importantly, and likewise reminiscent of Rousseau, is the fact that there is no desire to re-enact the state of nature, because (once again, in the women's imaginary) it is gone forever, and has been over-layered with the necessities of modernization (the institutions and their medicalization).

[23] Imm Issa means Issa's mother. It is the common way to designate people, especially older people calling them the mother or father of their first son.

have to do medical exams because the baby sometimes comes out abnormal. Sometimes the baby comes with malformations. Sometimes the head is abnormal. And science has improved. In her times, they never went to do medical exams. The daya and the old people would ask her how the baby's movements were. She would reply that they are good, that she could feel the baby kicking. But she never went to the doctor to get a test during pregnancy or after birth.

She does not know why some babies come with so many malformations. Maybe it is because some women get pregnant from hormonal drugs or other types of interventions.

She likes the doctors and is happy that her daughters-in-law go to them. She saw how they helped people. A niece of hers went to the doctor in her fourth or fifth month and the doctors told her the baby was not normal. It had no stomach. Medical knowledge is good in this way. Instead of having her cry and mourn over her baby at birth, they took it out early. It is better this way that he does not live any longer with these ailments and abnormalities.

Nowadays, she sees so many abnormalities. There are twins with their heads stuck together that need an operation. Nowadays, the doctor will explain that the kidneys are good, the stomach is good, the lungs are good. These are things they never could see or know in her pregnancy days. Children would fall sick and then be cured "with nature." They would boil herb teas and have the children drink them, chamomile, sage, anisette. They never went to the doctor and if they did, the doctor would send them home and say "just cure them with nature." Babies come with severe abnormalities, without hands, without fingers. She went to the hospital and saw wonders. One woman from Hebron

gave birth to a cow's head; another woman gave birth to a bunch of grapes. Lots of these kinds of cases. She crosses herself (she is from a rural Christian family) and says "God just send me a healthy boy or girl." Just that they come healthy and that the mother be healthy. Then, the mother will have a calm conscience. That the child go to bed happy/healthy (mabsout), that is a gift. We used to give birth and say: God, we don't want to give birth. The daya would say why? Ten minutes after birth, the daya would ask us again: so, do you never want to give birth again? When we feel the baby lying next to us, we say, oh God, I want another two! Now, birth is more complicated but so is life.[24]

Im Issa describes the rapid medicalization of childbirth in one generation. Her generation rarely went to see doctors. Her daughters get ultrasounds and give birth in hospitals. Nowadays, people need doctors because of the risks of modern living. This generational change was perceptible in most interviews with women who had given birth recently. In these interviews, medicalization is an indicator and measure of change in the country. It is one of the features of modernity.

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[24] The 'daya' asking the question "why?" when the woman in labor says that she doesn't want to give birth, reminded me of reading the reflections of midwives' relationships with women in a totally different context, in this case in Canada. "One midwife described a woman in second stage who suddenly said, 'I can't do this'. The midwife said her style had changed over the years in handling that situation and rather than having her push through that sense of panic at the end, she now stops and asks her why, as long as there is no physiological reason to facilitate the birth. When asked to reflect on her change in practice, the midwife said that she had learned how validating a woman's fears often facilitated her ability to handle them. 'When people said, 'I can't do it', instead of saying "Yes you can and sort of being confrontational with them, which I think initially I thought was an empowering thing to do..., I found [myself] saying, 'OK'-just accepting that...not trying to talk them out of what they are feeling about something, but just validating that their feelings are valid...they usually come around to grappling with it and moving ahead..." (Kennedy 2004). I saw this kind of interaction in the hospital setting as well and at first it took me aback slightly. I expected a supportive voice during birth to be telling the woman how well her labor was advancing. Midwives would sense women's fears often related to the absence of their husbands or relatives and would question them playfully about them: "does your husband really love you? We called him through the interphone and he has not come yet." These are similar stories of ways midwives relate to women and support them to give birth, which here cross the boundaries of space, culture, generation, and type of birth attendant. I say this not to show that there is a universal way to be supportive during births but to bring out the unexpected and surely culturally and historically specific meanings of support during labor

For her and her generation of women, "everything was like in nature" refers to giving birth the old way, with a daya, who is a family member in her own house. It refers to a set of practices and rituals in which particular herbs and foods are prepared, traditional customs play an important role, and the sweet words that the daya will utter to calm the woman's pain or to blow in the ear of the newborn have a particular meaning or religious significance.

The very term an "Arab daya" (daya *arabiyya*) refers to the ethnicity or national identity of the traditions. The fact that the "Arab daya" is opposed to the "certified midwife" (literally the "legal midwife"- *qabila qanuniyya*) on the paperwork of the Ministry of Health is telling. The term "certified" in English can mean stamped with legality. Similarly, the word qanuniyya means 'legal'. In opposition to the legal midwife, the Arab ways seem to be pre-legal. That is considered the authentic, national, traditional birth although the nationalist movement worked to create a modern birth system by marginalizing the daya and home births. In other cases, however, and depending on the social perspective of the narrator, the reference to birth with dayat "like in nature" may be used derisively, as referring to a class of rural or Bedouin women, meaning that they are primitive, uncivilized, or not modern.

The younger women who had given birth in a hospital did not speak of the birth at home with nostalgia. On the contrary, some referred to their mothers giving birth "alone" even though a daya or a relative was present. The mothers "trusted themselves alone," as opposed to the new generation which needs the medical assistance and hospitals. They were stronger but also more willing to sacrifice for their families. Now, women need the

hospitals and are not willing to sacrifice as much (I come back to the family histories of birth in the last chapter).

Thus, the people who work in the clinics and networks of birth think of their movement back to the villages as a modern return, as a return in new clothes: those of the doctor, the certified midwife and the clinic. The birth clinics and networks are marginal in a number of ways. Geographically, they assist mainly the hinterland of the country as opposed to the urban centers. They form the margins of the infrastructure. Historically, symbolically and financially, the hospitals in the urban centers are more powerful than a clinic in a village. Politically, some of their practitioners adhere to a politics of medicine and public health which runs against the policies of a centralizing government (see chapter 1 and 2). However, they catch on to knowledge and desire of all institutional centralized births. Everyone knows that the restrictions on mobility make that infrastructure as important as the centralized hospital infrastructure. Everyone wishes they could just have the hospital they need and "return" to the village.

The preceding section of this chapter told fragments of stories about births of women I interviewed in and around Ramallah. The four initial stories, Maryam, Rima, Rawya and Rama had given birth in Ramallah medical institutions. They show the centrality of the medical institution and thus the trip back and forth from the city, in Palestinian women's experience with birth. In these institutions, they relive class and national histories. The telling of these stories as an ordinary, every day event with short references to the ecology of anxiety tells of the strangeness of the ordinary, of the appearance of the uncanny. They contrast with the drama of birth stories in the press.

The Familiarity of Miracles

The previous section worked with birth narratives, the following one will focus on birth stories in the press. Since the beginning of the Intifada, the media has focused on two types of birth experiences in Palestine: checkpoint births and prison births. The journalists and their interviewees co-construct a sensational birth story where the Israeli Army and their checkpoints are criminal and the birthing mother is a victim. The stories have a common plot. They begin when the mother is in labor either on the road or in jail and end with the naming of the new person.

The stories of birth in the press are border births in three senses: physically, they take place on either side of a border, at a checkpoint or behind bars; experientially, they describe a liminal moment when the women don't know if they and their baby will live or die. Rhetorically, the women and the reporters talk of a transition from fear to courage, from oppression to redemption. The female prisoners can not fulfill their family roles but are given new social roles as political prisoners and courageous fighters. Checkpoint births end with the naming of a new Palestinian life. These are familiar transitions in Palestinian public rhetoric. The stories lie in a space with miraculous possibility in a field of seemingly immutable injustice.

The Abdel-Rahim family in *Al-Quds* newspaper, January 26th, 2003

(see Appendix for the translated article)

Following is the story of a mechanic who assisted the birth of his wife in a car. It has the plot and themes of many of the articles on birth. In this story, the husband is in the spotlight more than the birthing woman. The title of the article is "A mechanic from

Jenin is able to assist his wife's birth in his car." It gives us the husband's name but not that of the mother. While she is interviewed, he is the central figure of the story. The woman in labor and her husband set out for the hospital to give birth. They are stopped by the soldiers at the checkpoint who do not let them through. The husband is afraid because he has never been with a woman in labor. He is a mechanic. They are alone. He was afraid he would lose his wife and child "because of his ignorance." She was afraid too. "She lived moments she would never have expected, between life and death. She thinks that God wrote her a new life and saved her from death that she saw and lived literally as she watched the fear of her husband who knows nothing about birth and reproduction." She finally gave birth in the car. The baby came out black (maybe this refers to a "blue baby," a baby that has trouble breathing for the first seconds of his life). She and her husband thought the newborn was dead. At that moment, the soldiers permit the baby and mother to cross the checkpoint in order to get to the hospital. "When I got to Al-Razi hospital and they told me that my baby had survived, I named him Yahya [he lives] so that he lives [yahya] and because God gave him life." [...] In the end, in the naming of her son, the unnamed wife takes back her story.

Deliveries in Captivity: Mervat Taha, Manal Ghanem and Samar Sbeih

Prisons are microcosms of Palestine. Whether talking to people in hospitals, in homes or in the street, everyone feels imprisoned. "A big prison" (sijin kbir) is what people commonly called living under the closure with checkpoints scattered throughout the occupied territories. One of the conditions of life in prison that distinguish it from

those experienced by three million people imprisoned in their homes is that prisoners are separated from their immediate family members.

Since the beginning of the intifada, the number of Palestinian women in Israeli jails has risen, although overall, they form a small minority of Palestinian prisoners. There were only about a dozen during the period of Oslo. There were about 80 female Palestinian prisoners in Israeli jails when I was in the field in 2003. The press reports about 100 today, and close to 10 000 men. The female prisoners are disproportionately visible in the media and loom large in the communal imagination of suffering. The media reports show that the imprisonment of women is "shocking." *Al-Ayyam* newspaper dedicated an issue to female prisoners featuring some of their pictures and life histories—treatment not received by their male counterparts. Released women prisoners and the journalists also talk of gendered methods of intimidation in prisons such as showing women's nude bodies and sexual threats. The media reports that cover these cases of women in jail focus on the ultimate suffering of these women who must leave and hence disperse their families. Their roles as the nationalist reproducers and home-keepers of children and families have to be interrupted.

Media reports about giving birth in jail are part of a larger discourse about the ways in which imprisonment disrupts family life. Births in jail are the most difficult a woman can experience. She is alone with no family. According to Israeli law, a baby born in jail is to live in jail with its mother until its second birthday, at which point it is to be released to its family outside. The articles trigger images of women giving birth alone, raising a child in jail and separating from her son or daughter at age two.

Since the beginning of the intifada, there have been three births in jail. Again, the numbers are small but the coverage of these births is widespread; everyone knows of these three births. They are mentioned repeatedly in the press. In all three stories, there is outrage. The coverage of the cases brings to light three characteristics of the experience and discourse of birthing in Palestine. First of all, the birth of a live baby is a redeeming process. The birth of a baby is talked about as a productive and courageous act even for women in jail whose gendered social functions have to be re-made. Second, acquiring papers for the newborn is vital. Third, the stories of birth in prison bring alive what is frightening for all births in Palestine: "giving birth under the eyes of the soldiers," or "having a soldier birth me." These are sentences I heard from most women giving birth outside prisons as they were telling their story of an ordinary birth.

The first case of birth in jail since 2000 was the case of prisoner Mervat Taha who gave birth in jail to her son Wa'el and is serving a four year prison sentence. The reporters wrote of her birth in lyrical poetic language, describing the difficult conditions she and her son have been living and the disruption of her family life. Her role in the struggle is not about reproduction and child-rearing. She is given a new social role as political prisoner. What is important about her is that she committed her life and work to her country. At the end of the article, the author says that Mervat Taha is one of "the 80 women living in the belly of death, banging at the sides of the container, facing their captors... [who] turn into 80 princesses who have left everything for their country and humanity." (*Al-Ayyam* April 17th, 2004, see appendix for translation of article) These women in jail have given up everything. Their roles as family members, wives and

mothers, have been interrupted but that is redeemed by giving them a role in society as political prisoners.

