Gender and Nation Building in the Middle East
THE POLITICAL ECONOMY OF HEALTH FROM MANDATE PALESTINE TO REFUGEE CAMPS IN JORDAN
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GENDER AND NATION BUILDING IN THE MIDDLE EAST

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... We can also call unity health. The very word health means, ‘whole.’ Our deepest health, beyond even life and death, lies in our inherent completeness, integration, and connectedness.


Let not the flame of your awareness
be clouded by conclusion.

from *Strands of Eternity* Dr. Vasant Ladd,

**History as Spiritual Science and Medicine**

**April 1990**  Salwa and I visit with Nueva Esperanza, a grassroots organization, in the city of Holyoke, Massachusetts, USA. Dr. Salwa Najjab-Khatib is a Palestinian physician/gynecologist. She initiated the Palestinian Women’s Health Project under the auspices of the Union of Palestinian Relief Committees (of which she was a co-founder in 1988). Along with her colleague, Dr. Ruchama Marton, Israeli Jew and founder of Israeli Physicians for Human Rights, Dr. Najjab-Khatib is on a tour organized by the Middle East Peace Coalition of western Massachusetts (in 1987).

I drive along Route 5 to give Salwa a sense of the local landscape. A twenty-mile drive takes us past large plots of land with sprawling homes into the ‘heart’ of the city where tenement apartment houses are pushed up against one another. Here
the population is predominantly Latino/a, and most are struggling for economic solvency. In that period of its history Nueva Esperanza developed a women’s health project. We were on our way there to learn about the health issues facing Latina women in Holyoke and to learn about their methodologies and visions in coping with those issues.

A group of women warmly welcome us and direct us to a wall filled with posters made by women for women. Images tell the story – breast cancer, diabetes, hyper-tension, health hazards of smoking, hazardous work conditions, health hazards of high unemployment, health hazards of attendant poor housing and improper nutrition. We pour over hand-outs, so similar to the ones, written in Arabic, that Salwa’s staff prepare in her clinic in Beit Hanoun.

After sharing stories over tea, with hopes of staying in touch and building a network to share information and to explore historical links and struggles, we walked out into the gathering dusk. With her characteristic equanimity and penetrating gaze, Salwa turned to me noting that Latina women in Holyoke are coping with the same kinds of conditions that Palestinian women are coping with living under military occupation.

Connecting domestic and international ‘Third World,’ Salwa’s comment circumvented the ‘bifurcation’ that kept these world apart. Like Palestinian refugee women, women living in poverty in Holyoke were without services critical to their survival and were suffering from environmental degradation, inadequate housing, low wage labor and high unemployment, all stressful to health and well-being. Both sets of women live in communities whose streets are dangerous, heavily policed (‘occupied,’ in the case of Palestine), and whose populations have a history of dealing with police brutality and racism. Salwa’s observation became a motivating factor for continued research on the war over Palestine from a geo-political perspective rooted in gender/race/class analysis. In particular it opened a path for using the paradigm of healing, applied in a geo-political context, to explore causes and conditions leading to the war over Palestine.

For example, links between health issues of women in the U.S. and in Palestine emerge as part of empire building associated with colonial history. U.S. physicians experimented on the bodies of Palestinian women to test out the IUD (Intrauterine contraceptive
device) before it was put on the market for U.S. women’s use. (see, for example, Young, ‘A Feminist Politics of Healthcare.’) Although it was eventually found that the IUD can cause infertility, this was the device that the World Health Organization made available to Palestinian women during the period that I visited Salwa’s clinics in the late 1980s. In addition, British administrative policies controlling livelihoods of Palestinian *dayat* (midwives) during the British Mandate period were borrowed from American policies that put African-American granny midwives out of business. In both of these examples, control over women’s reproductive processes and livelihoods as midwives was part and parcel of imposition of particular gender/race/class hierarchies informing modern nation state building.

The visit of Salwa and Ruchama to western Massachusetts brought into the foreground ways women utilize health care as a paradigm for healing the planet from the politics of war. There are traditions and current practices among Palestinian women (and among Latina women) emphasizing continuity, integration, and wholeness in relation to biology, the earth, community, and politics that inform definitions of health and health care systems. Perhaps a closer study of such paradigms and awareness of their historical place could be a path toward recognizing ‘our inherent completeness, integration, and connectedness’ so vital to world peace.

Dr. Najjab-Khatib’s analysis of women’s health variables showed that Palestinian women’s health issues arise out of a nexus of local/global economic, social, historical, political realities. In terms of organizational structure, Salwa’s women’s health project and the health project of women at Nueva Esperanza were similar. Definitions of health and health-care systems were rooted in women’s day-to-day experiences of their bodies in their environments. Both projects trained local women and sent them back into their communities. Both utilized posters and easy-to-read and ‘digest’ pamphlets designed by participants with information about clinics and available health resources and treatments. In terms of medical knowledge accessed, both utilized a mix of allopathic and common-sense knowledges. Definitions of health ‘shaping’ the contours and practices of both programs of necessity linked historical and geo-political realities with daily life. Thus both encouraged a ‘resuscitation’ of indigenous knowledges that
have been buried, if not lost, in the wake of processes of ‘bifurcation’ and fragmentation characterizing colonialisms/nationalisms impacting our planet.

**Awakening**

Historiographical models both limit and illuminate awareness of causes and conditions informing the war over Palestine. The historiographical approach here takes as its starting point interconnections of mind/body/spirit rooted in definitions of health and health-care processes indigenous to the parts of the world addressed. In this sense methodology and content are linked— the historiography ‘does’ what the critique asks for. As noted above, Palestinian women’s approaches to health illustrated in this book take as their starting point the integration or ‘wholeness’ of earth, body politic, and spirit.

A central thesis of this book is that struggle for control of land bases and resources as part of modern nation state building has been a struggle (on-going) for control of knowlege making, and that this is a gendered/raced/classed process. These categories of analysis are themselves part and parcel of the production of knowledge that binds process to ‘end’ product. For example, research discussed in this book shows the interconnected gender/race/class politics of bifurcation of indigenous and allopathic medical systems into ‘Arabic’ medicine vs. ‘European’ medicine, with the former being relegated to a lower status if not altogether denigrated. Such historical processes are aspects of struggles for control of social, economic, and political processes in the region. What do these processes mean for the war over Palestine? How do Palestinian *dayat*, for example, work with and impact these processes? If health is ‘completeness’ and if a key phrase of modern nation state building – ‘self determination’ – is about ‘integration’ (wholeness), then control over knowledge making is a critical ‘ingredient’ of self determination and self determination is a critical ‘ingredient’ of health.

This book features interviews with Palestinian *dayat* and other women in refugee camps in Jordan. I ask them to describe their historical and current experiences and to share their visions of history as they re-member. The relationship between myself as initiator of the research and the women interviewed itself becomes a mirror for the subject matter addressed.
The women I interview are already ‘occupied’ by nationalist discourses, as am I. A Jew educated in and critiquing a Eurocentric and androcentric version of my history and the history of the region, what possibilities, if any, are there for me to relate to Palestinian dayat outside of nationalist/imperialist/colonialist discourses? Given that health is a contextual concept rooted in geography and in conditions and causes that are political, economic, local/global; and given that health is at once scientific/philosophical/sociological, how are relations between women impacted and shifted when we reach into that cauldron of causes and conditions to name common cause?

My first book, *Keepers of the History: Women and the Israeli–Palestinian Conflict* (Teachers College Press, 1992), reflected upon the gendered, raced, and classed aspects of nationalist versions of our histories, and it traced the impact on relationships between women, particularly Muslim, Christian, and Jew. S. D. Goitein, in his work on the Fatimid Dynasty (10th–12th centuries), discovered traditions shared among women intercommunally. For example, such traditions consisted of owning land and businesses together, utilizing one another’s court systems. These women bestowed honorific names on their girl children, and mothered one another’s children.1

Hegemonic nationalist discourse on the war over Palestine (including the term ‘Israeli-Palestinian conflict’) is premised on a bifurcated and Eurocentric view of its history, for example, the assumption that war in the region is inevitable given a fictive ‘eternal hatred’ between ‘Jew and Arab’ or ‘Muslim and Jew.’ Such discourses are based on racist constructions that obliterate both Arab Jews and the rich Judeo-Islamic tradition ((and Judeo-Islamic-eastern Christian traditions).2 Through documentation such as the Cairo Genizas, and research in this book, we can trace roots of connection that androcentric and colonialist discourses have ‘chopped off’, disrupting the ‘ecology’ of the region’s history.

**Palestine in Geo-Political Perspective**

1994–95 I am in Amman at the offices of the United Nations Relief and Works Agency. I need their permission to visit with dayat in Baqa’a and Jabal al Hussein Refugee Camps. At the University
of Jordan I pour over British archival materials. During evenings in cafés and living rooms, I listen to the heated conversations of Jordanian and Jordanian-Palestinian women about the recent Israeli–Jordanian Agreements opening the Allenby Bridge – whether to cross or not. Some say that the focus on the opening of the Bridge is a smokescreen for economic agreements that will disadvantage Jordanian workers. Women in the camps tell me that the agreements have been negotiated at their expense because their status has not been resolved: ‘A person who is poor is always lost in these situations …’

In fact, the Israeli–Jordanian ‘peace agreements,’ celebrated for allowing access to Israel through the Allenby Bridge, provided for duty-free export from Jordanian factories to the United States if at least 8% of their industrial outputs came from Israel. Prior to this, no textile mills in Jordan exported to U.S. retailers. Now more than 40,000 workers in more than 60 factories in Qualified Industrial Zones produce for Walmart and other big U.S. retailers. Ninety percent of the workers are women under the age of 22, paid approximately $3.50 a day – and fewer than half are Jordanian. Jordanians own almost none of the factories.

I pick up the SAWA (All the Women Together Today and Tomorrow) report on trafficking and connected prostitution of women and girls living under military occupation in the Palestinian ‘territories’ (OPT). Publication of this report is groundbreaking. Women are trafficked from the West Bank, Gaza Strip and Jerusalem, where four systems of law (Jordanian, Egyptian, Palestinian and Israeli) complicate attempts at drawing up a relevant penal code. The report notes that Israeli occupation limits implementation of Palestinian criminal justice, hindering the right of Palestinian women to legal redress when victims of a crime. The level of poverty among Palestinian women as well as rising levels of domestic abuse, both as a result of war and occupation, are key factors in their vulnerability to trafficking, as is the case for women worldwide. These women are refugees – their bodies are occupied. The word ‘territories’ makes me think of North American land wars and refugees from Katrina.

I think – ‘I’ll start here … with the ways in which women’s bodies are “capital” for modern nation state building.’ The phone rings. There has been a massive earthquake in Haiti. Haitian novelist Edwidge Danticat is asked to describe the death of her
uncle. Held in immigration detention while attempting to enter the state of Florida, as he had many times before, her uncle died because his jailers didn’t believe him when he said he had to have his medication. He had cancer and spoke through a voice box.

A friend reports from Jordan: the Jordanian government is building by-pass roads around the refugee camps. *The Jerusalem Post* reports that a large number of Palestinians have had their Jordanian citizenship revoked in order to prevent the possibility that they might become permanent residents of the country.\

I consider starting here … with the ‘feminized’ Third World male … ‘whore’ or ‘terrorist’ – but why not the flooded streets of New Orleans after Katrina … why not the bombed out hospitals of Gaza, the dead body of Oscar Grant at the Fruitvale Bart Station? A cell phone camera wildly gesticulating in a witness’ hand as it recorded Grant’s murder … the drone of the fighter jets over the mountains on the border of Afghanistan and Pakistan or the oil lying at the bottom of the sea between Somalia and Yemen – at the bottom of the sea beneath Haiti.

Or consider starting here: with Evo Morales dancing with Aymara women near Lake Titicaca in Bolivia; with Audri Scott Williams in Rabat, Morocco, on her Trails of Dreams Ancestral Journey; with Klimaforum – the People’s Summit bringing together 50,000 recognizing that we are all a part of nature; in Argentina, welcoming the international team of the World March for Peace and Non-Violence arriving in Punta de Vacas after traveling 200,000 kilometers; with the courageous women and men of all ages at sea on the Gaza flotilla who simply want to bring medical supplies, food, and hope with all those who sacrificed and sacrifice their lives daily in the name of healing.

**When History Is Sung By Griot(te), It Is A Medicine**

History is a spiritual science. Once that is said, we can begin to reconstruct world historical developments through awareness as we gather and re-gather ‘knowledges’ lost along the way. When history is sung by the Griot, it is a medicine.

The template emerges in Africa. Begin here. Palestine cannot be understood without Africa. At the Berlin Conference of 1884–85, fourteen European nations resolved disputes about their ‘spheres of influence’ in Africa by redrawing geographic
boundaries ignoring linguistic variations, disrupting customary land practices, tossing indigenous religious/spiritual life into the fire of an invented and racist concept called 'heathenism.' By 1914, Africa was divided into 50 colonized countries. Two years later, in 1916, the Sykes-Picot Agreement between Great Britain and France extended these historical processes into the region that military cartographers were calling 'the Middle East.' Authorized by the League of Nations Agreements after World War I, these colonial divisions had the same effect of redrawing boundaries, so that villagers and townspeople were separated from their neighbors by new currencies, official languages and new class structures. But 'redrawing' has a ring to it that does not sound like the bombs that filled the air – and continue to – that cut the life force out of millions, driven from their homes and dying cruel and violent deaths. Designation of geographic boundaries between the regions that the British called 'Africa' and 'the Middle East' itself established political alliances and ethnic–racial distinctions facilitating control of populations and land masses. Buried under the rubble lie centuries of symbiosis and creativity between the peoples of these regions – indigenous awarenesses that have shaped the contours of human endeavor on this planet.

When Palestinian dayat link health to homecoming, their words resonate around the globe. The historical processes described here continue to impact the ability of millions to be at home in our bodies, on the earth. Given the historiography of this book, the right of return has multi-dimensional interconnected meanings, for it refers to an end to poverty, homelessness, environmental degradation: the rights of all beings and of the earth to return to a state of balance and health.

To study the impact of modern nation state building on the environment of Palestine is to recognize the template for what we face worldwide daily. This is what the war over Palestine is about: it is not about a fictive eternal hatred between religious or ethnic groups – even the terms of such ‘identities’ have been colonized.

The study of history (like allopathic medicine) has lost its spiritual/philosophical foundations. The objectification of nature underlying social, political, economic constructions of race and gender, informs the expropriation of land bases and subsequent environmental destruction and disease wreaking havoc on our
planet. These processes happening within time become history and impact the study of history as a discipline.

Perhaps the point of history, then, is the end of history in each moment. Such a vision of history shimmers in the vibrations of song. We use categories, for example of gender, race, and class, in order to watch them dissolve. We open to questions rather than conclusions as a path of awareness and healing.

Thus the broader subject of this book is inquiry into the science of history itself; and serving as our case studies are definitions of health and changes in health care systems impacting Palestine, and sciences of herbalism and reproduction as experienced, taught and handed down by Palestinian women healers (dayat). What were consequences for specific dayat who became refugees, given that their land was their medicine? What is the significance of this inquiry for developments historically and currently in the region, and for preservation of the planet? What is the significance of this inquiry for our daily lives? What I am suggesting with this inquiry into the significance of developments in the regions addressed for our daily lives, is that we bracket the terms ‘Israeli’ and ‘Palestinian’ in order to allow historical processes shimmering in those terms to reveal themselves as part and parcel of all of our histories – of global (earth, air, fire, water, ether) yearning for freedom from suffering.

History is a living, breathing, cellular form. Like language, history has roots both within and outside of time. Oral history is a medicine that can heal history itself. Just as words have roots as well as branches, history leans into the hemisphere sucking the juice of the stars as it drags its mud laden shoes through oil spills, bombed out villages, and prisons of unimaginable brutality. The study of history thus takes us to the centrifugal place where inner and outer merge; to the place of interdependence and interbeing. This research is offered in that spirit.
Chapter 1

INTRODUCTION

Traveling from Amman to Ajloun and north into the mountains at the start of the Eid, March 2, 1995, I was treated to a blaze of color. The mountainside was covered with red poppies as far as the eye could see. The air was sweet smelling, the sun high – a perfect day for hiking and picnicking away from the fumes and chaos of city traffic. I had been in Jordan for a month; this was my first trip outside of the capital.

Three days later I lay on a stretcher at Palestine Hospital, feverish, and barely able to walk. I had succumbed to a respiratory infection that regularly plagues Amman’s inhabitants. I was expecting this, given the stress of international travel, new living conditions, new foods. Furthermore, I had been warned that such infections result from constant exposure to dust from the stone buildings typical of this region. I had arrived in Jordan prepared with a suitcase of Chinese herbs and homeopathic remedies, but that day I was grateful for the instant relief of antibiotics imported from France.

Several nights later, one of my Jordanian friends arrived at my room with an herb her grandmother used for curing respiratory conditions. When I was on my feet again, my Arabic instructor treated me to thyme she kept in her freezer. Most of the women I met here used plant cures regularly, along with, if they had health insurance or the money to pay for them, allopathic medicines such as antibiotics, either from private doctors, or dispensed through clinics.
But, as I would later discover, use of plant cures in Jordan is not without complex dimensions. For example, I learned that the state had discouraged use of herbs in refugee camps in favor of ‘modern’ medicines. In the twentieth century, changes in medical practices accompanying colonialism and nation state building had an impact on both the availability of herbal medicines and the population’s use of age old healing methods.

This book is an historical analysis of the politics of state building and health in Palestine and in Jordan. Processes of modern state building in the region of Bilad al-Sham (in Arabic, ‘land of the sun’, referring to the region of Greater Syria) brought about significant transformations in definitions of health, in the development of health care systems, and in medical practices. I examine three aspects of these changes. First is a gender analysis of ways in which science and medicine in the twentieth century contributed to colonialist processes of state building in the regions addressed. Second, I discuss how women’s health is impacted by a variety of factors related to state-building, including military occupation, war, displacement and expulsion, changing socio-economic and political conditions, and changing mores. I examine these variables for Palestinian women in refugee camps in Jordan, with a focus on the midwife/healer or *daya* (pl. *dayat*). And third, given significant changes introduced in health systems between 1919 and 1990, I explore how select women of the region define health. How do women interact with and affect health care systems as an aspect of state building?

The interrelation between women’s health and state building in Palestine has been described by Dr. Salwa Najjab-Khatib, founder of the Women’s Health Project of the Union of Palestinian Medical Relief Committees (UPMRC). According to Dr. Najjab-Khatib, the Israeli military occupation, poverty, and aspects of women’s subordination in indigenous social systems have all been key determinants of Palestinian women’s health. Dr. Najjab-Khatib and her colleagues insist that these critical dimensions defining health must be addressed through the structures and modes of operation of the new Palestinian state and its Ministry of Health. Thus, conceptions of health, theoretical and practical, have become a primary aspect of defining state building for Palestinian women on the West Bank. Using archival and current data, oral histories and observation, I explore transformations in conceptions of
health and health systems in Palestine, Transjordan, and Jordan, during the British Mandate period (1917–48), and in refugee camps in Jordan.

Why focus on a history of women and health in Palestine and Jordan? Studies analyzing the use of medicine as a tool of colonialism by British and French administrators in the nineteenth and twentieth centuries (for example in Egypt, Algeria, Sudan, and Tunisia) have addressed three critical aspects of this phenomenon. First, they have described the sending of ‘doctor diplomats’, to help pacify populations in remote areas. Second, these studies have illustrated how certain elites (foreign and indigenous) have subsumed medical considerations under economic goals (for example, the control of quarantine with the goal of control of trade). Third, they have examined the bifurcation of European and Arabic medicine. More studies of these processes in Greater Syria are needed.

Studies are also needed analyzing health as a gendered construct, and exploring consequences of the above phenomena for women. My interest in the historical significance of transformations in definitions of health and healthcare systems for women grew out of my interaction with the Union of Palestinian Medical Relief Committees (UPMRC) beginning in 1989. The UPMRC is a grassroots health care organization co-founded by Dr. Salwa Najjab-Khatib, who created the Women’s Health Project of the UPMRC to train and serve Palestinian women. UPMRC doctors consulted with grassroots health care movements throughout the world, building on a philosophy that rejected top-down medical models in terms of grassroots training, analysis of causes and conditions of health problems, and treatment. The goal is to affirm connections between self-determination and health in contrast with utilizing health care as a means to appropriate ‘colonized’ bodies, as described earlier. ‘Partners in Health’ is one example based in the United States: their courageous work empowers local populations in disaster areas and war zones while saving lives. (For more information on the UPMRC see my article, ‘A Feminist Politics of Health Care: The Case of Palestinian Women Under Israeli Occupation: 1979–1992,’ in T. Mayer (ed.), Women and the Israeli Military Occupation: The Politics of Change, Routledge (1994).) During
the 1980s, Dr. Najjab and Dr. Rita Giacaman of the Birzeit University Community Health Department were engaged in developing health related studies focusing on women. The women’s health movement in Palestine was one of the most cohesive among women’s movements in Palestine.

When I received a grant to conduct research in Jordan in 1995, I wanted to see how Palestinian women in Jordan were addressing health issues. I found an organized women and health movement in the refugee camps. In both Palestine and Jordan, changes in definitions of health and health systems bring into the foreground gender, race, and class struggles defining modern nation state building. However, to explore these issues requires a shift in dominant historiographical approaches to Middle Eastern Studies.

This book, therefore, is also about the politics of writing history. I approach the subject of women and health as, among other considerations, a study in structures of knowledge. The struggle over definitions of health in the period addressed is a struggle for control of knowledge making. The field of historical research, like all fields, defines what is constituted as knowledge. Historiography is informed by the politics of gender, race, and class that feminist theorists and historians identify as central to how we construct history.

**Approach and Methodology:**

**Knowledge in the Era of the Modern Nation State**

Middle East historian Beshara Doumani has shown that Zionist and Arab nationalist historiographies share the assumptions of modernization theory. Both, for example, posit a period of Ottoman decline from the seventeenth to the nineteenth centuries, until the coming of the West and Ottoman reforms from above. Both posit a sharp break between ‘traditional’ and ‘modern.’ Both mark the beginning of modern history with Napoleon’s invasion of Egypt in 1798, the policies of Muhammad Ali beginning in 1831, and the period of European Jewish settlement beginning in 1882. Doumani links these assumptions with the absence of a ‘live portrait of the Palestinian people, especially the historically silent majority of peasants, workers, artisans, women, merchants, Bedouin.’
Further, according to modernization theory, transformations that took place in Palestine beginning in the nineteenth century were merely reactions to outside forces. Some historians have judged societies of the Middle East as backward until those societies incorporated western scientific technologies, whether in regard to their armies, agricultural practices, or industry. Hence:

The image of European inspired progress against a bland backdrop of Ottoman/Islamic decline combined with the very real discontinuities caused by the sharp intrusion of the Zionist movement and British occupation to obfuscate the crucial connections between Palestine’s Ottoman past and its present.⁶

Doumani shows that it is critical for historians to develop new analytic frameworks that, for example, use ‘more flexible periodization, taking into account long-term socioeconomic cultural changes,’ since ‘changes are felt in an uneven and contradictory manner depending on factors of class, gender, geographic location.’⁷

Critiques of modernization theory have particular implications for the methodology and data of this study. The hierarchical West/East dualism of modernization theory invalidates and renders invisible historical interconnections between geographic regions shaping the history of science. If this study followed the dualistic model of modernization theory, the daya (midwife/healer) might represent a past defined as traditional (read Oriental), and medical doctors and allopathic medicine would represent modernity (read Western). The subject of women and health might be explored in the context of ways the ‘East’ has, or can, benefit from ‘Western’ assertions of scientific progress. Rather, this study looks at the subject of women’s health as determined by interconnected systems of social, economic, and political organization between geographic regions. It also looks at women’s health in the context of specific women’s actions in the world and specific women’s interpretations of history. The daya, for example, is viewed within her geo-historic context, and in relation to a range of historical forces which frame her limitations and possibilities. At times she may ‘represent’ a social, economic, or political system
of organization, whether of clan, kin, or state – at times she may stand against any or all of these categories.