The second case of birth in jail comes six months later. Manal Ghanem is 27 years old. She was arrested in April 2003 and did not know she was pregnant. She gave birth to her son, Nour, in jail. The articles are much more descriptive. Nour's father has yet to get permission to visit his wife and son in jail. Manal suffers from thalassemia and her son Nour has not yet been tested for the disease. She has three other children living in freedom. Her family has been dispersed due to her imprisonment. Her two youngest children live with her in-laws. Her eldest son lives with his father. The children have nightmares and remember with fear the day the soldiers came to arrest their mother. But what is most outrageous is that the Palestinian Authority does not recognize the birth of this child in an Israeli jail on the grounds that they have yet to see an original birth certificate (the faxed copy given to the Red Cross by prison authorities is not sufficient to prove the birth for them). According to the press, seeking papers for the newborn has always been problematic for women in jail, whether Israeli or Palestinian papers. It seems that a birth in an Israeli prison is not quite the birth of a Palestinian citizen. The press makes it sound like it is typical of the inefficiency, bureaucracy and weakness of the Palestinian Authority in the face of Israeli regulations. Israeli authorities regulate the delivery of Palestinian papers. They set the laws and supervise the way people acquire Palestinian papers. The Palestinian Authority appears in this process as the inefficient and pathetic intermediary. It is visible in the contradiction here. On the one hand, press releases of the Authority hail the women in jail as the ultimate example of Palestinian

suffering and perseverance. On the other hand, they make it difficult for the newborns to acquire Palestinian papers.

The third and final event of a birth in jail is the case of prisoner Samar Sbeih. She gave birth to her son Baraa' (which means innocence) in a military hospital. Samar was handcuffed during the pre-delivery tests and was not uncuffed until she was taken to the operating table for a cesarean section. According to human rights and media reports, all babies born in jail since the beginning of occupation were born by C-section and all except the last case gave birth handcuffed. Sbeih was only handcuffed during the pre-delivery tests because the Palestinian Authority and several human rights organizations had just managed to obtain a court order forcing the prison authorities not to handcuff Sbeih during the delivery. The article emphasizes the C-section, the handcuffs and Sbeih being without family during her birth.

The Cesarean is one of the undesirable attributes of Sbeih's birth. They felt the need to justify the operation. Lamis for example is embarrassed because she is a midwife and tells everybody they should have natural births, but she had a cesarean. She was under too much pressure. During the first months of the pregnancy, she and her husband were starting the procedures to get a divorce. Hence, no one in either family wanted her to give birth. Her mother-in-law was putting pressure on her to terminate the pregnancy. Her daughter was unwanted by her own family. Lamis was doing everything the right way for the pregnancy in terms of nutrition, exercise and care, but she did not have psychological support. Lamis thought that she was under too much pressure, was anxious

and therefore could not manage a natural birth. She had a Cesarean (I return to Lamis's family history in chapter 5).[25]

Sbeih's birth story sparks fear and outrage. When I read her story I remember the number of times women told me they were afraid of giving birth "under the eyes of soldiers" or of "having a soldier birth [me] them." It seems that in Sbeih's story, the collapse of the doctor and captor is disturbing. He births only via C-section. He handcuffs, sometimes only for the predelivery tests, most of the time for the entire birth. He makes women birth without their family members. This place where the birthing woman is without family, alone and forcefully abandoned is the most disciplined and controlled birth experience imaginable in Palestine. When I think of Sbeih's birth, a bizarre image of a hyper-medicalized but also hyper-medicalized "zone of social abandonment" (Biehl 2001) creeps into my mind. It is a place where living, being,

[25] More women than before are having cesareans in Palestine these days. The national cesarean section rate has increased from 6.8% in 1996 to 12.4% in 2004 (Palestinian Central Bureau of Statistics 1996 and 2004). Some reasons for this increase include the situation of conflict, rising poverty and food insecurity, and unpredictable access to maternal health facilities. More specifically, the explanation may lie in delayed arrivals at the hospitals, poor quality of antenatal care and of care during delivery with routine unnecessary interventions, stressed obstetricians and midwives who practice in more than one institution, and laboring women who are anxious to get back home. The new generation of obstetricians is also influenced by their training. Most trained in countries with a rising Cesarean section rate. The rates have risen to the point where it has been referred to by public health researchers as "a global epidemic" (Savage 2000). In some developing countries such as Chile, Brazil and Mexico, the rate is much higher (40%, 27% and 24% respectively) (Belizan et al. 2005). The WHO recommends 15% as the highest acceptable limit for national rates (WHO 1985).

In Palestine these birth stories reveal that some of the younger women do not necessarily object to technical procedures in childbirth, but that cesarean section has not been accepted as a preferable way to give birth as in other countries. In Brazil it has been claimed that cesarean section is now culturally accepted as a normal way of giving birth (Belizan et al. 1999). This is not yet the case in Palestine where Lamis felt the need to justify why she had undergone a cesarean, while advising other women to have a natural birth. In Mexico one author described the process whereby cesarean operations were adopted. Obstetricians created the demand by providing it frequently to the wealthy classes. Gradually the lower socio-economic classes began to perceive a cesarean delivery as a privilege and an alternative to the poor quality of care and birthing conditions which they endured. If the rich get an operation, it must be better. And obstetricians became more proficient at doing surgical deliveries and less at ease assisting vaginal births (Castro 1999). This trend is difficult to reverse once it has become part of the birthing culture. In Palestine, obstetricians state that the trend is Palestine is due to their training but mostly to the pressure from the restrictions on mobility. In this context, a scheduled operation is easier to handle than labor which is impossible to schedule.

birthing and dying are "constituted in the interaction of modern human institutions," where the institution of the army as prison authorities play a central role (Biehl 2001). The militarization makes it a different kind of abandonment than the one in Vita, the asylum Biehl describes, the place of the dying. The prison in these stories is a place where the prisoner is forced in abandonment but knows that outside his family and life are waiting for him or her. He or she is waiting for something, waiting to be released. Their waiting is different than the rest of people outside. They are waiting for something; it is longing. The people outside are preoccupied with waiting for something, anything to happen; it is an anxious waiting.

Imprisonment is a different kind of abandonment. While the women are isolated physically, they are not abandoned by Palestinian public rhetoric. The Palestinian media remembers them repetitively. It transforms these stories about the ecology of fear to one of courage. It is almost a utopian space of miraculous possibility: a new life in injustice, an order of things that seems immutable. It makes the daily ritual of reading these stories a kind of salute to the fallen soldier. It makes them just bearable to read.[26]

The women in the first part of this chapter don't talk in the language of dying heroes, suffering prisoners and princesses. There is nothing miraculous about their birth stories. They don't talk much of fear and surely don't talk of pride and courage. They seem to be speaking against this miraculous space which transforms suffering into courage. They want to avoid the story of Abdel-Rahim or of Sbeih. But these stories are too familiar to dismiss as freak events. The news broadcasts them everyday. The

[26] While I was on the field, I dedicated a notebook to newspapers in which I collected and glued articles from *Al-Ayyam* and *Al-Quds* everyday. Each time I open that notebook I am overwhelmed by the images and stories of suffering, mourning and grief (see appendixes for some these images and articles). The sheer number of them and the repetitiveness is difficult to bear.

neighbors retell them. The woman who owns the corner grocery store is the protagonist of yesterday's story. Snippets of the stories flash back in the form of sentences out of context in their narratives of the ordinary "I'm afraid of giving birth under the eyes of the soldiers," or "I don't want the soldiers to birth me." In a way, the stories from the morning rituals never let the reader be. They are always present in the form of a haunting specter. The women in this chapter know that tomorrow is not for them to predict or to trust.

The state of the ordinary, in which waiting, crossing checkpoints, being turned back, hearing gunfire, curfews, sirens, arrests, bullet injuries, mourning, accompany sleeping, eating, birthing and walking, is uncanny. The uncanny state of feeling in the ordinary of everyday life is usually a vague, diffuse, and enduring sense of anxiety, a disposition toward the world at any particular time with a timeless quality to it.

Chapter Five

"Speaking from the Heart"

In the following chapter, I narrate life histories of women who have given birth. I have chosen to keep the stories long and repetitive to try to better understand how their inner worlds are remade under the impress of economic, political and domestic pressures. This also communicates the intensity and disarray in their narratives.

Our interviews and encounters therefore attempt to illuminate the experience of birth and at the same time narrate the moment of our encounters, a moment well after their first births, often after the birth of the second or third child as things get reworked as the lasting experience of the post-partum. In the writing of these women's life histories, I identify the post-partum narrative as different from the birth narrative not only in its timing but also in its content. While stories about birth and pregnancy are about doctors, medical institutions, and the nation-state, stories about post-partum life are about the home, the family and the self. Similarly, whereas stories about birth are about crossing checkpoints, stories about post-partum lives are about being enclosed by checkpoints. Here it seems, the post partum mother becomes enclosed, de-medicalized and, as compared to the previously highly nationalized birth process, depoliticized after the birth. I define the post-partum in Palestine as the first year after birth, a potentially vulnerable period when some mothers feel confined and isolated by Israeli restrictions on mobility which more often than not separate them from their families and places of origin as well

as enclosed by family relations within their homes. It is an intense meaning-making period, sometimes a lonely one, when they must care for their baby before the child can speak and make sense of new family dynamics. Some feel that the closure is intensifying a process by which the village is turning into a refugee camp (i.e. an enclosed space with displaced people) and the extended family is turning into fragmented bits of nuclear families, where the social support of relatives is lacking because of restrictions on mobility and the migration of family members to other cities and countries.

These narratives start and end with references to love. Love between them and their husbands is the first step into their story of enclosure. Here, love marriages are not opposed to arranged marriages. Love is a bond that holds the couple together, sometimes even after separation and divorce. It is always there no matter how difficult marriage and family life has become. At the end of the narratives, love is also a hopeful and elusive moment.

While love is what brings them into their situation of enclosure, it is not a story of conquest on the part of the husband and confinement and passivity on the part of the wife. The women's narratives show both their initiative and deference. They allow me to explore issues of situated social commentary. In their stories, these women disrupt the flow of legitimate knowledge and authority, as they turn around and recast the story of having children from a story about nation and politics to a story of marriages, family support and love. Yet, the closure and political situation never disappears from their lives. They form a background to their family histories that imprints physically and psychologically on their lives.

The apparent longevity and arbitrariness of the policies of closure have prompted people to search for other resources and explanations to render their lonely lives livable.

This chapter illustrates how life narratives and family histories reflect a larger history of Palestine, but also how these histories inform interpretations of the experience of enclosure. Family histories of the making of the modern borders of nation-states, being displaced, living as a refugee, were told not only for purposes of recollection and memorial. They render the strategies of occupation more transparent and the mechanisms by which some of the victims of the conflict, especially women coped with their new conditions of life. They point to lineages of enclosure and explain how histories of state interventions and occupation imprint on processes of everyday life, on families and bodies.

New mothers tell their tales of loneliness and longing for love and family support to me when I visited them and to one or two women who are around them, very often their sisters in law (their husband's brother's wife). They "speak from the heart" with this person. In this new family, new mothers find support and make sense of their fragmented families and lives.

References to ties and friendships across class were not unusual. Where talk about birth seems to bring out national, class and group divisions, talk about what happens after birth bridges gaps, makes connections and brings together women living close to each other. More than just their memories, they share their feeling of longing for a certain closeness, love and freedom of mobility. Talking of the genre of lamentation, Veena Das suggests that in the women's work of mourning, "grief is articulated through the body" in such a way that the "inner state" is made visible, transforming death's strangeness,

making the world livable again and bridging divisions in society, at least momentarily." (Das 1990) I want to use her notion that there is a redemptive aspect to these intense moments in life that bridges divisions in society. In narratives of the post-partum in Palestine, the lonely narrators make alliances with other women around them (sometimes across class) making their world more livable. Nonetheless, there remains a sense of uneasiness about life as it is; sense that they are waiting for their children to grow; waiting for the closure to be lifted; waiting for political changes; a sense that there is a pathology to the waiting in everyday life.

Building on a rich literature of Palestinian oral histories pioneered notably by Rosemary Sayigh (1979), Julie Peteet (1991) identifies and analyzes sumud narratives as a gendered narrative in which domestic chores and the work of women at home are linked to the national struggle. In these sumud narratives, the women see themselves as feeding, nurturing and sustaining the nationalist struggle. The post-partum narratives I hear sound different. They are about the expectations of family, love and the self, and in that sense, they escape the nationalizing and politicizing that underscores the former birth narratives. However, these women are talking about access- to hospitals, to other cities, to their salaries, to their mothers who live in another village, to education, to a better life, to a manageable relationship with their husbands- and therefore these are deeply political subjectivities.

The women I interviewed long for the support that an extended family could give them in an imaginary place where there are no checkpoints and borders. They are isolated in their homes for extended periods of time. For some, the closure creates a situation where their husbands are out of work, frustrated and always at home. There is a certain

psychological distance or numbing from the frustration of waiting. For others, the loneliness makes them anxious even as they draw support from other women around them, who listen and share memories.

These new kinds of alliances and narrations of common experiences and demands are about access to family support, mobility and equality. And this forms an integral part of a political subjectivity. The de-nationalization of women's domestic narratives signals changing times, exhaustion from the policies of occupation, a growing lassitude towards a Palestinian leadership and fear of the changing family dynamics in a context of closure and emigration. It illustrates this dialectic of post-colonial, or not-yet-post-colonial, modernity, where it is difficult to have recourse to an anti-statist position in order to solve the problem of the failure of the state. In the end, by sharing their memories and stories with women around them, these women are creating for themselves a livable world in which they can wait, and not an alternative to institutions and political or social support structures.

Rama-

Rama is from a village near Ramallah that was relatively easy to get to. It is a fairly large village with infrastructures of schools, clinics and markets. I had conducted 15 interviews with birth mothers and health professionals in her village in 2002 and then again in 2003, and I had a few contacts there which led to others. Rama's story brings together the themes of many of the interviews. She and her three daughters were waiting for me in their living room when I arrived.

Our conversation starts with her love story, takes us through birth and ends with her enclosure at home taking care of her three children. It is a story that intensifies, moving from her concern with the closure, her anger at a negligent doctor and finally her anxiety in this time of caring for her children alone, with very little support from her husband and family. The person who listens to her when she gets her anxiety attacks is her sister in law.

Rama seemed to be in her twenties. She was originally from a neighboring village. She was engaged to her husband when he was still in jail. They had met and loved each other before he was arrested. Then came their love story separated by the bars of prison. He was in jail for a year or more. He had an injury in his leg. They had feared that he would be paralyzed in one leg as a result. But his leg healed and he was able to work when he was released. They had three daughters together who were all less than three years old.

I asked her to talk about her births and she said that it was a difficult topic to talk about but that she had so much to say about it. Her last pregnancy had been especially tiring from the beginning. She was constantly waiting at checkpoints. Each time she went to the doctor for a checkup, she had to walk miles over mounds and barriers to get to Ramallah. She would rest a bit sitting on the side walk, knowing that there was no one to help her once she got home. She knew that she would not be able to take care of her two girls at home. In the back of her mind during her whole pregnancy was the fear that her labor would start during the night when the roads are too difficult. She would tell her husband about her fears of not being able to get out of her village. He would reply that God will be with them.

Both her first girls came during the day and she was grateful for that. Her first labor started in the morning and her second mid-day. She went to her father's house and from there they went to the checkpoint. Her husband spoke with the soldiers who initially would not let them through, until they looked in the car and saw that she was tired and sweating. They then ordered that she be quickly taken to the hospital. And so finally they arrived at the hospital. She was already worn-out from the road.

Her first daughter was born in 2000, the second in 2002 and the third in 2003. The first two were born at the Red Crescent Maternity Hospital, a small charity, non-profit hospital, and the last at the larger government hospital in Ramallah. Rama liked Ramallah hospital even though she thought it was crowded and dirty. There was a nurse there who "felt with her" and took care of her. Even though the midwife was not married and had never experienced the pains of childbirth, she supported Rama and really "felt with her." She was *hanouneh* [loving]. The nurse assisted her birth and she was the person who handed her the baby. It was the first newborn she had been able to see even though it was her third birth. For the first two, she had been in so much pain during the labor that right after delivery she could not even focus her gaze to see her new child. There were 40 other women giving birth at Ramallah hospital, each lying on a separate bed. "A traffic jam", she said. Yet this nurse was able to give her the care she needed. There are no curtains between the women. The women are in labor close to each other. At one point during her labor, a man walked into the room. The doctor started fighting with him and told him he was not allowed. The man said he was coming to see his wife but the doctor pointed out that there are a lot of women in labor in this room and that no one is allowed to enter. Rama's husband thought that policy was terrible. From the moment she entered the labor

room without him, he started thinking that no matter how much it would have cost he should have taken her somewhere else. But she gave birth there and then went home and ended up thinking it was a good place.

Right after her delivery, she wanted to go home. The hospital told her that their policy was that women must stay for 24 hours after delivery. But her husband managed to get her out, saying that he was taking responsibility for her safety. She wanted to go home because both her husband and mother were waiting outside and they were worried. They had not seen anything and did not know that everything was fine because they were not let into the labor room. Plus, there were so many women in labor, and each one was waiting for her turn to give birth and there was not enough room and people were tired and poor. She too wanted to get home. But still, she insisted, it was a good place to give birth. The birth was difficult but the nurse was good to her. The nurse was doing such great work, going around to 40 women, doing pelvic exams. Then, during one of the rounds, Rama's turn came to deliver. The nurse stayed with her until she had delivered. Then the nurse cleaned her up. But she did not clean the baby up. The newborn went home unclean. There is no bath to clean newborns at the hospital. So her mother bathed the baby upon their return.

What Rama remembered most was the space of the hospital. There are two rooms. One is huge, where women stay during labor as they dilate. And then there is a smaller room where each woman is taken to deliver. The door stays open between the two rooms. When she was taken from the labor room into the delivery room, she was screaming. The other women in the labor room were waiting, waiting for their turn to deliver. They would say words and prayers to support her. She felt so tired when she went into the

delivery room that she cried out to the other women: "I want to die, come help me." All she could hear were the laboring women's words coming through the door. Then, after delivery she went back to the labor room. She talked with these women whom she did not know but felt she knew well.

As she was describing the space of her birth, I remembered my visit there on a hot Spring day. The huge labor room area she describes was made of numerous small spaces with about four beds packed together and a wall separating the beds from the next labor area with the next four beds packed together. Doors separated the labor area from the delivery area. Nurses and midwives would sit at a desk in between the two areas and every so often would get up to check the patients. If a woman was ready to deliver they pushed her bed to the other side, the delivery room side and women would start saying their words and prayers of support. Probably three quarters of the women when I visited had already given birth and were waiting to be released. Many smaller labor area sections were turned into post-labor rooms. And then there was the huge post-labor room. It was one bed after another of women who had either given birth, waiting to be released, women who had gynecological problems, women who had had an abortion and pregnant women who were bed-ridden. Alongside some of the beds there were bassinets with babies in them. Other babies were at their mother's breasts. The doctors were rounding during my visit. There was a cluster of young male medical students following their older professor, observing his practice as he moved from one bed to the next. As I am walking by, the nurse accompanying me points to a baby and says: whose baby is this? Is it yours?

- No, I had an abortion and my back hurts, the woman replies.

- Is it yours? Turning to another woman in bed.

- Yes, it is mine.

- It is hot. Take some of these layers off of your baby.

She did so reluctantly. But her face was beaming with happiness. It reminded me that in the end, birth is a happy moment.

We continue our walk through the room back to the labor and delivery rooms and out into the waiting room. There, it was hard to breath there were so many people. The stairs were packed with people waiting too. The labor room is shut off with a big metal door with a code. No one, except hospital staff is allowed through the labor ward doors.

Outside the door there was an argument between a man and a nurse. A man was shouting at the nurse to let him in to see his wife who had given birth. She is a foreigner. She does not speak Arabic. I have to get her released early. What do you think, the doctor does not speak English, the nurse replied. You'll see her in 24 hours. That is the policy. As Rama was telling me her birth story, I remembered the scenes from the hospital and imagined her labor and her husband and mother anxiously waiting in the waiting area.

Rama's two first births took place in a smaller private charity hospital run by the Red Crescent. The space there is quite different. At that hospital, there are two small rooms. Both rooms are labor and delivery rooms at the same time. Women are not moved to deliver in another room. One of the labor rooms has only one bed. It is for a private birth. The birthing woman can have her husband (or anyone else) to accompany her. And then there is another room where there are two beds, but the husband is not allowed in there.

For her first birth, Rama was in the room with two beds. The midwives came to her because it was her first birth. She was *bikriyyeh* [a woman who has not given birth before, literally means a virgin] and she was alone. A woman from the villages had come in after her, given birth on the bed next to her and left. So, she had the room to herself. The midwives wanted to know if she wanted her mother to be with her. She said she wanted her husband. So they called for him on the loudspeaker: "Will the husband of Rama please come up." But no one came to her. The medical staff jeered at her, saying that her husband did not love her that he brought her here and left. Finally, her husband came, and proving the staff wrong, he stayed for the whole birth and accompanied her through it.

She liked that her husband had "come to give birth with her [me]". When he is with her during birth she responds to him but when he is not with her she is afraid. With Myrna, her firstborn, he is the one who helped her. He took away from her pains. He talked to her. He was hurting too, with her. And then after she delivered, he was so happy. In the beginning he even yelled at her, but when she eventually pushed Myrna out, he became happy again. He was with her during Maya's birth too. But for Sherine's, they did not let him in because it is a governmental hospital. So she endured. She was obliged to.

During her first pregnancy, her mother helped her out a lot. She would tell her: don't be afraid and keep on walking. For weeks before the delivery, the moment she felt a tiny bit of pain here or there she thought she would get a contraction or that she was going to give birth. She would run to her mother in law because she lived close by and her mother in law would say: "Wait, not yet, wait a while". Hearing is not like seeing,

when she walked into her room and blood and water splashed down her legs, she was afraid. But then for the second and third labor, she knew exactly when she should go to the hospital. The contractions started but she stayed at home for two more days until her waters broke before they went to the hospital. For the first pregnancy, the waters broke before she got any contractions. That was an incredibly arduous birth: she had stayed in the hospital for 14 hours lying on her back with contractions, dilating very slowly. She was inexperienced and did not know what to expect. She wanted a Cesarean just so that it would not hurt anymore, but the medical staff refused. They told her: "Like your mother before you, you will have a natural birth. How many did your mother give birth to?" She replied: "six." They said, "Well then, you can and will give birth like her." Then, they gave her *talaq istina'i* [oxitocyn, literally 'artificial contraction'] and she was in so much pain that she decided not to have any other children. But then came another child and then another.

Negligence

If she gets pregnant again, Rama wants to give birth at the Ri'aya hospital, a private hospital which she heard was good and organized. She hopes that maybe one day she will have enough money to be able to deliver there.

The Red Crescent hospital was organized too and she cherished having her husband next to her. But she had a problem with that hospital. She was angry at one of the doctors there who had delivered her first daughter. Her daughter was born with a condition in her eyes, which the doctor did not detect. Four months after the birth, she began to notice that something was not quite right with her daughter's eyes, and that they

were constantly swollen. Very soon, her eyes became infected, at which point Rama took her to see a doctor. But, that doctor did not detect anything either. Rama felt that something was wrong, so she took her to yet another doctor, a well-known eye doctor in Ramallah. He was outraged that her daughter had this condition since birth but that the doctors had not noticed it. He said that it was almost too late to save her eye-sight. One more week and the girl would no longer have been able to see. She took her daughter to the hospital and recently the condition is better and she has healed but she needs glasses.

I tell people: I am an orphan

Rama does not want to have anymore children, but maybe they will, she thought. Her husband would like to have six. He loves his daughters and wants more girls. He is very *hanoun* [loving], but she is tired and children are demanding.

The girls are jealous of each other. Each one wants what the other has. The oldest daughter is always cranky and fighting with her sisters. She sometimes sits on the ground and cries and Rama is worried about her, especially because of her eye condition.

When work is done in the house, and she has a few minutes to think, Rama thinks about how much she loves her daughters and how much she enjoys them. Her husband always reminds her that when they grow up and get married the house will be empty for her. "Those girls," she says, "if you look at them. That daughter is beautiful. This one, her picture is in a magazine. I asked for her picture and they put her in a magazine because she is beautiful and because of her eyes…"

They are beautiful but they need so much work. After her last birth, her mother came to help her sometimes and her sister in law would also come to lend her a hand, but

at night she would be alone. She would have no one to help her and no one to talk to. Her husband helped a bit but he had to work and now her mother cannot come anymore because she has to look after Rama's sick uncle and her two young brothers who demand work too. Rama would often wake up at night, in pain and alone. She would call her sister in law who would come to her place in the morning and help her out.

She wishes she could take better care of her children. With her first born, she had made an album of the first 7 days of her pregnancy, then of her daughter at one month. For the second, she only has two pictures and for the third, she has none at all. Her youngest brother gets angry at her mother because she does not remember his first words or anything else about his childhood. But for Rama, to remember each daughter's childhood, you need to document it, and for that you have to have a video, but during these intifada times, they do not have enough money to buy a video.

Having had six children, her mother had told her about birthing before but she does not remember clearly what she had told her. When she gave birth to her first child, she felt first hand exactly how much a woman has to tire. When she and her siblings were young they did not listen to her mother who would have to do so much to make them obey her. As children, they were so much work. Now that she has given birth and is tired all the time, she feels with her mother. She loved her mother very much, and now, after her own births, she appreciates and loves her even more. Her mother must have been drained raising Rama and her five siblings, feeding them, cooking for them, washing their clothes, cleaning their home, but they barely felt it then. This she understands only now as a mother herself struggling to care for her own children.