A discussion of the inadequacy of dualisms is a starting point when considering the relationship between science and medicine in Europe and in the Middle East. Nineteenth century colonialists furthered their economic and strategic goals through the bifurcation of medicine into European (‘enlightened’) and Arabic (‘backward’). Historically the Arab world and Europe were not separate cultural areas in regard to science and technology. A highly sophisticated Islamic science grew up at the confluence of major Mediterranean civilizations, as well as in China, India, and Central Asia. Important Islamic scientists, among them Avicenna, Al-Biruni, and Al-Razi, are far more numerous than can be cited here. In addition, the experiential knowledge and discoveries of farmers and others worked its way into the scientific canon. Relations between the Islamic world and Christian Europe involved close commercial ties: ongoing exchange resulted in inventions and techniques for agriculture as well as medicine. From the eleventh century, Islamic medicine and pharmacology were known in Europe. By the sixteenth century, Europeans studied in translation Islamic science and medicine, which was at that time far more advanced than in Europe.  

The Prophet Muhammad encouraged medical research and practice, and thus Muslim rulers have had a long tradition of supporting pursuits of science and medicine. As scholar of Islam Fazlur Rahman puts it:

The Qur’an stresses that socioeconomic justice is the pillar of its teaching on monotheism (the two teachings are organically related in the Qur’an), and the literature of hadith, or reports of the words and deeds of Muhammad, strongly underline mercy toward all creatures, particularly humans, and even enjoin the Muslim community actively to exercise good will. These potent moral-spiritual factors prepared the ground for the widespread reception and astonishing evolution of medicine in Islam.

Translations from Arabic to Latin and medical pursuits in Iraq, Syria, and Egypt, also inspired medical activity in the West:
Arabic surgery influenced Spanish, Italian and French surgeons up to Guy de Chauliac (699–771/1300–1370), while Arabic ophthalmology continued to be superior for two more centuries thereafter. Contents of medical and pharmaceutical compendiums were repeatedly quoted in Latin texts and herbals up to the Renaissance. Hospital administration and organization, and medical teaching and specialization, influenced similar developments and applications in the West.¹⁰

Along with surgery, ophthalmology, and pharmacology, the earliest known hospitals were in the Islamic world. They were directed by lay physicians, with separate wards for men and women. Further, medical practices were regulated in order to weed out charlatans:

The hisbah system, as known in Arabic, originated in the early days of Islam and developed into an active bureau concerned about public safety and to guard against fraud in trade, market commodities, weights and measures, and incompetence in professional performances.¹¹

The relevance to gender relations of early Islam’s regulation of healing practitioners is yet to be studied.

As a consequence of the conventional view positing a decline in the Ottoman Empire until European reform, we lack extensive knowledge about medical practices and supervision under the Ottoman Empire. Practitioners of biomedicine in the Islamic world have historically coexisted with healers who practiced natural medicine and those who practiced spiritual medicine. Midwifery was a legitimate branch of medicine, and in addition to oral transmission and experiential learning, hospitals provided training for midwives. Respect for midwives has persisted in spite of their changing status through history: Jordanian government officials told me that when they see Hajj Anisa Shokar, the oldest living daya in Jordan, they kiss her hand and note that she delivered most officials in the kingdom.¹² Depending on the general political situation, rulers and state structures encouraged or discouraged scientific and medical endeavors; further research is needed on how these processes, over time and place, specifically affected women.
The incorrect bifurcation of traditional and modern medicine is reflected in transformations in health practices in the twentieth century. Developing a typology useful for this study, Wolfgang Bichmann contextualizes the dualist construction of traditional vs. modern medicine, distinguishing between four types of medical care. Domestic medicine refers to general knowledge and practices used within families and involving self treatment with household and modern medicines. Folk medicine is a professionalized extension of the former, involving a gendered division of labor in societies (women and men had different specializations and women often predominated). Traditional medical systems represent structured systems of ordering, classifying, and explaining illnesses, and elaborate concepts of treatment, some of which are codified into written sciences. Cosmopolitan medicine is derived from scientific and technical developments in Europe and North America, emphasizing biological scientific approaches, from the middle of the nineteenth century. Within this area of medicine, as in others, scientifically based and pre-scientific elements coexist. The conventional use of the terms ‘traditional’ and ‘modern’ to characterize medical practices reinforces Eurocentric versions of the history of science and medicine.

Thus developments in the area of science and medicine in the Middle East are often attributed solely to European influence by nineteenth- and twentieth-century British and French colonialists. Middle East anthropologist Soheir Morsy challenges historical accounts of Egyptian ruler Muhammad Ali’s (1805–48) extensive health programs as reliant on European physicians and texts. Morsy revises modernization theory’s periodizations. She maintains that Muhammad Ali’s reforms, as they affected medicine, were continuations of trends of indigenous intellectual life of the eighteenth century. The commercial sector of the eighteenth century, with its need for profits ‘within an orthodox framework,’ found justification for commercial practices in the hadith, the sayings of the Prophet Muhammad (himself a merchant). Similarly, in the nineteenth century, Muhammad Ali called upon kalam (speculative theology), logic, argumentation, medicine, and the natural sciences, to provide philosophical legitimation for his reforms. Thus, concern with positivist medicine involved a local revival which came to merge with external trends in science such as those developing in Europe.
At times Middle Eastern women benefited from ways in which indigenous traditions were reworked in the face of imperialist interventions. Morsy notes that ‘the adaptation of cultural traditions to historically specific political economic transformations is also evident in women’s relation to popular medicine, for example, peasant women’s involvement with Sufi healing rituals.’ As Middle East historian Peter Gran points out, Sufi orders responding to dangers of western encroachment appealed to women who were adversely affected by new market relations.

One way that Palestinian women have been involved in healing is through association with Sufi cults. Anthropologist Rema Rammami, in discussing the construction of peasant religiosity in Palestine, points out that women ascetics and dervishes were as common as men ascetics, and that they were accorded the same spiritual power. Some women were *shaykhas*, that is, they had special abilities to heal through spiritual mediation. Rammami conjectures that the belief in an inherited disposition to be touched by the spirit world gave women a ‘discursive opening to evade gender boundaries encoded in Sufi ritual and organization.’ Affliction in this case was taken as spiritual evidence of power to heal disease.

Aspects of Sufi practice were interwoven in the spiritual practice of Palestinian peasantry in nineteenth century Palestine. Spiritual life was predominantly centered on saints and their shrines and festivals and expressed through interaction with ‘nature, lifecycle processes and relatively egalitarian production relations at village levels …’ Spiritual power resided in living persons, in saints who were once human beings, in trees, wells, buildings, and at sacred shrines and ritualized festivals affirming communal solidarity. Peasant women’s central relation to saint shrines was connected to reproduction and child rearing as well as to ensuring family health and well-being. They may have asked a saint to cure an illness or to protect their families from the army, or ensure a good harvest.

A number of ritual days during the spring season of saint festivals were specifically women’s days. For example, on the first ritual day of the season, called *Khamis al-Nabat*, or Thursday of the Plants, ‘women go out into the fields in groups and gather herbs and flowers with which to wash their hair. The following day, they would don their best clothes and return to spend the
day sitting in the fields in groups, chatting and enjoying the new green of spring.’

One woman’s description of Khamis al-Nabat, as celebrated by Bedouin women in Gaza, notes that girls rolled in the grass without clothes covering themselves with dew and collected herbs and flowers, chanting, ‘Tägsš weh naqş shu dawa el ras ya shjarah [crack and scratch; what medicine for the head, oh plant?]’

A range of medical philosophies and practices coexisted in Palestine, just as formal and informal religious traditions informed spiritual life. Hammami is concerned with showing how different religious traditions (textual and customary) coexisted, and that only with changes in market conditions, such as the rise of wage labor, did Palestinians begin to experience textual and folk religious traditions as contradictory. Also, nationalist imperatives (Ottoman and Palestinian) led to appropriation of peasant religiosity, so that even Khamis al-Nabat is imbued with nationalist meaning, as teachers take students into fields so that they can teach them about the flora of their country. These processes, both indigenous and in reaction to outside forces, also influenced medical systems and practices, and influenced the role of women as healer.

While the Ottomans followed the developing positivist tradition in Europe, the mind/body dualism of positivist scientific method and of allopathic medicine that predominates in colonial medicine was not characteristic of Palestinian peasant women’s religiosity. It was not characteristic of women’s relation to nature, hence to healing practices. The overproduction of allopathic medicine by European colonials, fostering an uneasy relation between allopathic medicine and other kinds of indigenous healing practices, was a part of women’s class struggles against the British, Zionists, and Jordanians in the nineteenth and twentieth centuries. The social construction of ‘woman’ is historically situated in this complex of struggle, since women’s relation to healing is one way in which they are valued in Palestinian society. But among Palestinians in the period explored in this study, there was a renegotiation of biomedicine and biomedical constructs with Prophetic medicine (the medicine delineated by the Prophet Muhammad) and naturalist medicine, which impacted women differently. Some Palestinian women (though it seems that their numbers are small) had been trained in allopathic medicine in
schools in Egypt or Anatolia. British doctors integrated some Palestinian women into the process of promoting allopathic medicine by providing opportunities for medical education in Beirut or in Great Britain.

With British colonialism, disease etiology shifted to emphasize the biological rather than the social–spiritual. Public health specialist Rita Giacaman maintains that British colonialism in Palestine commodified health by emphasizing purchase of a cure, rather than social-cultural disease etiology and treatment. She learned that folk diseases (such as malaise caused by malevolent spirits) nonetheless persisted, as did indigenous cures, in a kind of synthesis with aspects of an imported scientific medical system. This mixture appears in her study of three rural villages in Palestine:

Means of healing can roughly be divided into four categories. Practitioners of them have been handed down the gifts of *al-Tīb al-Arabi* (Arabic medicine) from their ancestors. Physical means of healing include *tajbir* (bone-setting), *kawi* (cautery), *takhrim* (pricking with a needle), *kassat hawa* (cupping) and *tamlis* (massage). Herbal means include both the ingestion and the external use of some 70 locally available herbs and plants. Some of those are known to contain physiologically active compounds, whose therapeutic value is well established by Western scientific medical standards.  

Spiritual leaders emphasized healing through spiritual means, such as protection from the ‘evil eye’ by means of *hamsa* amulets, and also through dietary means. A constellation of forces was seen as producing disease: air currents, wrong diet, age, influence of spirits. For the most part, disease was explained in terms of social relationships, and preventive practices were incorporated into daily life, a facet of constructs of health that could have beneficial aspects for women. For example, she describes a case illustrating customary admonitions against the physical abuse of women healers. In this story the healing powers of a woman saint became manifest after a slap by her husband resulted in injury to his arm; his arm stood still, its nerves unable to move:
His arm was not cured until he begged her forgiveness and she finally massaged it for him while reading verses from the Quran. After this ‘sign’ Amna lived a life of austerity, refraining from sexual intercourse and devoting her life to reading the Quran. Her healing power was renowned during her lifetime and still draws those seeking health from the village, and beyond, to her shrine.\(^{28}\)

In this example, the human body is a part of, not apart from, the social and natural environment, which may be a reason why some Palestinian refugee women’s definitions of health were informed by analysis of power relations, hierarchy, and injustice. Historically, healers were perhaps no more engaged with finding solutions for local and international political crises than biomedical professionals.\(^{29}\) However, in the period of this study, women demonstrated a definite shift toward disease etiology inclusive of socio-economic-political global developments.