The hardest thing in Rama's life has been the illness of her eldest child. She remembers those times and how exhausted she became from going through checkpoints to take Myrna to the eye hospital in Jerusalem. She was constantly worried that the soldiers would turn her back. They told her more than once that she was a liar, that her daughter looked perfectly healthy, that she could take her to Ramallah hospital. But she wanted the best care for her daughter so she insisted and tried again and again, taking small roads to bypass the checkpoints in order to get her daughter to the eye hospital. During those times, she would neglect her home responsibilities as she could not think about anything else but the drops that she had to put in her daughter's eyes on the hour. She thought of Myrna all the time because she had stopped eating. Her appetite had changed since her eye condition had worsened. She wanted only her mother's milk and would be jealous if her mother would pay attention to anyone else but her. And Rama gave her, her undivided attention. When she first learnt that she was pregnant with Myrna, she had taken medication to abort her. She had not wanted that pregnancy but then, she changed her mind and decided to keep the baby. She wondered if somehow, she was responsible for her daughter's condition. She felt guilty because she could not attend to her other daughters the way she attended to her ill daughter. She tries to treat her sisters like she treats Myrna but finds it difficult. She is unable to keep her thoughts away from her for even a minute because of her constant, paralyzing fear that she may fall ill. She is furious with the doctor, whom she blames for having overseen the illness during her daughters first hours and weeks. She would do anything to keep her daughters healthy and happy.

After a long visit, I got up to leave. She asked me to stay. I stayed for a few more minutes. The children were getting very sleepy. Rama asked me to come back and visit her, "Not for your research," she said, "just to talk some more." She spends most of her time at home. Her family of origin cannot visit her very often because it is not easy getting from village to village with the closure. "I always tell people: I am an orphan," she said.

She had just explained to me that the combination of the closure which separated her parents from her, the economic pressures that obliged her husband to work for long hours and her role as the sole care-taker of their children had made her into a kind of orphan. I was struck by the term she had used to describe her loneliness, a term that connotes having no parents, no known relatives, no inheritance. She felt entirely abandoned, her only relief being the telephone conversations that she had with her sister in law.

Hiba-

My first discussion with Hiba took place at the hospital. She was in labor with her second baby, one year after the birth of her first baby. It was a long discussion that she said helped her forget labor pains and the hospital environment. Hiba's life history tells of her mother's experience of having to leave her family and live in a foreign village across a border. Like Rama, who equated the 'tiredness' she felt to that of her mother's before her, Hiba too sees similarities between her own marriage, her life and loneliness and that of her mother's. She too confides in and receives a lot of support from her sister in law.

I met Hiba in November 2003, in the hallway of the labor room as she was registering her name. I told her about my work and she said she would be happy to have me spend time with her during her labor. As a university student herself, she was interested in my work. She completed her law degree when she was nine months pregnant right before the birth of her first child two years ago. She was 24 years old.

Hiba's doctor had just seen her in his clinic in the hospital. He saw that she was dilating and advised that she should remain in hospital as it was uncertain whether she would be able to return to Jerusalem if she went home. Although her village is not far, and she had a Jerusalem ID, closure could nonetheless cut off anybody anywhere, she told me. She was afraid. She called her mother, who told her she would get to the hospital as fast as she could, flying. In the meantime, Hiba had walked into the labor room, taken her veil and shoes off and sat down. The nurse was preparing oxitocyn to speed labor and bring on stronger contractions. She said she did not want *taleq* [oxitocyn]. But the nurse insisted that she would need it because her contractions were very weak, and without the IV, her labor would take much longer than necessary. "In normal times you would have gone home," the nurse said, "but the closure makes it difficult for you to go back and forth." Hiba agreed reluctantly. With time, the oxitocyn began taking effect and the ensuing contractions became very painful. Shortly afterwards, Hiba's mother arrived at the hospital and was holding her daughter's hand, as Hiba's eyes welled up with tears. "We have all gone through this but it is so hard to see your child in pain," she sighed. She had smuggled in juice and biscuits against hospital regulations. But Hiba's contractions were so painful that is was hard to think about anything else.

Hiba led the way, however, in making our minds run off into different directions. In between contractions, she told us about her life and we talked about her husband, whom she had met and fallen in love with as she started university.

She had waited for her husband for years as he finished his medical degree in Russia, and now, she was waiting for him to come to the labor room. [Her account is interrupted by a contraction: the conversation stops as she grabs our hands and closes her eyes, cringing. Tears stream down her cheeks.] She had left a message for him at the Red Crescent clinic in the rural West Bank where he worked to come straight to the labor room because she was giving birth, but she had no news from him. Perhaps he had to see so many patients that he did not even have time to check his messages at the front desk. Perhaps he was on a house visit. Perhaps, he was at a checkpoint. But why could he not call her? [Another contraction: it's quiet again. She presses into our hands and lets out a sigh of relief when the contraction finally slows down.] "For the birth of my first baby Maram, it was not this painful. You know, it is because of the *taleq* that it is so painful. I wish they had sent me home." "Yes," her mother adds, "natural is always calmer, better and less painful. It is the way God made it to be." [Contraction: silence, she holds on the armrests and cries in pain.]

A young doctor walks into the labor room. It is getting too painful, Hiba says, how long is it going to take? The doctor examines her. She screams in pain, saying "please stop, you are hurting me!" The doctor does not respond to her. He says that the labor is not progressing and that she has dilated only 3 cm. He leaves, leaving a terrified Hiba behind. She echoes her mother, wishing she had gone home because a natural birth without oxitocin is less painful. She is still crying, as yet another contraction seizes her.

The doctor walks back into the labor room. He offers to give her an epidural. Her mother rejects this, saying that epidurals can hurt the mother and baby, and so Hiba declines the epidural. The doctor walks out. "Pelvic exams hurt like birth," Hiba said, adding that she wanted to go back to chatting because that made her forget the pain.

Genealogies of Enclosure

It was clear to me that Hiba's contractions were changing. She seemed to be more relaxed, as she began telling me about her mother's story.

Her mother came from Beirut. When she fell in love with Hiba's father, she knew that if she married him, she would have to go back to his village near Jerusalem and possibly never see her parents and family again. And sure enough, since the marriage, she has not been able to see her sisters and brothers. Even her mother, she cannot see, as she has never been back to Lebanon. [Contraction: silence. Hiba's eyes are closed but very aware. She seemed calmer during the contractions, letting herself go somewhere else.] Sometimes, her mother gets to send a few presents with the few people who are allowed to go back and forth across the borders through a third country. Every Friday, her mother calls one of her family members because they cannot call her. It is not possible to call from Lebanon to Israel/Palestine (only the other direction works). She is from a camp in Lebanon but during the civil war, her family lived in a beautiful house in Ain Mraisseh, which they had to vacate at the end of the war. She fell in love with Hiba's father, who was then a doctor working temporarily for the Palestinian Red Crescent Society in Lebanon. When she said goodbye to her parents and family, she knew it was probably forever. [Contraction: Hiba again seems to be going somewhere else, loosing herself in

the contraction.] Her mother's move to the village was traumatic. She didn't know anyone. She was a city woman. Her husband's village was small and conservative. Neither she, nor anyone in her family in Beirut fasted during Ramadan, but now, she fasts and wears a *hijab* [headscarf]. The most difficult thing was that she missed her mother in Beirut. She struggled in her loneliness, but still managed to raise a family with love and care. [Contraction: Hiba's eyes open but somewhere else.] In Hiba's own life, her mother was the person who helped her the most, because she knew about birth and she knew about isolation and closure. Like her mother, Hiba too has had to struggle and fight to finish her degree. She was pregnant and had to climb up and down mounds, checkpoints and mountains to get to her university. [Contraction.]

When she fell in love with her husband, her parents did not want him, even though he comes from the same village. His family was too conservative, they thought. Her mother warned her of marrying into a family that is more religious than her own. But she did not listen. Her fiancé insisted that they would be able to live the life they wanted to live even though his family was more religious than hers. Her parents also thought he was too timid, how will he stand up to her mother in law, who will be her neighbor when she moves to her husband's house? "But they were in love," Hiba insisted. Like her mother loved her father and went to live with him far away from her family, she too loved her husband, and would do the same. Such is love for women. Love for women means loyalty. [Contraction.] But you know for men, it is not the same. They are not as loyal, neither to their mothers nor to their wives. While her then fiancé was in Russia finishing his studies, Hiba was terrified that he would meet another woman. She had nightmares about him meeting a beautiful Russian woman. Her husband's friends told her

that Russian women make good wives because they blend in well into Palestinian communities. This caused her tremendous anxiety for the duration of her husband's absence. [Contraction.] She was receiving many marriage proposals and he too was worried that she would accept one of them. She would urge her fiancé, "come back soon! Everyone is telling me to forget you because you will come back with a Russian woman." And in this way, Hiba told me, she was able to put pressure on him to finish his studies quickly. [Contraction] Finally, he came back and they got married. And soon afterwards, she was pregnant. Her pregnancy was arduous, because she was still studying and under much pressure to finish her degree despite the difficulties of physically getting to university and back. But the first birth was much easier than this one. The labor had started at home and she was calm and walking around. Then her husband and her mother took her to the hospital. The contractions were much less painful than this. [Contraction.]

Her mother also talked about Hiba and her love story. Hiba was beautiful and slim, wore high heels and tight clothes. All through her studies, she wanted to marry the traditional way. Not for love, as she was afraid of love. "I want a husband who will not betray me," she would say. Many suitors would come to their house asking for her hand in marriage, but she refused them all, saying that she had not found the person with whom to share her life. But when she met Salim, she abandoned her desire for an arranged marriage. She loved him instantly and intensely and waited for him all those years while he was in Russia.

She had met Salim at her sister's pharmacy in the village. Or, more precisely, he had seen her at the pharmacy, liked her and said that he wanted to meet her. So she saw him again and again and that is how they fell in love. She again wondered where he was

at that moment, why he had not come to the hospital. He had been with her during the first birth, which had made it so much easier to bare.

Hours had passed. I could not stand up anymore. I was exhausted and wondered what the roads were like at this hour of the night. I still had a long ride home. I marveled at Hiba's energy during her labor. I wanted to stay and see her through to the end, but I was too tired. So I left her my phone number and told her I wanted to see her baby and visit her when she was more comfortable and back in her own home. As I was leaving, she told me that there were so many things we still had to talk about.

The next morning I called the hospital. The midwives transferred me to the post-natal unit and Hiba answered with a faint voice, saying that she had given birth only a half hour after I had left and that she had called her daughter Noura.

Five months later, Hiba called and invited me to her village. I was touched to hear from her and went to see her the next day. She lived in a village between Ramallah and Jerusalem. I was very familiar with both cities but I realized that I had rarely left the 10-mile stretch of the main road that connects them. From the moment I stepped out of the collective taxi onto the street of her village, I was surprised to be in an unfamiliar place. A man carrying a little girl greeted me and said he was Hiba's husband and showed me to their house. They lived on the second floor of a small, new, modern-looking apartment building. Hiba, her newborn baby, her sister in law and her two children were waiting for me in the living-room. Hiba's husband quickly left us, confirming her description of him as a shy and quiet man.

Hiba's sister in law (her husband's brother's wife), Amira, was in her early twenties. She had married at 17 and had two children. She was the daughter of a rich man

in the village who owned a large villa at the top of the hill. She had married a poorer but educated man, but she herself had not finished high-school. She missed her father very much. She was the only girl and he pampered her. Her father used to feed her chicken with his hands and he still does when she visits. He used to wash the fruit and bring them out to the veranda where they would sit in the summer breeze for hours. Her move to her husband's house was a shock. With her husband, it is different. She has to clean, cook and take care of their two sons, and her husband does not help with these chores. She and Hiba had become very close since Hiba married and moved into the family. They were now neighbors, they keep each other company, help each other with house work and above all share memories. They were from quite different backgrounds, however. Hiba was a lawyer and the daughter of a doctor. Amira was the daughter of a land-owning family but she had married young and had not finished her high school degree.

Hiba pointed this class difference to me in private a number of times, saying that what brought two women from different backgrounds so close together was precisely the moments of loneliness that they experienced in their lives as wives and mothers, and the support they gave each other.

Hiba feels the same way her mother did upon leaving her family in Lebanon even though her parents live relatively nearby. She had been feeling lonely after her first and second births, even though she sees a lot of people. Her in-laws may live across the street, but she misses the support of her family of origin. They visit her but they can't give her the support and help with the children that she needs because it is not easy getting back and forth, and her sisters have now married and moved abroad. She feels like her family now functions like a nuclear family and no longer has an extended family,

because her closest relatives either live too far to be with her everyday or have emigrated. So she and Amira listen to each other's recollections and feelings of loneliness, as they try to help each other. She would not have been so close to Amira had they not gone through this together. Now, she "speaks from the heart" with any woman who experienced the hardships that come after a birth.

During my visit in Hiba's home, two women came to visit her. As coffee was served, we learnt that they had come to announce that the daughter was getting married. The daughter explained to us what her life had been like.

She was divorced, and her ex-husband let her see her children only once a week. Each time she would give them presents or clothes, their father's new wife would take them away. Sometimes, the new wife, who was strict with the children, would hit the children so that the daughter would come home to her mother with a blue eye. "What will come next?" She exclaimed. "Next thing we know, my daughter will only be doing dishes and cleaning." The young woman herself had had a step-mother. "It is impossible to love them," she sighed, tiredness defining the contours of her face. She was getting remarried, she told us, because she knew it would make little difference as regards to how much she could see her children, which in any case, she only gets to see once a week. It could not get any worse. Her husband had said that he would let her see the children after her marriage. But the children were worried. They had cried as they were saying goodbye to her the last time she saw them because they thought they would not be allowed to visit her after her marriage.