Imperial politics in the nineteenth and twentieth centuries produced a particular reconfiguration in the history of Islamic and European science and medicine. Scientists have always been involved in imperial politics within and between regions: alliances of scientists and diplomats, and scientists and capitalists, determined how scientific knowledge was disseminated. As Peter Gran, Soheir Morsy, and others point out, medicine was linked to the outcome of larger social and cultural struggles in various periods. Medical history was interlinked with class struggle and with effects of socio-economic political developments globally.\(^{30}\) For example, Morsy notes that in the late nineteenth century, positivist allopathic medical practitioners in Egypt, ignoring the social production of sickness and health (like North American biomedical specialists of the period), diagnosed women spiritual healers as ‘hysterical.’\(^{31}\) Such medical trends, reconstructing health and disease by denigrating women’s spiritual practices, might have had effects in Palestine, given ongoing exchange of knowledge between Egyptian and Palestinian women. Effects of macro-political and economic processes on women healers have far reaching implications for all aspects of women’s lives. The loss of land, the concomitant loss of connection to sacred shrines, and the loss of respect for women constructed as saints and healers meant the loss of both protection and participation.
The work of Mohammed Thaishat at Yarmouk University in Jordan provides a relatively rare analysis of the social, economic, and political upheaval, and the long term consequences, associated with transformations in medical philosophies and practices. Thaishat examined major socio-economic changes in a small town in northern Jordan over the course of the twentieth century. Until the 1940s, healing practices were based in religious teachings. The main healers in the town were shaykhs who were from the ashirih, or land owning class. The economy of the town had depended upon agriculture and animal husbandry; but in the fifties land fragmentation and increased dependence on modern educational systems for jobs in government or in the army brought about increased differentiation in the social system. Over-use of modern biomedicine in the town led to a shift in emphasis from religious to secular interpretations of disease. Healers were no longer connected to political positions in the town. Contrary to customary practice, healers began to receive patients with whom they had no relation. Impersonal health care situated health within a wage labor system that separated doctors from patients in ways that were not familiar in the region, at least in terms of folk medicine and healing. Thaishat’s findings, although limited in that he does not explore these processes for women, nonetheless show how macro-politics in the region of Jordan influence local medical practices. This study shows how the politics of women and health are germane to these historical developments, including the transformations in existing medical beliefs, in the social position of practitioners, in practitioner/patient relationships, in types of medical knowledge of practitioners, and in the relationship between indigenous and imported medical practices.

Feminist Epistemology and Modernization Theory: Transmission of Knowledges

In addition to offering far reaching assessments of the gender-, race- and class-specific biases of mainstream epistemologies, feminist theorists have also critiqued traditional beliefs in ‘universal’ knowers and ‘impersonal’ knowledge. They insist on situating both knower and knowledge in specific historical contexts. For example, philosophers Vrinda Dalmiya and Linda Alcoff critique
epistemological theories that delegitimate the knowledge of European midwives as ‘old wives tales.’ Dalmiya and Alcoff show that the focus on propositional knowledge, or ‘knowing that’ as the paradigm of knowing subordinates ‘knowing how,’ or skilled activity, creating a gendered hierarchy of knowledges that replicates mind/body and mental/manual hierarchies. Using the history of midwifery in the western world from the nineteenth century as their case study, they discuss the difference between the orientation of midwives toward their work from that of most male physicians and professionally trained obstetricians.

Midwives attended women throughout the entirety of their labor, rather than only for the delivery. They provided psychological as well as physical support, and they were much less prone to invasive and interventionist techniques. Male physicians, by contrast, sometimes practiced such radical techniques as squeezing and trampling on the abdomen to force the baby’s descent in a difficult birth, or hanging a woman from a tree for this purpose. It was also male physicians who invented caesarean section, the use of forceps, and the infamous ‘twilight sleep,’ which rendered the woman semiconscious, unable to remember the experience afterward, and completely inactive and vulnerable to the doctor’s decisions. And it was male physicians who introduced the lithotomy: the manner of giving birth from a supine position. Midwives, by contrast, often carried an obstetrical stool with them so that women could give birth while sitting up, thus making use of women’s physiology and increasing the possibility of women’s active control over the process.

Midwives in Palestine had a similar orientation to their work and were also highly respected for their skills, as Dalmiya and Alcoff point out about midwives in Europe:

Midwives could turn the baby in the womb to avoid a breech presentation, they could perform abortions, and they provided a wealth of practical guidance on everything from inducing conception to curing breast infections. Midwives also had knowledge of herbal remedies that could hasten a protracted labor, reduce the pain of childbirth, and inhibit the chances of miscarriage; many of these herbal concoctions are still used today in modern pharmacology. Up until the 19th century and even into
the beginning of the 20th, midwives were recognized by many doctors to be just as successful – or more so – in their occupation as were trained physicians. Certainly among women, midwives had ‘the right to be sure’ in matters concerning childbirth.\textsuperscript{38}

In the British Mandate period in Palestine physicians subjected indigenous midwives to many of the same types of accusations and pressures to conform to the changes in birthing techniques that Dalmiya and Alcoff describe above. When physicians in Europe took control of obstetrics, thousands of women died from puerperal disease, a fever produced by bacteria on the hands of birth attendants. Since midwives only attended at births, they were not as likely to transmit bacteria as were physicians who had many other patients. Yet physicians insisted on the safety of the hospital and on the alleged ignorance and uncleanliness of the midwife.\textsuperscript{39} I spoke with doctors in refugee camps in Jordan who, whether Palestinian or not, often denigrated the midwife and her skills. Midwives asserted that they were blamed for mistakes the doctors themselves had made. In the view of many midwives interviewed for this study, based on their experiences, doctors at times endangered women in childbirth.

On what basis, Dalmiya and Alcoff ask, could midwives’ knowledge and practices be denigrated as superstition and untrustworthy? Just as modern scientists rely on empirical knowledge sanctioned by a community of experts, so midwives’ skills are based on ‘direct empirical sources, practice, experience and a reliance on the body of beliefs accumulated by the acknowledged community of experts on childbirth (that is, other midwives).’\textsuperscript{40} European and European-trained male physicians disqualified midwives because the knowledge of midwives remained oral and experiential at a time when modern science and medicine authorized knowledge through documentation. Women’s associative knowledge ‘eventually came to be seen as not knowledge at all but merely a set of hunches and tales circulated among gullible and prerational “old wives.”’\textsuperscript{41}

The struggle for control of definitions of health and medical systems has particular relevance for women. One aspect of control of women and reproduction is, in Dalmiya’s and Alcoff’s analysis, related to knowledge forms and their authorization.
They note that those who discredit orally transmitted knowledge also discredit the practical knowledge of male peasants as unscientific.\textsuperscript{42} For example, French physician Antonine-Barthelemy Clot is credited with establishing Egypt’s first medical school during the reign of Mohammed Ali. Although Clot supported the teaching of medicine by Arab professors to Arab students, he also considered the \textit{daya} a ‘symbol of the whole complex of “old-wives medicine” with its magic potions, charms, incantations … and he did everything in this power to undermine her persistent popularity.’\textsuperscript{43} According to Rosemary Sayigh, Europe’s appropriation of the Arab Muslim world focused on women ‘as a central, summarizing symbol of a society that was alien and challenging to them.’\textsuperscript{44} Imperial control involved control of both the definition of woman and the definition of women’s practices in the arena of women’s health.

\textbf{Epistemology and Oral History Methodology}

The time I spent in refugee camps in Jordan made it clear to me that women address health in part through a set of ethical assumptions – some continuous, some changing – that ensure their integrity as women. Postmodernism is one approach to questions of veracity and knowledge authorization. Postmodernists deconstruct knowledge and deconstruct women as subject. Postmodern analysis, although useful in affirming the need for contextualization, may not be a useful theoretical stance for analyzing the ethical features of women’s definitions of health. Feminist theorist and medical ethicist Janice Raymond observes:

Postmodern theory and practice have also decentered the ethical in the sense of regarding principles such as the dignity or integrity of a woman’s person as without any determinate meaning. Since there is no stabilizing center such as truth, conscience, or integrity of being, the ethical dimension vaporizes. Everything is text and more text, signs and more signs, signifiers and more signifiers, encouraging endless rounds of self-devouring equivocations.\textsuperscript{45}

My goal here is not to make the category of woman disappear, but rather to assert its authenticity. This does not mean that I attempt
to define a homogenous woman: within a Palestinian refugee community, for example, women’s experiences and views vary according to class, generation, geography, and numerous other factors. My approach acknowledges women as subjects who use a range of strategies depending upon age, employment, marital status, and other elements, in order to cope with forces threatening their self determination. I attempt to understand ways in which women make meaning, given shifting social–economic–political structures affecting these women’s possibilities. I am concerned with the truths of their experience as they perceive and construct those truths. I am also interested in how the women I interacted with for this study constitute epistemological communities, that is to say, I ask: how do women construct meaning and authorize knowledge as a community rather than as individuals?

The usefulness of approaching refugee women in camps in Jordan as epistemological communities grows out of what I learned as I conducted oral histories with those women. The question of how knowledge (both authored and validated) is authorized underpins my interest in oral histories. For example, the invaluable study of the 1936 Great Revolt in Palestine by anthropologist Ted Swedenburg uses postmodern approaches to address historiographical issues related to oral history in ways that both overlap with, and diverge from, my study. Swedenburg analyzes how some peasants remembered the Revolt. He is influenced by the Popular Memory Group (PMG) which critiques conventional oral-history methodologies as presenting the past–present relation mainly as a problem of the unreliability of memory. The PMG asserts that this conventional model of oral history and of memory is a passive one in which memory:

... is the sedimented form of past events, leaving traces that may be unearthed by appropriate questioning. It is a completed process, representative of the past which is itself dead and gone and therefore stable and objective ...

The PMG asserts that memories are, on the contrary, complex cultural productions, involving interrelations between private experiences and present situations.

A similar subjectivity affects the investigator. Swedenburg begins by exploring his own contradictory positionality in relation
to his subject matter, as someone who is both sympathetic to the Palestinian nationalist project, and as a representative of western hegemony. Further, he finds it necessary to unlearn the academic belief in the possibility of uncovering objective truth:

This ‘truth’ seemed to originate in an unequal relation of power, between occupier and occupied, between researcher and subject … I have tried to write not from an Olympian location of disinterested and all-seeing objectivity, but from a series of vulnerable, contingent, and situated positions that invite rather than resist contention.⁴⁹

Just as his subjects conceal some ‘truths, forget others, and embellish the positive,’ the historian himself produces a narrative based on ‘its own partial truths and strategic excisions.’⁵⁰

Swedenburg does not assume that oral histories will reveal ‘objective truths.’⁵¹ Rather, he investigates the histories his subjects make in the context of struggle for control of nationalist discourse. Palestinian popular memory is a contested terrain where, on one hand, the Israeli state apparatus attempts to suppress and erase Palestinian history, and on the other, the PLO, official representative of the Palestinian nation, attempts to forge a national–popular past.⁵² In addition, memories of the people interviewed were fused with awareness of the role of international forces in the present, particularly the United States:

Thus their memories of revolt possessed a kind of multiple vision or consciousness, as they maneuvered delicately between articulations of the popular and the national. At one level, their memories were situated in a subordinate and partially antagonistic relation to Palestinian national memory. At another they were aligned with nationalist discourse in opposition to Israel’s ideological and repressive apparatuses and Israel’s international supporters. Through their discussions with me, they attempted at the same time, to appeal to the international community.⁵³

Swedenburg’s articulations of positionality and of historical contingency are useful for this study. Palestinian women’s assertions in regard to health can be partially understood as an aspect
of nationalist narratives. Indeed, British, Zionist, Palestinian, and Jordanian nationalist projects all impact in critical ways women’s definitions of health. And just as nationalist projects are in a constant state of flux and renegotiation, so women’s relations to health systems and medical practices are likewise dynamic and negotiated. That negotiation is a central theme of this study. Notions of multiple fields and contested terrain are relevant for any discussion of historical memory. But for the women I interviewed, these issues did not serve as hidden agendas lending a sense of fabrication to their stories. Most women I interviewed stated clearly their hope that I would tell their stories to women in the United States. By talking to me as an emissary, in a sense, to women in the U.S., they underscored my own paradoxical positionality. And they talked openly about the effects of Israeli, Palestinian, and Jordanian nationalist goals on their study.

Women interviewed clarified the impact of nationalisms on their health as an historical reality informing their struggle for self definition, a struggle central to defining health. Poverty and other economic consequences of nationalist struggles were a major focus in the interviews. For example, while some trained midwives benefited from their new status in the British Mandate period, many lost their livelihoods and found themselves in desperate straits.

The aim of oral history methodology in this study is to acquire historical information that cannot be acquired in any other way. The purpose of this study is to fill gaps in our knowledge of the period, to raise methodological questions, and to connect the subject matter to those questions.