After they left, Hiba explained that the young woman had loved her neighbor, Ali, from whom she was inseparable. They were so in love, but one day they disagreed and she left him. Ali became so ill, ill from heart ache. People intervened on his behalf and talked to her until she finally agreed to marry him. "But his manhood was hurt by her initial rejection, and he sought revenge," said Hiba. They had two children but in his bitterness he created lots of problems. He is a complicated man, and he continually beat her. In the end, they got a divorce, but matters only got worse. She had many suitors since then, about four or five, but every time she and a suitor would like each other and get engaged, Ali would intervene to prevent the marriage. He would convince the suitors not to marry her, by raising doubts about her character. Although she was happy to be finally getting married now, she feels that she could have found a better match had it not been for Ali's interventions. Amira responded that when children are involved, so much it at stake. They become your heart, your body, your life. You realize that after you give birth. You become so much stronger and richer and yet so much more fragile. You can be broken. She realized after the birth of her first-born Mohammad, how much she missed her life as a little girl with her mother and doting father. She missed her parents but she cherished her new family. Her two children were the center of her life. And now that Hiba had become very close to her, they feel like they share a life.

"Opening a New Page"

The following oral histories are about the lives of Tahani and Lamis. Both of them are midwives from refugee and rural backgrounds. I had originally planned to interview them simply about their work as midwives, but as our relationship and

conversations unfolded, they took a turn to more introspective narratives about their family lives. Both had gone through difficult pregnancies, births, post-partum and divorce and have now, almost four years later, found spaces for themselves to continue with their lives through a combination of work, prayer and children, with very little family and societal support. "Opening a new page," is how Lamis described the beginnings of her new life as a divorced woman.

Tahani –

Tahani is from a refugee camp in the Bethlehem-Hebron area, originally from a village close to Ramla. She draws upon her mother's experience as a care-taker for her family after they fled their village to the camp to illustrate the kind of life struggle she is experiencing during closure, as she tries to keep her family together. She criticizes her mother's generation, however, for not "seeing" the abuse in their marriages and in many other Arab families.

I had known Tahani for two years now. She worked in a hospital. After she completed her shift, Tahani and I went to her room in the nurses' dorms, which she shared with one of her colleagues who was out. She began by telling me that if she had to talk about birth, she would have to tell me about her family as well as her work, because birth is part of both.

Tahani is from a village that is now inside Israel, close to the town of Ramla, near the "green line." She had visited it when she was a child but did not see it again until she was 20, as it gradually became harder for people in her refugee camp in the South to move around. The situation started to become difficult with the wars in Lebanon in the

1980s and then the Intifadas, one after the other, until it finally became illegal for them to enter the 1948 areas. But at least she had seen her village. The younger generation has not even seen the location of their village of origin, she said. Her parents left and moved to the refugee camp in 1948. They had tried to live in Jordan for a few months in the late 1940s; but that did not work out, so they quickly moved back to the camp. Her mother gave birth to her eldest child in Jordan and the rest were born in the camp. She had raised the seven girls and two boys in a place she did not know. She was from a village where they worked the land. Now she lived in camp on the outskirts of a town where they had to find jobs as day laborers in Israel. The two boys, Mohammad and Ahmad, came after all the girls. Tahani is the middle girl, with three sisters before her, and three after.

Her father was a construction worker and her mother, a housewife. When they were little, they thought their economic situation was good with their father being a worker. They went to UNRWA schools, like everyone else in the camp. The schools are free and she and her siblings did well academically. Her eldest sister was the first of her siblings to finish the *tawjihi* [end of high school exam]. She went on to study nursing for two years at Caritas [a Catholic charitable hospital in Jerusalem], where she then worked, bringing additional income into the family. In the summers, the whole family would work in and Israeli linens factories. During the school year, the children worked there only on Fridays, their day off from school.

She now realizes that they were in fact very poor, and that the family had relied heavily on her sister's salary. She wanted to alleviate the pressure on her father and sister by contributing to the family's income. As such, soon after her second sister got married, and moved to Saudi Arabia where she and her family now lived, Tahani quickly finished

school. She got accepted at Bethelehem University as she had obtained a high average on the *tawjihi*. They even offered a half-scholarship, but she could not afford the other half of the tuition fees, so she had to turn it down. Instead, she and her older sister went to Jordan, where they studied nursing for three and a half years on a Jordanian government scholarship.

Tahani enjoyed nursing from the very start, but her sister did not like the profession, and only decided to study nursing because it ensured a steady income. Her sisters had decided to study nursing because nursing ensured a steady income. But Tahani loved nursing. She had wanted to become a nurse for a long time.

In 1982 at the time of the *ahdath* [events – a restrained word to describe a series of events of political and social turmoil in the Arab world] in Birzeit and in Lebanon, before Sabra and Chatila massacre, she was injured by a *dumdum* bullet [a type of bullet that expands and fragments upon contact with flesh] in her stomach. She was injured in a demonstration that took place in her camp, following an attempt by the Israeli army to close off the camp by encircling it with a wall and putting checkpoints at all the entry points. The night of the demonstration, her parents were asleep, when Tahani slipped out of the house with one of her sisters. After the injury, she was rushed to Hussein hospital where she had to stay for a few nights, and where they operated to stitch up her stomach. This experience left its mark on her, and intensified her resolve to become a nurse. She admired nurses, whom she described as very giving, not because of their salaries, but because they love people. She felt that they were much closer to the *insan* [Man, humanity] than other people and more so than other medical practitioners. They were with people, the ill and dying, caring for them in difficult times.

These events had a profound impact on Tahani's desire to study nursing, despite her relatives' discouragement. They argued that it takes too long, and that there was not enough prestige in it. But she was stubborn, and wanted only nursing. When studying for her "diplome" in nursing, she was disappointed and frustrated by the teaching in Jordan. It became clear to her that the profession was more about being a machine than a human being. She returned from Jordan with a "diplome" in nursing at 22. A year later, she married and wanted to continue at Al-Quds University, at the nursing college in Ramallah. But the Ramallah campus was closed because of strikes and military orders. The University was breaking the military orders by teaching the courses in the Saint Joseph Hospital in Jerusalem. Although it was close enough for her to attend classes, she did not continue because there was "a big problem" with her husband. He did not want her to continue her studies. It had been three years since their marriage and they could not have children, which frustrated and angered her husband.

They had planned on having children, but they had so many problems. It started as a small problem and became bigger and bigger. And when the children did eventually come there were even more problems. She had twins, a girl and a boy, when she was 26. When they turned one, she went back to her studies and enrolled in a midwifery program even though her husband did not want her to. For a year and a half, she had to cope with babies, work and training.

She had been offered to study midwifery long before she started. Right when she started working as a nurse, the doctor told her that there was a midwifery program she should get into. But at that point it had not entered her mind. Nonetheless, she ended up finding herself in the program, studied it and loved it more than nursing. She loved

midwifery, especially having had her own children. It was a beautiful time in a woman's life, she told me. She was further encouraged by the building of the maternity clinic in her camp, as this meant that she could work there and avoid the trip to Jerusalem. But the clinic never opened. Now people are saying that they will open a health center not a hospital. But nothing at all has materialized. Fatah had money to open a maternity hospital. And as her husband was a member of Fatah, he told her that she would work in that hospital once it was established. This was another reason for her to continue her studies in midwifery.

A year and seven months after the twins, she had her third child. It was an exhausting period, in which she would pray simply to get some sleep. Once again, she had a newborn, this time in addition to two infants, and she was studying and training, all at the same time. Her relationship with her husband was worsening, and the problems at home increasing. Looking back now, Tahani considers herself as having achieved a lot during that period. She recognizes just how much she had to struggle to achieve those things, and she questions why a person's battles in attaining their degree are not written in diplomas. Some people get diplomas easily, but for her, it was not easy. She studied and worked and studied and had children and worked because she needed the money. Her husband did not work. It was the first intifada and he was not allowed to work in Israel where he had worked earlier on. Back then, this was relatively unusual. "Today," she said, "no one is allowed to go into Israel whether from a camp or a town."

The distance between her work and home was a strain on her marital and family life. She finished work and she had the children at home to take care of. And then it was time for her to leave home again. When she left home, her husband was out already. The

next day her shift would be in the morning, so she would be obliged to sleep in the dorms because she would not be able to get back to Bethlehem and then come back to the hospital in Jerusalem. She thought of her children all day long, whom she would leave with her mother in law. They were safe and well taken care of. But her husband would have to take them at night and take care of them and he would resent that. Their financial situation was very bad. She was obliged to work and her husband was obliged to let her go to work and take care of the children. He was obliged to be patient. But then things accumulated, his unemployment, his duties in the home and his wife's continued employment. He accumulated frustration. But their problems had started long before his unemployment. Tahani firmly believes that her work would not have been as disruptive had her relationship with her husband not been problematic from the start.

Her husband loved her very much, but was not as educated as she was. Their main problem concerned decision-making. At the center of their dispute was that her husband wanted to be in control of her salary even though she earned it. She earned the money but was not allowed to decide where the money should go. In his mind, she was *mamluka* [owned]. "His idea was: you work, I take care of the children, I have to endure the fact that you are far away from me, so the salary is mine. It is here that problems started." He wanted the situation to be inversed, for him to work and for his wife to sit at home. But, she had sought an education and she was a woman and therefore was more mobile than her husband in the current situation of checkpoints.

This was actually a common remark of employed women. Their husbands were frustrated that the closure gendered mobility in new ways. As in the case of Tahani, it is

easier for a woman to get a permit to get to Jerusalem or any other city and easier for a woman to get by on small bypass roads avoiding checkpoints. For me, it was usually more difficult to obtain permits to work in Jerusalem and they run the risk of getting arrested if crossing with no permit.

Tahani describes her typical workday as follows: she would finish her morning shift and having slept little the night before. She would leave work and begins the arduous journey home. When she got home, she would have to do the house work. Soon afterwards, her children come back from school, and she would cook and feed them. In the meantime her husband would be out, because often he comes in the evenings to stay with the kids so he takes advantage of the time she is home to go out. So they were barely ever at home together. Then when the children have eaten she steps out to find public transportation to go to Jerusalem to do a night shift and come back in the morning.

The main problem, Tahani tells me, is that husbands feel that wives are something like *mulk* [property]. Wives are supposed to stay with their husbands 24 hours a day. In the case of Tahani and her husband, this was not possible. If her husband would try to get a degree and work, things would be easier for him. So many times had she proposed to him to study, to do something. But his response would be just to go on a trip for two or three days. She was fine with that, if that was what he needed. She was careful to never make him feel that he could not go away, and that he had to stay home with his family. He used to go to visit his friends in the Galilee, and she felt he should be free to do so. If he felt he needed to change scenery from time to time that was fine. He went to Jordan too. But as for her, he does not think she should have that freedom. She should come straight back home from work every day, even though at that time they did not have

children. She could have stayed at the dorms, instead of taking the tiring road every day, but the thought of it made him angry. She had to go home whatever the road conditions may have been. It was exhausting her. During the Gulf War, all the roads were closed, so the hospital would send them home once a week. This had also angered and frustrated him. It caused so many problems between them. But at the same time her husband could not do without her work because she was the sole breadwinner in the house, especially as there was no work anywhere, and he was already unemployed. He was sitting at home all day long. She would come home from work and find him playing cards. He was tired psychologically, because she was not at home and he was stuck there.

"He never accepted that these were their living conditions," she said. She would tell him that if he could make a living and make the family comfortable financially, she would stay at home, had they been able to afford it. It tore her heart when she would leave for work and her children would tell her that they did not want money, they only wanted her to be with them. But what could she do? Their conditions were difficult. She used to make 2000 NIS or if she did many extra hours, she would make a maximum of 3000 NIS. Even when her husband was employed, working for the ministry of health, he only made 1200 NIS. She decided to take time off work in an attempt to save her marriage, so she resigned for a year in 1997. She was physically exhausted and felt that her children needed her at home. Plus, she was frustrated because she had been working but never saw a penny of her salary and had no say in where the money went. It was a matter of obstinancy. She wanted to be with her children and make a point to her husband, but very soon, they started having financial problems and getting in debt.

Birth in her Life

Tahani's children were born at the hospital. They were all normal births even though she gave birth to twins. The first twin came out from the head and the second came from the heels, a breech birth which the midwives pulled with forceps. It was a scary birth because she had a tear from the beginning when she was only dilated one centimeter. She was in labor from 10pm until the morning. The oxytocin they gave her did not make things any faster.