Rosemary Sayigh’s groundbreaking oral histories with Palestinian women in Lebanon give us insight into some Palestinian women’s historical memory, and they raise the question of whether or not women’s memory is different from men’s. She asks the important questions: what do women reveal when they remember history that men do not? How do older and younger women control each other’s speech? And she conjectures that women often will disclose information that is embarrassing to men. Certainly, women’s memories are distinct in the area addressed in this study, since remembrances concern their health and their craft as midwives. And, of course, women’s memories
are always gender distinct, as they draw from their relations as women both with other women and with men.

With regard to the issue of female remembering, in certain historical periods in the Middle East, and in some societies, men negated women’s speech. For example, before Islam, women were highly respected as poets and political commentators, a tradition that continued under early Islam, and that has persisted to the present. According to Middle East specialist Leila Ahmed, although Muhammad fostered an attitude of ‘listening and giving weight to women’s expressed opinions and ideas,’ during the Abbasid period women’s speech was suppressed:

At many times in Muslim history, including the Abbasid period, women were so debased that even their kinship with a great man would not have rendered their words worthy of note. 57

Silencing of women has prompted historians to recover women’s experiences, visions, and analyses through the use of oral histories. Feminist theory and global feminist movements have focused on the need to validate women’s speech. Oral histories are helpful vehicles in this regard for historicizing women’s experiences and perspectives. Theoretical developments in feminisms, especially African-American feminism, have particular relevance to my approach to women’s oral history.

**Feminist Theory and Middle East Studies**

When I first began interacting with scholars from the Middle East engaged in and following feminist movements and methodologies, I was struck by the ways in which many scholars characterized Western ‘feminism.’ They tended to reduce Western feminisms to women and movements with access to the press. In addition, scholars sometimes homogenized feminisms based, at times, on the positionality of particular Western feminist scholars. In addition, feminist theorizing by women of what some characterize as the domestic Third World (for example, African-American, Latina, and Native American women) seemed to have penetrated the Middle East only as it related to identity politics.
Yet parallels in historic and current oppression of both African-American women and of Palestinian women provide a basis for considering the relevance of African-American feminist theory to Palestinian women’s lives. According to African-American feminist Patricia Hill Collins, “race and gender oppression revolve around the same axis of disdain for the body—both portray sexuality of subordinate groups as animalistic and deviant.” Colonialists abroad, academicians, and the popular media in the United States spread similar portrayals of disdain for the body and sexuality of Middle Eastern women.

Analogies exist between the proletarianization of African-American women in the marketplace in the United States and Palestinian refugee women in Jordan in the twentieth century. Palestinian women in refugee camps in Jordan define health given a trajectory of forces that resonate with those of African-American women in inner cities in the United States. Both face environmental hazards related to poverty, poor housing, and lack of employment options, all of which negatively impact women’s health.

Patricia Hill Collins’ critique of traditional epistemology and her presentation of a combined Afrocentric and feminist approach provides a meaningful framework for exploring the possibility that Palestinian women working in health movements in refugee camps in Jordan construct knowledge as a community rather than as isolated individuals. This is not to establish an identity politics of the mind, nor to assert homogeneity among women, but rather to point to uses of ways of knowing, as I describe below, that transcend nationalist boundaries. As Patricia Collins defines it, Afrocentric epistemology illuminates ways subordinate groups create knowledge that fosters resistance. She considers that shared conditions of oppression foster Afrocentric values permeating family, religion, culture, and community life. Collins sees intersections between Afrocentric understandings of what constitutes knowledge and feminist critiques of androcentric knowledge building. From her perspective, both epistemologies reject Eurocentric masculinist privileging of impersonal procedures for establishing truth. From the perspective of Afrocentric and feminist epistemologies, concrete experience is a criterion for credibility: ‘With us distant statistics are certainly not as important as the actual experience of a sober
person.\textsuperscript{60} Black women’s stories and narratives become a basis for core beliefs defining key ethical issues. For black women, knowledge claims are ‘rarely worked out in isolation from other individuals and are usually developed through dialogues with other members of a community,’ using dialogue as a way of assessing knowledge:

Black women’s centrality in families and community organizations provides African-American women with a high degree of support for invoking dialogue as a dimension of an Afrocentric feminist epistemology. However, when African-American women use dialogues in assessing knowledge claims, we might be invoking a particularly female way of knowing as well.\textsuperscript{61}

In addition, Collins makes the point that:

Neither emotion nor ethics is subordinated to reason. Instead, emotion, ethics, and reason are used as interconnected, essential components in assessing knowledge claims. In an Afrocentric feminist epistemology, values lie at the heart of the knowledge-validation process such that inquiry always has an ethical aim.\textsuperscript{62}

\textbf{Research Summary}

During February, March, and April of 1995, I conducted in-depth interviews in Arabic and English with twenty Palestinian women, half of whom were living in the Jabal al-Hussein refugee camp (established in 1952) in northern Amman and half in the Baqa’a refugee camps (established in 1968) in Jordan. I asked those who had experienced war and exile to describe health related issues. In addition, I addressed the following questions: In the context of the camps, did women view health as they had in Palestine? How did their experience of war impact their view of health? I also asked those women who were refugees of war as well as women born in the camps, about how women’s on-going status as refugees affected their health. Did women’s healing practices change? What were their major concerns about health systems and practices?
The sample interviewed included five single women in their twenties who were born in the camps, seven women who were refugees of 1948, and eight women who became refugees in 1967. Of those who came from Palestine to Jordan, all were from peasant, rural backgrounds. All women were with their families at the time of the interviews. Half of the sample were midwives, and many were involved in organizing to gain resources relevant to women’s health. Most were politically active within the camps. None referred to religion in the course of the interviews.

The interview segments were chosen because they are representative both of the interviews as a whole and of informal conversations with refugee women in the two camps. I have either changed women’s names or chosen not to use their names to preserve their privacy.

I conducted interviews with the assistance of a Jordanian–Palestinian woman who works with Palestinian women from the camps at the Jordanian Women’s Union in Amman. Her ties to these women gave me access to the camps, for the most part tightly controlled by the United Nations Relief and Works Agency (UNRWA). The fact that I was North American was significant to the women interviewed; they believed women in the United States who were made aware of their plight would want to help. Women interviewed also knew that I have been actively concerned with the Palestinian struggle for self-determination. I asked about their relations with Jews, since associations between Muslim, Jewish, and Christian women healers is a part of the history of women and health in the region.

Interviewees interwove past with present, reciting stories of their lives and health in Palestine as they detailed changes in health practices in the camps. They discussed realities of day-to-day health concerns, and at the same time often used ill health as a metaphor for homelessness. Their concerns in terms of health were inextricably linked to their concerns about their fate as refugees, and hence linked to their historical experience. From this perspective, improvements in their health status or access to resources were overshadowed by the threat of having resources withdrawn, and by the possibility of continued exile or resettlement outside of Palestine. Whatever their situation upon return, as healers and in terms of women’s health issues, the fact of return was itself a metaphor for health and well being. Some told of how
they had become politicized in the course of war and exile, and as camp dwellers. Even for those born in the camps, the land of Palestine was a formative memory shaping their present both as political actors and as healers whose practices were rooted in plant cures and in a way of life that they had lost.

The goal of the interviews was not to gather health related statistics, nor to verify narratives against other kinds of data. The goal was rather to document a history as perceived by the women addressed, and to discover how these women conceptualized health. While these interviews typify views of a cross section of women in the camps I visited, they do not necessarily represent Palestinian women in other camps in Jordan or in refugee camps throughout the Middle East, where circumstances vary widely. The interviews do, however, provide a basis for beginning to understand how some Palestinian women have experienced war, exile, and refugee life. In particular, they focus on how these women, given those experiences, construct health and health practices, and on the situation of women healers in Jabal al-Hussein and Baqa’a refugee camps.

These interviews demonstrated ways that some Palestinian women create knowledge that fosters resistance and the role of health concerns as central to this process. The interviews revealed multiple knowledge bases of women (history, politics, healing practices) and uses of those knowledge bases to create a vision of social organization supporting women’s health.

Among Palestinian midwives and other women in refugee camps, memory is often a group activity, invoking a past which is never completed, and which informs, in a continuous way, their evolving present. Memories give witness and evoke ethics as an activity, and as a set of values. Memories are about knowledge claims, about connection, and about resisting and overcoming life threatening obstacles. Individuals are respected when their actions reflect a ‘core set of beliefs’ constitutive of community and of women’s experiences. Women’s narratives reveal how what it means to be Palestinian and what it means to be a woman are intertwined and redefined in new contexts. They are constitutive of the types of knowing that are given ‘high credence’ by Palestinian women in assessing knowledge. In considering questions of historical veracity, Afrocentric epistemologies and epistemologies of some Palestinian women provide further information
about how knowledge and memory are constructed given the challenges of loss of home, land, and livelihood.

State of the Field: Research on Jordan

Having explored methodological considerations informing this study, I turn now to a brief review of literature on Jordan at the time of this study. (See Additional Resources, p. 154, for an update.) Research on and by Palestinian women is a phenomenon of the past several decades. For a very informative discussion and critique of studies of Palestinian women in the Israeli occupied territories and of Palestinian autonomy: see ‘Gender and Society’, Working Papers, Women’s Studies Program, Birzeit University. 1995. Research on and by Palestinian refugee women is also scarce. Orayb Najjār’s *Portraits of Palestinian Women* (1992) contains informative and moving interviews with Palestinian refugee women. Rosemary Sayigh’s groundbreaking *From Peasants to Revolutionaries*, and *Too Many Enemies* (1994) and many of her published articles are based on comprehensive interviews with Palestinian refugees, including women, particularly in camps in Lebanon. At the time of this study, there were no monographs on Palestinian women in refugee camps in Jordan (but see Afterword for update); Rima Yusuf Salah’s Ph.D. dissertation, ‘The Changing Roles of Palestinian Women in Refugee Camps in Jordan’, is an important contribution to future studies. Mona Al-Khalidi’s thesis, ‘The Determinants of Health Status in Jordan, 1960–1988’, contains a section on the refugee camps that includes some attention to women. My study, therefore, relies for the most part on oral histories that I conducted in 1995, my observations in Jordan and in Palestine, and primary documents obtained in Jordan, including archival documents of the British Colonial Office, Department of Health documents, Palestine, Transjordan, and Jordan, and reports of non-governmental organizations. My information on women in Jordan in general, including health studies, also derives from oral histories I have conducted, from unpublished papers (often produced for non-governmental organizations or relevant conferences), from published governmental documents and statistical data; and from a few available published sources, for example, Sateny Shami’s study of work patterns and gender relations in Jordan, as well as those noted above.
Most versions of Jordanian history reflect nationalist historiographical approaches, privileging colonialism, Zionism, and Palestinian nationalism as constitutive of Jordanian state building. Within that category, a majority of studies focus on the important complexities of Ottoman, British, Israeli and Palestinian politics and diplomacy. The central debates raised among historians, for example, about Hashemite connections to Zionists, continue to be critical for unraveling politicians’ motivations and circumstances, and for characterizing the historical development of the region, as historians make use of declassified documents. Of note among those studies, Mary C. Wilson’s *King Abdullah, Britain and the Making of Jordan* (1987) carefully builds a history of Jordan’s emergence, and it offers a revised portrait of Abdullah’s role in that history based on hitherto unexplored primary sources. Laurie Brand’s *Jordan’s Inter-Arab Relations: The Political Economy of Alliance Making* (1994) situates economic security as more central than military security for Jordan’s inter-Arab politics. Miriam Lowi’s *Water and Power: The Politics of a Scarce Resource in the Jordan River Basin* (1993) places the critical issue of control of water at the center of the politics of state building in the region. *Village, Steppe and State* (eds. Tell and Rogan, 1995) revises conventional periodization informing histories of Jordan. The articles focus on a variety of ways that Jordan exists as it does because of continuity with the Ottoman past, rather than solely as a result of British imperial politics and the upheavals of modern nation state building. Linda Layne’s *Home and Homeland* (1995) is an ethnography of the Abbad confederation of the Jordan Valley. She looks at on-going negotiation between tribal and national identities, which she demonstrates are flexible, rather than static. Her approach helps to overcome the often rigid and erroneous definitions and boundaries prescribed by terms such as ‘tribe,’ or ‘Bedouin.’ My study of state building and health was enhanced by ethnographic studies by Jordanians, most by medical anthropologists, published at Yarmouk University. In addition, the work of Brigitte Curmi (1994) and of Jocelyn DeJong (1993) were invaluable in this endeavor.