Her births were especially important to her because the first three years of her marriage, she could not get pregnant. The injury to her stomach had made it difficult for her to get pregnant. After her operation, the tubes to the ovaries were blocked. She went twice to the doctor. They gave her hormones. She was reluctant to take them because she did not think highly of such a treatment, but the doctors insisted. One of the doctors with whom she worked decided to do an X-ray to see if there was any apparent reason for her not to menstruate despite her taking drugs that induce ovulation. This was to no avail. He then gave her a different combination of hormones which succeeded in opening her tubes, leading to her finally getting pregnant. She thinks the twins are probably a product of the mixture of hormones she was taking. But, then again, she did have a family history of twins. Her mother's sister and their daughters all have twins. It is the story of women in her family and is inherited through the maternal line.

With twins, she could not do anything. She could not sleep, walk or sit during the pregnancy and thereafter for the first two years of their lives. She could not go anywhere with them. She would go straight from work home, and she worked at night, because she could not be away from home during the day.

Tahani described her twins as loud and crazy. They screamed a lot. They were little at birth. The girl was 1,700 g. and the boy 1,500 g. "Very *sghar* [little]; and I too felt very *sghira* [femine singular of *sghar*, but here it means young]." She continued, "even though I was 26 I felt it was a really new experience. I did not know how to hold them even though I had studied nursing. I felt like I knew nothing."

When she gave birth to her second daughter, she set out for the hospital during curfew, but the army stopped her. It was the day of the Hebron massacre, when a settler killed people praying in a mosque. Her birthday is on the 28th of February 1994. This is a memorable date in Palestinian political history. Not only is it the date of a commemorated massacre but thereafter the armed wing of Hamas (and much later that of Fatah) turned to suicide bombings.

Separation in her life

She separated from her husband and lived with her parents for six years but her husband would not agree to a divorce. The first year she would go to the police to seek refuge and complain. She managed to gain custody of her children through the courts, which applied an Islamic law ruling that allowed the mother custody as long the children were young and the mother did not remarry. She took them to her house, where they stayed until their father started taking them. He would collect them from school, and they would not come back. They would go out to play, he would take them, and they would not come back. He lived in the same camp as Tahani and her children, so wherever he would see them, he would take them. Once, she was taking her son with her to the hospital because he had a fever. Her husband ran into her in the street and took the child. People rushed to them as they were fighting and shouting at each other. She found herself

going to the police station every day, trying to get her children back each time. When enough pressure was placed on him, his husband would send the children back, but after a day or two, he would again take them. All this had a huge effect on the children: "they went crazy," she said. They were afraid that their father would take them, and they eventually stopped wanting to go to school. When their father would pick them up, they would start crying and yelling. It was so distressing for her, and it created problems for her parents, because her husband would fight and insult them in their neighborhood. The children would refuse to go. Then, the police would come and get involved. And the children would go to their father's place. For a period of six months she did not see her children. Only the youngest lived with her. She was the one asking for the children now, so she went to the courts again. The children wanted to come back with her, but that was impossible. She got so tired of the back and forth, of the whole separation story. The police was also so tired of the story. They just could not do anything anymore. They were powerless. They would go to his house and her husband would no longer give them the children. The only way the police could have gotten the children would have been by force and they were powerless, she said.

Her husband never regained custody through the courts but he kidnapped the children. It is not clear why the police is so powerless in this story. The police have no recourse except the go to his house and take the children to their mother. However, the police and Palestinian Authority can not threaten with jail as these don't exist. Later on in Tahani's story, she presses charges against him and the courts fine him. But he manages to put pressure on her so that she drops the charges in exchange for his agreement to a divorce. It seems that in their disputes, Tahani turned to the courts and her husband

would repeatedly turn to episodes of illegal and "crazy" activities such as stealing the children from school or yelling and insulting in the streets in the middle of the night. Her husband managed to tire the police and even tire her to the point where she dropped the charges against him. She did however manage to negotiate her divorce in return.

She thinks that in the end, what her husband wanted was divorce too. But he wanted his court case to be dropped. After the police dropped the case of Tahani's husband, she did not see her children in the open for two years. She would see them in secret at their school or at their relatives homes. Or she would sneak after them and follow them as they were going back and forth from school or to the store. Sometimes, she would not plan it. She would just find herself in their path.

Of work and money

Her husband was angry and wanted a divorce because she had sued him and the courts were asking for him. The courts wanted money from him. She did not want that money. She wanted to put pressure on him in order to see her children, by using money and the courts. It seems in a first agreement, she did not drop all the charges against him and she got some money from him. She said she did not use it for herself, she used it for her children.

Finally, they agreed to divorce, but that took six months. He would not appear to court. He would say that he was coming the next day and then not show up. In the end, she did get her divorce but at a cost; she would withdraw her court cases against him. She wanted nothing but the children, and he knew she would never let go of the children in court. She would have remained married to him all her life if the condition of the divorce had been not seeing her children. The agreements for the divorce in the court were that

she see the children once a week and that the youngest live with her. For the first week, he lived with her and then her husband broke the agreement and took him from her and she stopped seeing him too. He was putting pressure on her to retract all the demands for things he owed her, material things. The children, he knew, she would not retract from. She had built their house. She had bought their car. But she was so tired, she was willing to concede to anything just to get a rest. And she was wary and concerned by the effects their problems were having on her children. Sometimes now she thinks that she acted too quickly by giving up everything. But now she is at a different place than she was back then. In the middle of the problems, she was under so much pressure.

The major problem was the abuse, the hitting and throwing out of the house. Any tiny problem they would have, her husband would say: go to your father's house. She used to leave with nothing, only with a gown and scarf to cover her head. But the last time she said: "This time I will not leave." She stayed until the next day. He went to work and she prepared a bag with her belongings. She took her books, her passport and her clothes. That was the last time she entered their house. Her husband sent many people to do *sulha* [reconciliation] but she had had enough.

Her husband had problems with her work and money. She tired herself at work and got nothing in return. From her salary she took only pocket money, that is money for the road between work and home. She bought nothing. That was not permitted. And she would constantly nag, asking him where the money was going. He would say he was putting money aside. And he really did put money aside. He was smarter than she was, she said. He saved money and she ended up with nothing. After they separated he bought a Mercedes (a communal taxi), worked on the road (as a taxi driver) and remarried.

Nightmares and Daydreams

Tahani told me that had she been following the path of religion, the better thing to do would have been for her to live with the children. However, her husband created such problems and in the end the police were powerless. Most importantly, the children started suffering from all this, suffering psychologically. One of the twins, the older one started wetting his bed at night. All three children suffered from fear and nightmares at night. And then when they would sleep at her place, they would not leave the house, fearing that their father would take them from her. The children were under so much pressure that she thought leaving them would be the best thing for them in the current circumstances. She took the decision to let the children live with their father, but she went through the hardest time in her life. She saw her children once a week, but they would be stuck at home in fear of the outside. "You can't imprison a child at home," she exclaimed. During that time she was very tired *nafsiyan* [psychologically]. She was tired and felt guilty, crying the whole time. She would run away from the reality she was in by sleeping. After work she would come back to her house and sleep. She hated waking up. And then as she worked in the house, she would hear her children's voices. Her children were calling for her. She would see a mother and child in the street and collapse. With time, she got used to her children not being with her. She busied herself with studies at the university, with work, and with daily prayers. Her studies in particular distracted her thoughts from the children. Had she not gone back to studying, she would have gotten much worst.

How our mothers gave birth

Tahani's mother gave birth with the aid of dayat. In fact, "everyone's mother gave birth with dayat," she said. Very few people of her mother's generation gave birth in a

hospital. She does not think it is about money. Her father was working in Israel he could have arranged for her mother to give birth at the hospital, had his wife wanted to. Women would rather give birth at home than in the Israeli government hospitals. They preferred staying in their houses near their children. "Back then," she said, "the more they gave to their children, husbands and homes, the more they were satisfied, even if this verged on abuse." Today, women don't think in the same way, Tahani said. Tahani's generation is different. She, for example, in her relationship with her husband, could think of separation, and did separate because she was financially independent. Women no long share their mothers' willingness to "give and stay." She is not willing to be in a marriage half in the house half out of it, hearing 'go to your father's house' or being hit. Ten years she lived with her husband. During those ten years, she did not live in his house as much as she lived in her father's. Every year, it is a must that he kicks her out a month or two. And after he kicks her out, he sends people to negotiate with her family for her return. Women of her mother's generation used to be much more "patient" because there was no money nor place to go to after a separation.

Tahani thinks that if you go around and talk to women, talk to her mother, her neighbor, so many of them, if you go around into the families you would find so many problems within them. "It is frightening and much more than we think," she tells me. But if the woman is not financially independent, or if the woman is very patient [*min bab al-sabr*], she keeps the marriage together. But for her mother's generation, it was very unusual for women to see marriage in this light. They did not have the choice that she had given her financial independence.

It is first the children, then the wife who pay for a divorce not the husband. She has to calculate from the point of view of the children. The children will suffer. She has to calculate how she will make a living on her own and how she will be the most supportive to her children. If she did not have a job and were sitting in her parents house doing housework, she would have thought a million times before she got the divorce.

While she was debating whether or not to get a divorce, Tahani was thinking about how her children would think of her when they grow up if she were abused, beaten and insulted. How will her son respect her? And what will her relationship with her son be like? She will have no opinion or authority in his life. "In the end, she would have been abused, not free," she said. Now, her children come to see her once a week. She feels that she can give them an emotional boost for a week. Now, she can buy them what they want and do what she wants with them while they are together. In the past, she did not have that freedom.

The children are doing much better emotionally since she is divorced and since they have started coming to visit her. They dream the whole week of their meeting. They tell her about some of their problems. There are things she knows she oppressed them with [*thalamthom*] but when they come to visit her and she sees them, she feels she can give them back part of what she took. She sees them, talks with them, goes on walks with them. Even their grades are better. So she thinks that in the future she can do something for her children more than if she had stayed with her husband.

She is of course angry at the fact that the children live with their father. She is able financially and thinks she should be allowed to live with her children. Sometimes women divorce and go live with their parents or sibling, off the charity of that house. In

those cases, fathers often take the children. And then, some women divorce and want to get attached to another man, because she is not financially independent. Tahani is financially independent. She covers the costs of her children and parents with her salary; hence, she is not thinking of remarrying. She does not need a husband and no desire to go through all that suffering and harm again. Maybe a woman who has not had children would want to remarry for that reason. She may think she will live a better life. Or even a woman who hated her husband and separated from him, she may think of remarrying. But for Tahani, with the history of abuse in her marriage, she lost her trust in men. She sees many good and educated people. She had four suitors come ask for her hand since her divorce but she turned them down. Maybe one day she will find the human being she loves. "As they say, love is blind." She won't forget her marriage experience, but she could forget her resolutions if love came her way.

Lamis –

Lamis' family is settled in a village near Ramallah. She was from there she said. Another woman from her village said that she was from Gaza and had resettled in the village. Her family was from Gaza, Lamis had responded but she was from the village. She was one of the first people I met on the field. I met her during my preliminary research at a hospital. She had been working there for a number of years. She took me through the labor room on my first visit and talked to me about how difficult work and family conditions had become with the closure. She was in her mid-thirties, was divorced and had a daughter. She complained because her workload was so large and she had to live in the nurses dorms because it was too difficult to get back and forth from her

village. In the beginning, she used to travel from her village to the hospital every morning, but that was just impossible. Then, she started going back once a week, but soon, she stopped getting permits to get into Jerusalem. So, she would come in and out illegally through side roads, but that too became difficult so she moved to the nurses dorms and would go back to see her daughter every two-three days. Now, she cannot even go back to see her daughter once a week. At least, she can send money home. It made her sad that she could not see her daughter but she said that her daughter was what gave her motivation to stand strong on earth.

I interviewed Lamis again two years later. This time, I asked her to talk about her birth experience. She started with her own birth in a village in the Ramallah area. She came from a big family. They were 7 boys and 5 girls. She completed the 8th grade in her village and then went on to a school in Ramallah where she studied in the scientific branch. Her father died while she was studying there, so she had to leave school. Later, she was sent, along with her three sisters, to *Dar al Tifl*. This is a school in Jerusalem for families in need of boarding for their children. It was founded in 1948 by Hind Al-Husseini, a notable family from Jerusalem, after the Deir Yassin massacre. The school boarded and educated orphans of Deir Yassin and soon started taking in other children in need.

There, she worked as a daycare teacher for a year and then asked the director if she could finish her secondary education. She felt lucky to have gone to such a great school. She had about 12 children under her supervision. All the students there were either orphans, very poor or in a difficult family situation. After being a daycare teacher for a year, the administration of the school thought it good for her to go back to studying.

Upon graduation, Hind el-Husseini, the late founder of the school, proposed to her to go abroad and work for a family but she decided not to because she was the eldest girl and felt she should help her mother with bringing her siblings up. So the director proposed that she study nursing at Makassed. She protested saying that with the average she got she should be able to go to University but the problem was funding. Al-Husseini said that she would try to find financial help for her to go to the Arab College for Nursing at Al-Quds University. In the meantime, she went to Jordan to see if she could enter University there, but her relatives there were of no help whatsoever, so she came back to Palestine.