My work contributes to contextual studies of the construction of gender and health as a central aspect of modern nation state building in the twentieth century. I critique and analyze conventional historiography as inadequate for interpreting historical
developments. My focus on Palestinians in Jordan follows conventional lines, while shifting the focus away from elites and men to bring women refugees into the forefront.

My methodology brings together Women’s Studies, Feminist Epistemology, and Middle Eastern history to examine effects of global politics on issues of women and health in the regions addressed.

**Chapter Outline**

For this study, treating mainly the twentieth century, I use an overlapping sequence of events for the macro-framework, rather than a linear chronology. Each chapter raises a number of methodological and content issues and themes regarding changing definitions of health and medical practices. This study focuses for the most part on women and health in the period from 1919 to the present. Borrowing from Doumani’s approach in his study of merchants and peasants in Nablus, 1700–1900 (1995):

The chapters are arranged the way transparencies might be overlaid to progressively add detail, color, and depth to the final image.63

In Chapter Two, I inquire into connections between uses of modern science and medicine and economic and political control of Palestine and Transjordan between 1919 and 1939 (the British Mandate period). Specifically I analyze the interconnected racial and gendered constructs of nature, and their ecological ramifications, expressed in archival materials documenting malaria control programs in this period. These programs continued to be highlighted in Department of Health reports from Palestine and Transjordan for the next several decades. The British made these programs a priority in terms of funding in order to support the health of troops, and in that process secured control of water and land. During the period of the malaria control program the British Mandate ceded land to the Zionist affiliated corporation, the Rutenberg Electric Company. Health issues noted by the British-led Department of Health during the 1936–39 Great Revolt are related to ways in which the Revolt affected the work of the Department of Health (including malaria control) rather
than to political or economic developments (the creation of a two-tiered labor structure) motivating that uprising. Such reports help us analyze the consequences of constructs of health for the local populace.

Chapter Three has two goals. The first is to analyze consequences for Palestinian women in Palestine and Jordan of the professionalization of the daya during the British Mandate period (1917–48). The second is to explore the consequences of this history of professionalization for Palestinian women who became refugees after 1948. This is done through discussions with dayat in Jabal Al-Hussein and Baqa’a refugee camps and in the city of Amman. The British Health Administration, and later the United Nations Relief and Works Agency, recruited midwives for training and registration. Distinctly diverging views of health and medical practices, particularly between British officials and doctors and indigenous women healers, were negotiated in the face of newly emerging regulations and institutions run by European doctors, nurses, and indigenous health practitioners trained in Great Britain. In the course many women lost their livelihoods. In addition, many indigenous women healers became dependent upon a British administrative support apparatus that held specific interpretations about who these women were. Thus the daya is a focus for examining the politics of health, because she was central to British officials’ access to women’s bodies and the control of reproduction. Views of dayat themselves provide insight into this history, detailing the benefits and harm of these processes.

Chapter Four tells the story of women and health in refugee camps in Jordan, beginning with the 1948 wars and ending with the Jordanian–Israeli Agreements (1994). It begins with a description of the establishment of refugee camps in the early 1950s and after the Six-Day War of 1967. After a detailed discussion of dispersion, refugee status, and relief efforts, I then build the chapter around oral histories conducted in Jabal al-Hussein and Baqa’a refugee camps. The themes of the chapter are set by the interviews and include the following: the effects of militarization, including rape, on women in the region; the effects of Jordanian–Palestinian politics on women in the camps; refugee women’s activism in the camps; how conditions and health-related policies and practices in the camps are affecting women’s
health and women health practitioners; and issues of health and human rights.

A listing providing additional resources on women, health, and refugees is available at the end of this book.

We turn in the next chapter to a textual analysis of the politics of British colonial medicine in the Mandate period.
Figure 1
Figure 2

Figure 3
Figure 4
Figure 5
Figure 6
Figure 7
Figure 8
Chapter 2

IMPERIALISM AND HEALTH: POLITICAL IMPLICATIONS OF MALARIA ERADICATION CAMPAIGNS IN PALESTINE AND TRANSJORDAN, 1919–1939

An Imperial Pursuit: Malaria Eradication and Land Reclamation

‘Civilian work in the control of malaria in Palestine was begun by the British authorities in 1919.’ Thus begins a ‘Statistical Review’ of malaria in Palestine by Persis Putnam for the Rockefeller Foundation, issued in January 1928. However, a brief outline of the history of the study of malaria control in Palestine in a 1925 Report of the League of Nations Health Organization notes that British investigation into malaria prevention had begun as early as 1901.

The goal of this chapter is to review British- and American-led malaria eradication in Palestine in the post-World War I period. Beneficial effects of European and American imported medical practices that reduced devastating effects of epidemic diseases are well known. However, the language of relevant reports during the period of the British Mandate as well as some consequences of health-related programs themselves, is a basis for inquiring into the paradoxical role of health care. While malaria eradication aided the indigenous population, one question that arises is
whether or not health-related policies abetted loss of control of their environment.

Throughout this chapter and this book I attempt to avoid use of monolithic terms such as ‘the British,’ or ‘the Americans,’ or ‘the Palestinians,’ or ‘the Zionists,’ or the ‘Israeli state.’ Use of such terms without contextualization lends a solidity to history that history does not have. Use of such terms ‘essentializes’ and thus type-casts populations and fuels dualistic/oppositional models of interpretation of events. It furthermore conceals the complexities of organizations, cross class alliances, local variations, paradoxical motivations, and more. In addition, use of such terms equates populations with particular leaders/politicians and their policies. However, when necessary and instructive, or when it is impossible to avoid using such terms, the term can point to a range of causes and conditions resulting in consequences that we can learn from. Most importantly, as noted in the Preface, the importance of this research lies in its connection to similar findings throughout the globe during this period. In other words, the historical emergence of war and suffering in the regions addressed is part and parcel of world historical developments. Even given the particular variations, this material needs to be understood as a ‘case study’ yielding data that can teach us in the context of other data about the kinds of problems that we face today and possible solutions to them. The burden and the revelation, inherited by all, belong to all to ponder and respond to.

In Palestine and in Transjordan, malaria eradication set the stage for policies related to water control, development, and regulation of land use. The League of Nations (San Remo, 1920) required the British Mandate to institute a malaria eradication program. The British-led Department of Health was a vehicle to move Palestine and Transjordan into a new socio-economic order in the Mandate period. Malaria eradication would facilitate British (and American) policies targeting Palestine as an area for economic development. The Rockefeller Foundation, whose wealth came from financial and industrial corporations, played a key role in this process. Hence, United States’ involvement in Palestine began with medical diplomacy as early as 1919.

When British forces occupied Jerusalem in 1917, they immediately put in place measures to destroy the malaria-carrying
mosquito found in water storage receptacles. The British authorities continued the extensive work of investigation and control of malaria in Palestine in 1919. Documentation of malaria control in Palestine, as well as in areas of Transjordan, shows that, by the time the British Mandate for Palestine was issued in 1920 at the San Remo Conference, the British were already shaping Palestine’s future economic and political role in relation to British interests in the area.

Given the dominance of the French in Syria and Lebanon, the British were concerned about establishing a secure foothold in Palestine and Transjordan. They also wanted to protect the Suez Canal area and the overland route to India. After World War I, Transjordan was administered as a province of Syria under King Faisal I until July 1920 when the French ousted him from his throne in Damascus. The British then subsumed Transjordan into their Mandate over Palestine, which had been conferred by the Supreme Council of Allied and Associated Powers at San Remo in April, 1920.¹

The scientific goal of the malaria eradication program was to eliminate the *Anopheles gambiae* mosquito that carried the disease. In addition to cataloging wells and cisterns, the process involved spreading pesticides containing arsenic that killed the mosquito larvae such as, Paris Green dust, or oiling with pyrethreum paraffin. DDT (dichloro-diphenyl-trichloroethane) was also used in later stages, and eventually became the primary tool for eradication. While there is no doubt that in the short term British public health policies reduced suffering from malaria, associated consequences, examined in this chapter, are less sanguine. The malaria eradication program cannot be separated from colonial politics in the twentieth century.

During the imperial age, views of disease and of ‘primitive’ colonized regions were linked in an antithetical relationship to a sanitary, civilized Europe:

Although European healing during the early nineteenth century was no more effective than Greco-Islamic medicine, it was nevertheless asserted that only through European knowledge and intervention would it be possible to bring under control the diseases of the empire’s colonies. Supported by political and military power, European
medicine was considered a form of progress toward a more ‘civilized’ social and environmental order.\textsuperscript{2}

Malaria control and control of other epidemic diseases could become convincing examples of the ‘superior progress’ of a more ‘civilized’ imperial order. The structures and practices of malaria eradication reflected the use of biological science to support imperialist politics. Some Americans and some European Zionists supported the British-led program by contributing funds. British documentation at times reflected a prioritizing of Zionist settlement policies based on monetary assistance for malaria control. Thus the question arises whether or not the political economy of malaria eradication supported the eventual transfer of control of land and water to particular wings of the Zionist enterprise – and if so, what were the motivations of British officials involved, and the range of consequences for the local populace?

In what ways, then, did British and American conceptions of Palestine and its inhabitants shape the politics of malaria eradication and what were those conceptions? This chapter analyzes British and American constructions of the land and its inhabitants as transmitted through the scientific endeavor of malaria eradication.

\textbf{Race, Gender, and Class Politics of Malaria Eradication}

In 1921, British government officials, furthering the goal of malaria control begun in 1919, drew up a program for major anti-malaria works ‘embodying drainage and reclamation schemes of some magnitude.’\textsuperscript{3} By 1926 the assigned ‘Section’ (designated workers for a particular geographic area) had completed surveys and schemes in connection with the drainage of marshes involving an area of about 52,000 acres, including the Beisan, Huleh, Kishon, Naamein, Birket Ramadan, and Wadi Rubin regions. The projects also included the remodeling of drainage and irrigation in parts of Jericho.\textsuperscript{4}

Malaria was, according to the British, both endemic and epidemic. The disease was a problem in areas dependent upon cisterns for collection of water, since stagnant water is a breeding place for the disease-carrying mosquito. To that end, British engineers identified and oiled cisterns. The trajectory of the disease
was uneven, depending upon rainfall. In swampy areas the eradication program initiated rerouting of water and drainage with dynamite. In a cursory insert, one report acknowledged the increase of malaria in the region as a result of war, and also acknowledged that there were more cases of malaria in areas suffering from economic hardship. A British report in 1937 on the Beisan area connected Bedouin ‘misuse’ of their habitat, as British officials characterized it, with a negative assessment of the indigenous economy. Malaria was endemic, according to British reports, because of the ‘ignorance’ of the indigenous population.

The author of the report, British land surveyor Lewis French, said that the Beisan area was:

... inhabited by fellahin [peasant farmers] who lived in mud hovels, suffered severely from the prevalent malaria and were of too low intelligence to be receptive of any suggestions for improvement of their housing, water supply or education. Large areas of their lands were uncultivated and covered with weeds. There were no trees, no vegetables. The fellahin, if not themselves cattle thieves, were always ready to harbor these and other criminals. The individual plots of cultivation, such as it was, changed hands annually. There was little public security, and the fellahin’s lot was an alteration of pillage and blackmail by their neighbors the Bedouin ... The Bedouin, wild and lawless by nature, were constantly at feud with their neighbors on both sides of the Jordan, and raids and highway robberies formed their staple industry: while such cultivation as the Bedouin were capable of filling in the intervals of more exciting occupation.5 (emphasis mine)

Here, malaria became part of a litany of fellahin shortcomings and an expression of the constructed diseased nature of a wild and lawless Bedouin. The notion of a general state of decline marking the region was expressed in the equation of malaria with low intelligence, criminality, uncultivated land, and little public security. Health became the province of the British, dependent upon their knowledge of science and technology. Thus British policies for economic improvement necessitated control and reshaping of both ‘native’ human ‘nature,’ and the environment.
Such Anglo-American politics regarding land and water use reflected nineteenth-century European and American constructs of progress and enlightenment. Scientists and academicians expressed power by constructing an inevitable progression from savagery to civilization; a progression that philosopher Peter Hulme notes marks the geographic boundaries of Europe:

In the 17th century Europe 0 or more precisely certain people living on the north-west of that landmass – began to define themselves as different in significant respects from the rest of the world. That difference was represented by positing an imaginary continent with a somewhat flexible eastern boundary ...  

The geographical self-definition of European implied secular and progressive values, so that:

... by comparing skulls and skeletons of different vertebrates, including humans, anatomists built up pictures of the gradation between what they thought of as ‘species’ and ‘races’, and conceptualized nature as a ‘lawful system instituted by God,’ both a ‘generous mother’ and unpredictable, destructive, submissive, anarchic. 

Such thinking was an extension of two opposing characterizations of Palestine which had developed in nineteenth century ‘western’ literature. On the one hand, Palestine was divine, sanctified, the ‘Holy land’; on the other, it was backward, desolate, devastated, sparsely populated, and undeveloped. The idealization of a glorious past long over, and the resultant stagnation, that, like pools of water, could only breed disease, was evident in reports of investigators on behalf of the League of Nations in the 1920s.

This thinking provided justification for colonization beginning in the nineteenth century. In 1848, an American expedition, in one of its first such overseas ventures, attempted to continue explorations begun by British explorers of the Sea of Galilee, the Jordan River, and the Dead Sea. Western researchers John MacGregor and Claude Renier Conder portrayed nomads in the Hula region as ‘American Indians’ – and suggested these nomads
represented a lower level of civilization. In a derogatory way, researchers characterized Muslims of the area as on a parallel with ‘American Indians’ and ‘Australian aborigines’.9

Scientists and settlers described their triumph over the ‘ignorant native’ and over local diseases in similar terms. For example, Walter Clay Lowdermilk was an American soil conservationist who designed a proposal for diverting water from the Jordan River to benefit areas of highest Jewish settlement. Lowdermilk described the triumph of Jewish settlers over malaria in 1944 as follows: ‘Subject to attacks by nomads and brigands, of all the difficulties they had to overcome, malaria was the worst.’10 Malaria was an implacable foe, eventually conquered by settlers at Petach Tikva, but only completely eradicated when adequate control measures were instituted as part of the new Zionist program of reclamation and settlement. In Hadera, built in a deadly swamp and in Nahalal in the Huleh, settlers reclaimed land from ‘waste and disease.’11

Lowdermilk connected Palestine and Palestinians with disease. He equated ‘scientist’ with ‘beneficent conqueror.’ Such notions became characteristic of what would be identified in an essentialized and monolithic way as ‘western thinking’ (building a binary opposition of ‘eastern’ vs. ‘western’). While recruiting indigenous laborers to spray pesticides, European, American, and Zionist officials’ accounts dismissed the labor of Palestinians by denouncing ways in which ‘the Arabs’ had neglected the land. Some American colonists used similar arguments as they wrested control of the Americas from its indigenous inhabitants.12 American engineers studied, learned from, and competed with British engineers who made possible British occupation of India, Egypt, and Palestine:

We have in the Colorado [River] an American Nile awaiting regulation ... and it should be treated in as intelligent and vigorous a manner as the British government has treated its great Egyptian prototype.13

British engineers found support from industry and private philanthropic organizations, such as the Rockefeller Foundation in North America, as they took a leading role in developing Egypt and Palestine. During the Mandate period, British administrators
rationalized government control of water in Palestine, quoting irrigation laws of Wyoming:

> Water being essential to prosperity and of limited amount, its control must be in the State which, in providing for its use, shall equally guard all the various interests involved. The waters of all natural streams, springs, and other collections of water are hereby declared to be the property of the State.\(^{14}\)

Some British officials assigned a qualitatively different ‘nature’ to ‘Arab’ and to ‘European’. Their ‘typical’ ‘Arab’ was ‘dishonest’, ‘lazy’, ‘uneducated’, ‘greedy’ and ‘unpatriotic’.\(^{15}\) British scientific methods would rehabilitate the Arab, opening a window of health never before available, particularly given the debased state of the Ottoman Empire, before its demise after World War I, characterized from a Eurocentric perspective and in the context of modernization theory as the ‘sick man of Europe.’

**The Political Economy of Health and Rehabilitation**

Some aspects of this rehabilitation were efficient and cheap; others, for example, re-organization and repair of irrigation systems, were costly and time consuming. In either case, the British Department of Public Works and Rockefeller officials depended upon funds from the Colonial Office and upon cooperation from the local population. According to the Department of Health Report, 1921, the Ottoman Medical Service ‘could have served the primary needs of the country, but its plans were not carried out.’\(^{16}\) It seems that, following the characterization of Ottoman decline in the period, the great tradition of building hospitals and medical schools under the Ottomans, as well as centuries old practices of sanitation associated with Prophetic medicine, had come to an end.\(^{17}\)

The word ‘sanitary’ appeared often in reports. The new department had to shoulder responsibility for sanitary services throughout the land, as well as establish hospitals and dispensaries ‘with existing voluntary and charitable efforts.’\(^{18}\) However, the Supreme Muslim Council (created by the British Mandate in 1921 to manage Islamic institutions) contributed funds for
malaria control, and local laborers were persuaded to take up the cause. The 1922 Department of Health Annual Report gave an encouraging picture of ‘native’ cooperation:

It is a remarkable fact that a people unused for centuries to sanitary reform has grasped with such readiness the essential fact that good sanitation means good health and health spells prosperity. Such has been our experience amongst the Arab population, who by careful and tactful dealing on the part of the P.M.S. and their medical staff have responded readily to sanitary enterprise and health projects and have co-operated with the Department of health in its campaign against dirt and disease.

The 1929 Annual Report of the Department of Health noted that 2,286 laborers had worked for 17,698 days constructing a total length of 280,756 metres of canals and drainage ditches, and did so without cost to the Government. Other Department of Health reports talked about the need for propaganda to persuade workers to participate, without specifying what that propaganda should consist of. An antimalarial ordinance enforced work in rural districts: the Department of Health Annual Report, 1930, noted that application of the ordinance was required for the most part in cases involving provision of mosquito-proof covers to cisterns and wells.

Malaria eradication was a site for negotiating class alliances, which were in turn inseparable from nationalist alliances given opportunities typical of colonial situations. Large landowners benefited from cooperating, just as some Palestinian doctors benefited from charging higher fees through their association with the new Department of Health. In 1928, the Malaria Research Unit, with the financial assistance of the Palestine Jewish Colonization Association and a number of indigenous land owners, canalized malarious wadis (riverbeds) and marshes. After a Jewish concern bought into ownership of part of the Kishom River near Haifa, it paid for a major portion of a scheme to improve drainage, including substituting cement drains for stone lined canals. The enactment of thorough malaria surveys was motivated by the goal of industrial and agricultural development, by concerns for Jewish settlers, and
by attention to the welfare of British and British-led troops, such as the Transjordanian Frontier Force.

Attempts to persuade local workers to cooperate in health projects by arguing that health meant prosperity were somewhat ironic given the negative economic consequences for many indigenous laborers and farmers resulting from World War I and the British Mandate. The British Mandate continued Ottoman policies of heavily taxing the peasantry. As a result of the British invasion of 1917, draft (work) animals were appropriated for the war effort, crops were lost, and fields burned. Under the Mandate, cheap imports meant loss of livelihood for many, although some peasants benefited from new markets. British regulations, Zionist settlement, reductions in infant mortality, and increases in population all contributed to the ongoing privatization of land, which resulted in land holdings that were often too small for subsistence.\(^{25}\)

Palestinian women were among those particularly disadvantaged by British economic policies. Many peasant women lost independence in a capitalist wage labor system that increased the ability of male heads of households to manage women’s labor.\(^{26}\) Rema Hammami has argued that the agricultural labor of Palestinian women gave them societal power, since such labor was both compensated and recognized as a critical contribution to the productive unit of the family. When family labor was subsumed under a capitalist wage labor system targeting men as the primary source of income, women’s labor became the ‘unrecognized property of the family.’\(^{27}\)

Another aspect of British economic policies related to malaria control and to the imposition of a predominantly capitalist wage labor system was the introduction of monocrop agriculture. Drainage of swamps in antimalarial campaigns prepared the land for monocrop agriculture: the British used reclaimed land to grow cotton. And increasingly there was the matter of Zionist land expropriation, facilitated by Zionist participation in malaria control.

In 1921 the British High Commissioner of Palestine, Sir Herbert Samuel, granted a concession to Zionist entrepreneur, Pinhas Rutenberg, for the generation and distribution of electricity throughout Palestine.\(^{28}\) The Rutenberg Hydro-Electric Corporation remodeled large areas of land and controlled the
use of water for irrigation as well as the flow of water. The corporation drained springs and seepage areas, and when breeding places could not be eliminated, they were treated regularly with the pesticide Paris Green, and, on occasion, with a pyrethrum paraffin preparation. In addition, working with the Jewish Joint Distribution Committee of America, the Rockefeller Foundation, which was experienced in malaria eradication, also assisted. With the rationale of humanitarian concerns, British and American workers made field surveys of the mosquito breeding areas in 1928. The collaborative effort involved drawing maps, supervising construction of drainage projects, assisting local health officials in routine malaria control, and conducting experiments to determine the source of mosquito infestation. The work of the Department of Health (overlapping with Zionist interests) was augmented since it was found that areas where malaria incidence had increased corresponded closely with the areas of Jewish agricultural settlement.

The involvement of the Rockefeller Foundation in malaria eradication was a bonus for the United States, which began to look at further economic development:

In view of the recently awakened interest in this small strip of country on the Mediterranean, it has seemed advisable to set forth somewhat comprehensively a survey of conditions as they are, and to point out the line in which commercial development is possible and which may offer opportunities to American trade.

The American Consul at Jerusalem, Addison Southard, submitted a report to Herbert Hoover (then a successful mining engineer) in 1922 in which Southard noted that investigators found hydroelectric power to be ‘by far the most important project which exists for the economic rehabilitation of Palestine’. The report also noted that the large amount of capital required would be a serious obstacle to its full realization. Through cooperation and coordination among the British, Americans, and European Zionist leaders, this problem was solved. According to the American officials involved, the majority of the Arab population would make its contribution too:
The main factor in the commercial rebirth of Palestine is the sentimental and material attention it is receiving from one of the most active and virile commercial races in the world which appears determined to spare no effort in making the best of every economic possibility which the country possesses. Plans include the purchase and preparation of land for immigrants, the founding of Jewish institutions involving building activity, the development of irrigation and hydroelectric power, credit banks (which are of greatest importance in a land without capital), agricultural research and reforestation, public health, social welfare, and other undertakings. This is to be the contribution of the Jewish element. The majority population of the country, which is of Arabic origin, is not in a position to provide financial capital to any great extent, but it will supply a valuable capital of certain physical and mental virility which should react mightily to the various economic factors that will probably be set in motion.33

What is meant here by ‘commercial rebirth,’ by ‘one of the most active and virile commercial races in the world,’ by ‘certain physical and mental virility?’ Gendered racialized constructions reduce whole populations to caricatures. But some among the Arab population did, as we know, ‘react mightily’ to Zionist involvement, particularly to the ‘various economic factors set in motion.’ Many protested the official Zionist policy of separation of settler and indigenous labor. This policy not only contradicted the promise of benefits to Palestinians from Zionist capital investment, but also threatened the indigenous economic base. Consular and League of Nations reports noted the opposition of the indigenous population to British and Zionist policies aimed at controlling land and labor only in so far as these reports dismissed political problems as out of place in a commercial report.

Hence, reclamation of land continued through malaria eradication programs involving mapping, rerouting, and control of water sources, and granting of concessions for development of hydroelectric power. Referring to the Huleh Basin Scheme, which aimed to reclaim the Huleh swamps, a League of Nations Report noted that:
It appears to us that it is in large schemes of reclamation of this kind that the Mandatory Power can best fulfill its obligation of encouraging ‘in cooperation with the Jewish Agency … close settlement by Jews on the land.’ The sum proposed would be, we consider, a justifiable charge on public revenues for a scheme which eliminated malaria from an extensive tract, irrigated 60,000 dunums outside the concession, and inside it, after reserving 15,000 dunums to Arabs, provided 36,000 dunums for Jewish colonists.