It was the beginning of the First Intifada, and things had changed. With a high grade on her *tawjihi*, she could get a scholarship to go to University. She studied nursing and finished college with a high average. That year, Makassed was hiring the best students of each year from the nursing college. Her interest was in mother and child health so the hospital was enthusiastic about hiring her. She worked there for six months then received a grant from the Norwegian government, through the hospital, to train in midwifery.

For six years, she worked at Makassed. During that period, there was a big change in her life. She got married, to a returnee, a civil servant for the Palestinian Authority. He is originally from Gaza and maternal cousin. He worked in Jericho and then in Ramallah. They had agreed to live in Ramallah together after their marriage. But soon, problems started and escalated out of proportion. Her husband told her that his mother became sick and that he had to go to Gaza, but he never came back. He said that the Israeli authorities did not let him come back, but Lamis did not believe him. She did not think it was possible that his parents did not have a contact in the Authority who could get him a

permit from the Israelis. He was angry that she thought that he was lying. Matters got worse when she found out that she was pregnant. She was under pressure from her family to get an abortion but she wanted to get pregnant because she wanted to have a child. She was 27, and wanted to be a mother. She knew that her life with her husband had ended from the moment her problems started. From an emotional perspective, the pregnancy was very difficult, a hard experience and that is why she feels close to all the women who go through these experiences especially those who went through emotional *atha* [harm]. Some women go through emotional abuse without knowing it and that, she thought is even worse. However, she knew the minute the problems started that she was being mistreated and she calculated it: she was not capable of going to Gaza and putting up with her mother in law because she is really *mit'asbeh* [conservative]. Even though she was marrying from her family, she had grown up in another region. She felt there was a big cultural gap between Gaza and Ramallah in terms of the customs and traditions. It is not about religion, she said. It is about *thaqafa* [culture, education, way of thinking]. Women in Gaza think differently. Here, she talks with her colleagues, men and women; most are younger than she is and they respect her. She wonders whether that would be true in Gaza. Moreover, her mother in law never wanted this marriage. She objected to Lamis' "being from Ramallah," and wanted to find a way to have them divorced. Her son was engaged to another maternal cousin before leaving her for Lamis, and the mother would do anything in her power to have him now leave her, and marry this maternal cousin. Yet Lamis was also his relative, from the maternal side. After her mother visited him in Jericho she invited him to Ramallah. Lamis was then in her fourth year of university. Things happened quickly. Their relationship developed and they loved each

other very much for a long time, whilst remaining respectful of customs and traditions around love and relationships. Then they married, but after that, she does not remember many things. She does not know how the problems started.

In the sixth month of her pregnancy, her husband *talabni la bet atta'a* [demanded her [me] to go to the corrections court] – he took her to court to start divorce procedures. She stopped him by promising to go with him to Gaza, she would give him a chance, even though she would be away from her family, work and familiar environment. In response to that, he started crying like a child and asked her to forgive him, admitting that his mother had put pressure on him to do all this to her, to take her ID card and permit into Jerusalem and to demand a divorce. She had gone to Gaza and could not stand it. Her relationship with her mother in law and even husband was difficult. She considers that she gave him a chance. She had done a lot to save the marriage. Moving to Gaza was more than she ever thought she could give for a marriage, so far away from her family, colleagues and village. She realized he had no character, no backbone. So she told him she wanted to end everything and go on with the divorce process. She came back to Ramallah, gave birth and divorced.

Her daughter was born at Makassed. She is embarrassed because she is a midwife and tells everybody they should have natural births, but she had a Ceasarian, because she was under too much pressure. Her mother in law was putting pressure on her to terminate the pregnancy. "I was the only person who wanted this child." So she was doing everything the right way for the pregnancy in terms of nutrition and exercise. She did not have psychological support. She did not have a husband who wanted the baby the way she wanted the baby. And there was pressure from her side of the family too. They did

not want this baby. It is so hard for her to forget this period. She wanted the baby but neither her family, nor her husband's wanted her daughter.

The families did not want any remaining connection between the husband and wife after it was clear that they were going to have a divorce. They wanted to make sure that there was nothing that could bring them back together. The families knew that he loved her very much and that she loved him very much as well, for this reason, they feared that if she were to give birth to his child, and spend two years without remarrying, chances were that they would try to be together again. Instead, he re-married and had a girl and a boy. He speaks to his daughter with Lamis every day on the phone. Recently he has been calling Lamis more and more and he tells her that he still loves her.

Lamis says, if someone were to tell her that she should get married to any man she wants she would ask for her daughter's father even though he has remarried. She would do it for her daughter. She wants her to be psychologically healthy to feel that she has a father and is wanted by her father. But her problem is fear. She will always be afraid of marriage with him. She will never trust him or his family. Even though she loves him, she considers that she "opened a new page" when she got her divorce.

Of course, she wanted a normal delivery. She would push anyone to have a normal delivery because she knows how important it is. But she also knows how psychosomatic it can be. "The woman will take the pain for her husband, in order to beget him children. She wants to share this baby with this person, her husband. The birth and the baby is something a man and wife have together. The husband and the wife's blood are in this new person. The husband is the person who can do the most to lighten things during the birth. He can support his wife, be nice to her. He can make things much

easier for her." She used to notice this during the closure. The women would come to the labor room frightened, they would not be able to go home, and they had to come alone without their husbands because often they could not get into Jerusalem. Lamis would think this woman is going to get complications because she is afraid. Complications during birth usually come because women are afraid, she tells me. "So what do you think of a woman who lost her husband and loved-one from the beginning? And then, even her family of origin did not want the baby." She repeated that no one except her had wanted the baby, and that she was under too much pressure to manage a natural birth. Until the last moment she felt she wanted a normal birth, but when they told her it looked like her baby was tired, she knew that it would be hard for her to have a normal birth. She simply could not manage the natural birth.

She works a lot without coming home and she does not want her daughter to ever have to feel alone. That is why she tries to go back to her village as often as possible. And she made her husband stay in contact with her daughter even though he can not come to visit her. She is the one who asked him to call to speak with her daughter. In the beginning, he did it because they had an agreement. Now, he does it because he misses his dauthter.

When she got her degree, she started teaching at the governmental nursing college, Ibn Sina, for two years. She had a lot of work and was paid 1900 NIS. She stayed with them because she had the dream that the authority would give her a scholarship to finish a masters degree. She waited two years and the scholarships did not come. Her financial situation had deteriorated. She worked in the mornings at Ibn Sina and in the evenings at a hospital for a year and a half until she finally collapsed. She was working

from 7am to 11 pm. She would go back to her daughter exhausted and again her daughter would be at her breast all night long. She wanted a solution. Her daughter was now 3, and salaries were going down at that hospital. So, she decided to go work in a hospital in Jerusalem even though it meant crossing checkpoints and leaving her daughter with her mother.

As much as she loved her profession and through it feels a connection to women, she says it is a job that puts pressure on the home and family that is why she does not want her sister to study midwifery or nursing. It would complicate her life, especially if she marries a poor man.

Lamis said that an unusual number of midwives were divorced or unmarried. She thought that the reason that midwives married late or not at all was because they studied and became educated. It becomes more difficult for them to do what society wants them to do. Men from their villages and communities think that having an educated working woman will mean a difficult family life.

She kept her sisters away from nursing and midwifery. Both of them are now married. They married young. They look at her life choices, to study, to get a divorce, to have her baby and to work and they tell her when their husbands are not listening that she has made better decisions that they did in their lives. But lives are made of *qararat* [choices] and *qadr* [providence].

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Tahani and Lamis's narratives of enclosure describe new gender and domestic dynamics. Checkpoints gender in new ways. For a woman, it is easier to pass through

checkpoints. For women from families who need their income, the closure has meant that often, they can find employment whereas their husbands can not. It inverses gender roles in the homes in a frustrating way for both Tahani and Lamis' husbands.

All the narratives refer to their mothers' experiences to tell of genealogies of enclosure. While drawing on their mother's histories, Lamis and Tahani, those who have "opened a new page" after the post-partum, see themselves as having liberated themselves from some of the restraints on their mothers lives.

The post-partum stories seem to be de-politicized and de-nationalized compared to the highly nation and institution centered birth stories. They are about being enclosed in homes whereas birth is about getting out of homes, across checkpoints and in contact with the institution. Yet, these domestic narratives of enclosure may be precisely where to find new kinds of deeply political subjectivities in Palestine. They are about their conditions of enclosure and a kind of dislocation in their own homes, their villages and their occupied country. They describe a transformative moment when their conditions of enclosure makes them seek new alliances and ways of thinking and seeing the world. In a sense, they have all "opened a new page." They describe eloquently both the force and the pathology of waiting in everyday life.

Conclusion:

In August 2006, two years after the completion of my fieldwork, the situation in Palestine as regards the issues I have dealt with in this dissertation remains much the same. Newspapers still carry stories about women giving birth at checkpoints; women still discuss births, their locales and their political and personal implications; doctors still run for parliament, and politicians still appeal to their background in the medical profession to garner support for their campaigns. And the various types of small or big, temporary or permanent closures remain in place, sometimes relaxed, sometimes reinforced. As Hamas won the historic legislative elections in January 2006, marking a change of government through the ballot, most unusual in the Arab world, the turn of events echoes the previous characteristics identified in my work with remarkable continuity. Suffice it to mention here that the post of Foreign Minister, one of the most important functions in such an isolated entity, was filled by Dr. Mahmoud al-Zahar, a surgeon from Gaza (who is also the only remaining founding member of Hamas to escape assassination). The encroachment of the medical domain (and its persons, rituals, imageries) on the practices of governmentality in Palestine, therefore, goes beyond a particular moment in time and certainly beyond party politics to seep into the very structures of everyday life.

The central question that informed this project at its inception concerned the world of birth under the regime of closure and fragmentation that governs the lives of Palestinians. It was a matter of employing birth as a window onto local society and

politics. From there, I let my ethnography carry me along the winding rocky roads of the Palestine hillsides, and discovered that my questions changed and, ultimately, accepted that the practices of everyday life, however fierce the regimes of power they are subjected to, demand the space and flexibility that will make them be heard.

When I first went to the field of my research, everyone spoke to me about particular social and medical movements that were understood to be at the heart of the building of the health infrastructure in Palestine. This was confirmed by my reading of recent Palestinian history. I had expected to be confronted more directly with state practices and the formation of individual subjectivities. Instead, I was struck by the importance people attached to networks and movements as fundamental units in understanding the recent history of state and nation-building processes. This position resonates with Michael Fischer's (2006) identification of toxic waste stories, water stories, urban stories, medical stories as well as animal and biodiversity stories as a site where "processual narratives of structural transformation" as a set of stories about political economies, modernizations, forms of governance, mappings of ecological feedback systems and new modes of self-organized civil-society coordination sometimes takes place in polyvocal, interactive and experimental ways. Furthermore, it finds resonance with Blecher's (2002) work on the history of the region during the late Ottoman and mandate eras, stressing that the genealogy of individual rights should not be seen as simply relating to an ever more encroaching disciplinary regime. Rather, the dialectic between the modern state and individual subjectivities should be understood as being mediated by overdetermined and yet autonomous networks and movements that have a history and praxis of their own.

It is for this reason that I decided to open my discussion with an engagement with social movements and health care, whilst at the same time offering a short historical background of the practices of birth registration in Palestine. The two health movements I examined are quite different in outlook: where Makassed hospital signifies an urban, technological model of health, the UPMRC, by contrast, symbolizes a decentralized, grassroots model of health. They nonetheless meet in their explicit overlap with the political sphere, and this, not only on the ideological level of differing articulations of the nation, but also in their very structures and hierarchies.

After the fall of the Soviet Union and the rise of neo-liberal politics, the primary concern for social movements became the quest for ways to mobilize people and resources in a post-socialist, market-driven age. Despite the incessant talk of the end of history, of grand narratives, of ideologies, my ethnography demonstrated that the new public health infrastructures actually show remarkable continuities with the previous social movements of sumud and popular health, even though they explicitly participate in the market-led liberalization of politics and discourse, thereby marking a break from previous practices. The social structures of the neo-liberal moment are often seen as a simple, direct, unilinear subjection to a larger, globalized capitalist machine. However, looking more closely at and listening more attentively to the particular histories of local movements, it becomes apparent that they have distinct organic genealogies and are not entirely donor-driven. In fact, their trajectories are in some ways analogous to those of the older, explicitly socialist and nationalist, movements. Beyond the level of the relationship to the market, the shift, then, happens at the discursive level, with a

humanitarian ideology anchored in a discourse of rights replacing the now passé ideology of socialism and class struggle.

Another thing that struck me during my fieldwork was the preponderance of stories of medical malpractice, critiquing doctors or even vilifying health professionals. At the first level of analysis, these constituted a genuine critique of the medical system and the type of care women received. But it also appeared to be a mechanism for some kind of community supervision of the provision of health services in the absence of a functioning legal system; forcing, for example, a vilified doctor to flee a village, or a criticized one to be fired from a hospital. It could therefore be understood as a locally based system of checks and balances. Finally, and perhaps most revealingly, these stories demonstrate that in Palestine, doctors overlap more directly than elsewhere with the political leadership, not only symbolically, but indeed substantively. Doctors *are* politicians. Their work as doctors forms a powerful claim to a proximity to their political and social constituency, and the doctor here heals, saves, or sometimes even kills, both patient and nation.

Having presented the structural topography of medical practices in a framework of institutional mechanisms, I quickly realized that it was nonetheless important to scale down from that level in order to hone into the more individual and personal stories and narratives. As such, the last two chapters aimed at letting loose the narratives of the central actors of the world of birth, the mothers; who are sometimes portrayed as voiceless. Yet, mothers were at the very center of political and medical discourses, just as they were primary to my ethnography.

I identified two important genres of birth stories, the first, narrated by mothers, and the second, culled from the print media. Each genre has a common structure, style and finality. The former is told in a very ordinary register. The mothers remember the space of the hospital – a socio-economic space signaling class and origin –, they talk of the travel from home to hospital and back. However, these stories have an uncanny dimension to them, which is embodied in the fact that, in the context of occupation and closure, waiting, check points, and low intensity warfare end up partaking of the ordinary. The newspaper birth stories, by contrast, are dramatic and sensational. They tell stories of births at checkpoints or in prison, and revolve around the themes of occupation, suffering and resistance. Most importantly, they carry a redemptive essence: although the imprisoned woman can no longer fulfill her family obligations, she takes on the role of a political prisoner; the woman who cannot reach the hospital names her checkpoint-delivered baby by a signifier of struggle and resistance; the baby or mother who dies at a checkpoint is a martyr. The genre of birth stories that appear in the field of print media thus cultivates a space of miraculous redemption, but, in opposition to the birth stories narrated by mothers, the reader experiences the stories as familiar and ordinary, an accompaniment, perhaps, to a morning cup of coffee.

Such considerations led me, finally, to attempt to understand and recount the lives and stories of individual women under the impress of political, economic, and domestic pressures. These interviews took place with women at least one year after their first birth. In sharp contrast with the birth stories, which entrenched highly political issues into the discourse on health practices, post-partum stories paint the world of selfhood and subjectivity. They are about family, homes and selves. While birth stories are about

crossing checkpoint to get to a hospital, stories on the experiences of the post-partum are about being enclosed by checkpoints, and by the four walls of the home. While the underlying critique of the socio-economic, political and gender-based hierarchies of society remains present, the post-partum stories speak to these issues through the apparently a depoliticized realm of emotions and psychological states. It is in the lexical field of loneliness, love and enclosure that they are articulated. This discursive shift indicates the move from a moment of contact with the institutions of medicine and state to an elongated and intense period of reflection on family and self.

And in this way the various different components of the study came together to speak of the politics of birth in Palestine, fragmented by closure and characterized by multiple hierarchies, narratives, and selves.

It remains to be asked what is particular to this study and what can be generalized to other cases of the politics of health and birth in the context of competing ideological claims and processes of state and nation-building. It is evident for example that Palestine shares an Ottoman past with its neighbors and a post-colonial condition with most of the world. The alienation of patients from medical practices and of subjects from state practices are a staple, if not a condition, of the age of modernity. Popular social and health movements surely cannot be considered the monopoly of a specific people or anti-colonial movement, and the globalized neo-liberal moment has been accompanied by autonomous local movements and histories everywhere. Similarly post-partum depression and its concomitant sense of loneliness and isolation is a story known to women in many parts of the world. What is unique, specific and peculiar to the

Palestinian situation, however, is the systematic and yet unpredictable presence of closure. Closure is the unifying element in all the actors and all the narratives in this dissertation. For Palestinians, it defines the parameters of everyday life and it has equally shaped the analytical and practical contours of my ethnography and research – it is, quite simply, at the very heart of the Palestinian experience. It forms the oral history of past movements, fosters the creation of new infrastructures of health, regulates the spatial and temporal realities of individual and collective experiences, and leads us to reformulate our imaginary of politics and existence. It is indeed hard to imagine freedom beyond the checkpoint. The closure appears as the powerful, chronic motor that regiments the pathologies of the quotidian. Hence the centrality of waiting in my narrative, and in the stories of all those involved in its construction.

Birth is always a window onto the political and social characters of a place and this is true in the case of Palestine. We have seen that the protagonists of the world of birth – doctors, midwives, nurses and mothers – produce a continuum of narratives around birth, power and resistance in everyday life, which in the end comes together to produce a central image of occupation and closure. These become an all-encompassing, determinant force that continues to drive these different stories, from which they cannot break free, and that is seen as present for many years to come. Waiting becomes the state of facing the world. The challenge is not only to render everyday life livable and intelligible but also to find gaps and interstices in the structures of power that permit quests for justice and the contestation of the very essence of the system. And until then, we continue to dread, to hope and to wait.

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Appendices

Following is my translation of an excerpt of the article from *Al-Quds* Newspaper on January 26th 2003.

A mechanic from Jenin is able to assist his wife's birth in his car

[...] Fakhr Abdel-Rahim was able to surmount his fear as his wife's screams for help became louder. He collected his strength and had no choice except to try to help. Abdel-Rahim lived in the village of Sila close to Jenin. In the early afternoon, he left his village in a hurry to accompany his wife to the hospital because his village has no health center. [...] On the road, he called the Red Crescent who set out with an ambulance to meet them on their way. But they were stopped by soldiers and kept waiting at a checkpoint. When he called them, they said they would do their best to pass the checkpoint.

Minutes passed. "They felt like days," Fakhr said. "I sat at my wife's feet praying that God help us and I had no choice but to help her in childbirth. I was in a terrible state. It is hard for me to describe it. I found the newborn in my hands. His color was black. This was the first time I had seen or assisted a birth. I thought the child had died. I tried to save him. But I had this feeling that I would lose my wife and baby due to my ignorance."

The wife's state was not very different. She lived moments she would never have expected, between life and death. She says that she thinks that God wrote her a new life and saved her from death that she saw and lived literally as she watched the fear of her husband who knows nothing about birth and reproduction. "What is this oppression that

we must live and what law does not allow me to get to the hospital and makes me suffer in a car? I never imagined my birth would be in the street."

She adds: "It is not possible to imagine what happened to us, there are no words to describe our state when the newborn came out black. I was so exhausted by the fear of losing my child. [...] When I got to Al-Razi hospital and they told me that my baby had survived, I named him Yahya [derived from life; to live] so that he lives [yahya] and because God gave him life." [...]

Excerpt from an article by Ali Samudi in *Al-Quds* newspaper, January 26th, 2003.

Two children see Light Inside Jail

80 Female prisoners in Occupation Prisons living terrible inhuman conditions

[...]There are 13 prisoners who are mothers, two of whom gave birth to their children during their jail time. Their names are Manal Ghanem and Mirvet Taha. The freed prisoner Umm Hani says that prisoner Taha who is serving a four year prison sentence gave birth to her son Wa'el in jail about a year ago. He lives with her in difficult conditions, not proper for the demands of their lives.

In addition, prisoner Ghanem gave birth six months ago to a child she named Nour [meaning light], who lives with her in difficult conditions, especially because she suffers from thalassemia. Her son has not been tested for the condition. [...]

Legal and human rights organizations have affirmed that Hasharon prison has between its walls, in its rooms and cells, many humane stories about Palestinian women

who loved their country, living and working for it. Their destiny was imprisonment in inhuman conditions missing the simplest parts of free and generous life.

Nevertheless, the female prisoners continue life in the belly of death, ringing the walls of the container, facing their captors ...and they turn into 80 princesses who left everything in the name of country and humanity.

(Excerpt from *Al-Ayyam* daily newspaper from the April 17th, 2004 issue on the occasion of prisoners' day; my translation).

Female Prisoners...Bitter Experiences!

Mothers

[...] "A female prisoner is suffering in multiple ways. She is the mother who gave birth to her child in prison and cares for the child for two years in custody in the darkness of the cells. The examples are multiple like Omaima al-Agha, Samiha Hamdan, Majida al-Salaima, and the last ones, prisoner Mirvat Taha and prisoner Manal Ghanem who gave birth to their sons last year.

She is the woman who suffers illness and medical negligence which prison administrations are known for. She is the woman who waited patiently for many years sometimes for more than 10 years such as Itaf Alian, Zahra Qaroush, Nadia Khayyat, Fatima Birnawi, the first Palestinian female prisoner and others. [...]

Palestinian Laws do not recognize a child born in an Israeli Jail

In the darkness of jails, Nour is now four months and he has not received a birth certificate

The child prisoner Nour Naji Ghanem who is four months old has yet to get a birth certificate proving that he is a Palestinian national because his mother gave birth to him in the prisons of occupation.

This child's difficulty is part of the sufferings and hardships that women who give birth in jail must face. It is well-known that it is difficult for prisoners to send an official document of birth to the Ministry of Interior to produce a birth certificate with the name of their child.

Naji Mahmoud Ibrahim Ghanem, the husband of Manal Ibrahim Abd El-Rahman Ghanem (27 years) who was arrested on the 17th of April 2003, says that he has not been able to visit his wife since her arrest for alleged security reasons. He has yet to get permission to see his son Nour, born in jail even though he was backed by efforts of the Red Cross and other human rights organizations. He said that through the Red Cross he was able to secure a faxed copy of the birth certificate but the Palestinian Ministry of Interior requires the original birth certificate and refused to work with the faxed copy provided by the Red Cross and Prison Authorities. Hence, he went to the offices of his governorate which would not do anything for him.

He said that the laws that the Palestinian Ministry of Interior rely on do not recognize the legality of a prisoner child born to a prisoner mother still suffering in Israeli jails. [...] He said: My wife named their son Nour [Light] because he has never seen the light of natural life. He has always been imprisoned [...] He does not have a birth certificate proving that he is of Palestinian nationality because he is born of the suffering [...] of female prisoners in occupation prisons. I am worried and scared for my wife and child.

He said that his wife suffers from thalassemia and has three other children: Ihab (8 years), Niveen (8 years), and Majed (6 years). Majed also suffers from thalassemia.

Ghanem said that his family's difficulties started on the 17 of April 2003 at dawn. Soldiers entered their house in an aggressive manner at about 4 AM and started beating him up. The children were terrified and tried to protect their mother. The soldiers then pushed the three children violently to the ground and took his wife to one of the army jeeps ignoring the screams of her children.

His family is now scattered because of his wife's absence. Majed and Niveen live at their grandfather's house and Ihab lives with him. Ihab says that life without his mother is difficult. He remembers vividly the day they came to his house. They beat his mother before they pushed her to the floor aiming their gun at her. I feel scared when I think of what will happen to my mother. But my father tells me that my mother is strong and is able to be steadfast in the face of the occupiers.

Ghanem was arrested (...) because she had been riding in a car with a number of wanted men on her way to work in Al-Baqa al-Gharbiyyeh inside the green line. [...]

(Excerpt from *Al-Ayyam* newspaper April 17th 2004)

Prisoner Sbeih Gives Birth to Her Child at an Israeli Prison Hospital

GAZA, May 2, 2006 (IPC + Agencies) - - At the Mair Military Hospital near the city of Kfar Saba, north of the Israeli city of Tel Aviv, the first cries of a young Palestinian baby "Baraa'" echoed throughout the hospital, following a cesarean operation for his mother, prisoner Samar Sbeih. Samar's husband, Rasmi Sbeih, who is also a prisoner at the Negev Desert Prison, said that his wife gave birth to their first child at an Israeli hospital operated by the Israeli Prison Service. Sbeih added that his wife gave birth under harsh

measures, and was handcuffed during her pre-delivery tests, and she was uncuffed only when the doctors decided she would undergo a cesarean operation. The Ministry of Prisoner and Ex-Detainee Affairs, along with several human rights organizations, have managed in the past weeks to obtain a judicial decision forcing the Israeli Prison Service not to cuff prisoner Sbeih while giving birth to her child - as was usually done when Palestinian prisoners give birth. "I want to know if there is a law in the world that denies me the right of being transferred to another prison to attend my wife's delivery," Rasmi Sbeih said, calling on the international and human rights organizations to intervene and allow him to see his wife and new-born son.

Samar gave birth to her son without the presence of any member of her family, after Israeli occupation forces refused to enforce verdicts that allowed the prisoner's sister and husband to attend the delivery.

The 22-year-old prisoner who is originally from the Gaza Strip, is married and lives in Tulkarem. She was arrested on September 29, 2005 and was sentenced to 28 months in prison, after Israeli authorities accused her of receiving military training and affiliating with the Hamas movement.

Samar's husband has been administratively detained at the Negev Desert Prison, and recently his detention was renewed for the second consecutive time. (From the International Press Center, the Palestinian National Authority State Information Services, May 2nd, 2006).