Malaria control was necessary in order to provide new areas for colonization. It had the contradictory effect of allowing Zionists land use while claiming to benefit indigenous cultivators. British officials, supported by the Rockefeller Foundation and Zionist officials, fulfilled strategic and market-related goals by configuring their strategies as humanitarian. Yet, it is unclear whether the benefits of malaria control were absolute or relative to wartime conditions created by the Europeans themselves.

... it is difficult to know how much of the decline in prevalence of malaria in Palestine during the last few years has been due to the control measures in force, and how much is simply the result of a natural decline from war-time epidemic conditions.

If malaria had been a serious problem before the Mandate period, it was now a problem with new and paradoxical dimensions. For example, program officials gave serious consideration to the crisis caused by the hydroelectric works of the Palestine Electric Corporation:

The damming of the River Jordan has caused flooding for about three kilometers of the river which necessitated a large amount of cleaning and control of breeding by chemical means. The Yarmuk basin in which water will eventually be impounded will constitute a Lake many acres in extent, a large part of which will consist of shallows. The growth of aquatic vegetation which will naturally occur very rapidly over this shallow area is likely to prove ideal
for anopheles breeding which will constitute a serious danger to the Transjordan Frontier Force Camp near the basin, to the staff of the Electric Corporation, an elaborate set of plans are being evolved to carry out all measures of control necessitated by the new conditions which have been created by the works.  

Reports to the Rockefeller Foundation acknowledged that drainage was not the main problem. Rather, at issue were conservation and control of available water supplies. Still, the Haifa Bay Development Company and Land Corporation undertook extensive drainage projects to afford adequate areas of land for industrial development in the neighborhood of Haifa.

Perhaps in conjunction with facilitating industrial development, surveillance was another aspect of malaria control. British administrators carefully watched religious festivals, which increasingly provided occasions for nationalist demonstrations. They asserted that the large numbers attending such festivals could result in outbreaks of the disease. For example, the malaria eradication program initiated use of the insecticide pyrethrum for the wholesale destruction of adult mosquitoes at the annual gathering of 40,000 people at the Nebi Rubin festival on the banks of the River Rubin. With forty gallons of the insecticide, mosquito destruction was resorted to in tents and huts and throughout the camping area. In addition, surveillance of the health condition of all arrivals facilitated control of travelers by land or sea.

The British Mandate also acquired vital information through its malaria eradication program in Transjordan. In 1926 it conducted the first surveys of the northern Jordan Valley area and along the eastern coasts of the Dead Sea. It cleared vegetation around springs and streams, reinforced banks, oiled wells and covered them with iron lids. Supervised by medical officers and sanitary inspectors from the Department of Health, local villagers carried out the work. The Department of Health registered water resources, ‘so that through the anti-malaria campaign the central government began to acquire a mass of vital data on Transjordan’s water resources, their type and location.’

In 1927 the Rutenburg Palestine Electric Corporation started the construction of a large hydro-electric plant at Jisr al Majami in the valleys of the Jordan and Yarmuk:
As the field of operations was partly in Palestine and partly in Transjordan, the Departments of Health of the two countries were asked by the Corporation to undertake the malaria control measures at its expense. Anti-larval measures were necessary over an area of approximately 160 square kilometers to protect the Corporation’s camp of 250 men adequately. In Transjordan, after a rapid engineering survey of the irrigation systems originating from the Wadi Arab and Yarmuck [sic], work was started early in March on some 28 kilometers of the main canals.41

Malaria control in the Zarqa area of Transjordan was precipitated by investigation of the area by the Department of Health after the site was selected by the Transjordan Frontier Force as a permanent camp site.42

**Mighty Reactions and Anti-Malaria Measures:**

**A Testing Ground**

The British Mandate introduced health initiatives through increased hospital and clinical services, public health measures, use of drugs, medical surveillance, and ordinances proscribing medical practices. Its programs and policies contributed to measurable improvements according to newly defined parameters defining the health status of the populations. While British officers raided homes between 1936 and 1939 and shot women and men, the Mandate government instituted relief measures for persons whose livelihoods were affected by the disturbances. Politics may have been a hindrance to the British-led Department of Health, but a hindrance that could be easily overcome through the dedication of a loyal staff. The loyal staff included Palestinian doctors who benefited from working for the British-run Department of Health. At the same time, some among the Palestinian nationalist leadership considered Palestinian doctors accountable to their people and to a Palestinian agenda. According to one British physician who served in Hebron during the 1936 rebellion, two Palestinian doctors from the Health Department were hauled before a rebel court and reproved for taking too much money from poor patients.43
Moreover, in this period a history of interrelationship between Jews, Muslims, and Christians in the area of health, medicine, and medical practices was disrupted. Palestinians competed with Jews for scarce services, since the British Health Department was short of funds. Owing to disturbances beginning in 1929, Jews had begun seeking admission to Jewish hospitals. A separation of ‘Jew’ and ‘Arab’ (disappearing Arab Jews) health facilities, along with separation of ‘Jewish’ and ‘Arab’ labor, redefined health customs and practices. Historically, Jews and Muslims, including female midwives and doctors, were accustomed to interaction in the area of medical philosophy and practice. One Palestinian woman interviewed for this study put it this way:

My mother had Jewish friends. Hatt al-Nassar is named Sarina after her Jewish neighbor, and there is another sister Sarah also after her neighbor ... they were Arab Jewish ... They had their own feasts, each sect and religion, but they used to have cooperation with vegetables and so on and also they used to exchange different sweets during the feasts. My father brought for my mother a Jewish doctor and there were also two Arab doctors ... there was no segregation.44

During the 1936–39 revolt, one woman doctor, a Jew who attended to Arab villagers in the al-Tayyiba area, concealed a rebel chief and treated his wounds, returning his favor of having rescued her from thieves.45

Gradually during the Mandate years, women began seeking health support in separate spheres. Jewish women began receiving antenatal care and treatment from British women doctors in separate clinics rather than from other Arab women. Hospitals began to service separate populations. Jewish women attended hospitals sponsored by Jewish organizations. And (Jewish, Christian, and Muslim) Palestinian midwives ‘who had been secretly and illegally carrying on so-called gynecological practice of a most unsatisfactory kind,’ were increasingly phased out.46

During the period of increasing unrest characterizing the Mandate, many European Jews increasingly had access both to health care through private sources and to means of economic survival not available to the majority of the Palestinian population.
And while Palestinians benefited from British humanitarianism in the sphere of health care, many suffered from deleterious economic policies.

Palestinian women and men of peasant background shared with anthropologist Rema Hammami their remembrances of hardship during the Mandate period:

The British used to play with the prices. In the good harvest year the British would put a ceiling on the prices we’d sell a *rutl* (approximately 3 kilos) of wheat for two piasters. When it was a bad year they would make a *rutl* of wheat for 20 piasters. They didn’t want us to raise our heads. It was part of their colonial plan. Abu al-Abed from Faluja similarly remembered: It was a colonial policy, and when the muhassil (tax collector) would do the accounts the government would lower the prices, a kilo that was five *qurush* they would make it for two *qurush* – so we’d lose so we made the strike in 1919 and then in 1936 the strike for six months.47

In 1937, the Annual Report of the Department of Health noted much poverty among the Arabs in towns and in villages: ‘The villagers have been accustomed to produce and exist on their own grain, vegetables, and farm produce, but adverse economic conditions and rapid increase of population have diminished their means of livelihood.’48

Stress on households from colonial economic policies no doubt had health consequences for the population, as did rebellions, termed ‘disturbances’ by the British, in 1919, 1929, 1936. The 1929 Annual Report of the Palestine Department of Health noted considerable casualties as a result of ‘disturbances.’ The Jewish hospitals of Jerusalem, the Rothschild, Shaare Zedek, and Bicur Cholim, and the English hospital of the London Jews Society received the bulk of Jewish casualties from Jerusalem, from neighboring areas, or from those transferred by the Department of Health in ambulances and omnibuses from Hebron. Hadassah hospitals at Safed and at Haifa dealt with those in the Northern District. When Safed Hospital became overcrowded, 22 severe cases were transferred to Haifa. Arab casualties were dealt with in the main by the government and Municipal Hospitals of
Jerusalem, Jaffa, and Haifa, assisted by the Ophthalmic Hospital of the Order of St. John, and the French Hospital in Jerusalem. The Bishop and East Mission opened up a hospital at Hebron at short notice. For a few days the situation taxed the medical resources of the Department to their utmost. It was a matter of regret, the Report noted, when requests to exhume corpses of the Hebron victims were acceded to in an attempt to prove mutilation after death.  

1936 again proved to be a testing ground for the Department of Health. Anti-malarial measures in Palestine were held up by the general strike. Increased military activities were carried out throughout the malarial season, April to November. There were military patrols on roads and railways by day and night, guards stationed throughout the country, and ‘frequent operations involving the movement of considerable bodies of men for several days on end over large parts of the country.’ Although considered susceptible to malaria, the young British soldiers benefited from the routine anti-larval measures of the Department of Health, so that out of a force of 15,000, there were 117 primary cases of malaria, and 22 relapses. The disturbances impeded work because of the difficulty of obtaining labor. But during the acute stages of the rebellion, the District Superintendent of Police supplied guards for anti-malarial labor gangs in the Northern part of Jaffa sub-district: ‘A breakdown of the measures for the prevention of malaria in this area was thereby narrowly averted.’  

Even though surgical work increased considerably, 1936 saw no increases in expenditures for health from London, particularly to wounded soldiers admitted to government hospitals. Furthermore, according to the Department of Health Report, on account of the poverty and semi-starvation of the women and children, many more attended out-patient clinics sponsored by the Department of Health. Additional supplies of drugs and dressings were furnished on credit. The British nursing staff was augmented by two to handle the increased work resulting from casualties in the disturbances. Nonetheless, new construction of departmental buildings was suspended, along with a project for a new mental hospital, reconstruction and addition to a tuberculosis sanatorium at Nazareth, expansion of Nablus hospital, construction of Ramleh hospital, nurses quarters at
Safad hospital, the maternity block at Jaffa, and the infectious hospital in Jerusalem.\textsuperscript{56}

The Department was satisfied that there were no epidemics and that the general health of the region’s populations was satisfactory given disturbances and privations. Unrest in Palestine from May to October 1936 presented difficulties in carrying out services in rural districts where personnel were in danger of attack. But it was to their credit that they (Arab, Jew, and British) carried on their duties in urban and rural areas with ‘the greatest loyalty and devotion … First aid in casualties amongst troops, police and civilians [was] readily available, and in certain instances gallantly administered, by the department’s medical officers and by voluntary and charitable medical organizations and units.’\textsuperscript{57} However, due to an increase in the British police force, and in the wives and children of British government and army officers, more hospital beds were needed. The 1936 infant mortality rate at 121/1000 (general population average) was the lowest recorded in Palestine; and the death rate at 16.11 was the lowest yet recorded.\textsuperscript{58} From the point of view of British medical officers’ statistics, the health project was a success.

The picture looked different from the perspective of many Palestinians, who saw and experienced the brutality of British troops raiding their homes and imprisoning men and women; and from the perspective of indigenous Palestinian Jews caught in the crossfire between European and Palestinian. Villagers could not reach hospitals. Wounded Palestinians would not seek admission to government hospitals for fear of police investigation of the circumstances of their injury.\textsuperscript{59}

The British expanded prisons during the 1936–39 rebellion. They established a detention camp at Auja al-Haifr and then at Sarafand, where they held political offenders. Medical treatment required was considerable, ‘and conducted under frequent reproach from interned persons whose estimate of their own ailment was influenced by their desire for the more comfortable circumstances of hospital.’\textsuperscript{60} When two Jewish nurses who worked at a Government Hospital at Jaffa were murdered, a temporary infectious hospital for Jews only was opened north of Tel Aviv.\textsuperscript{51} The 10,000 Arab laborers and their families living in shacks in and around Haifa endured conditions of ‘appalling filth.’\textsuperscript{62} Several municipalities had difficulty maintaining sanitary
services because Palestinian members of the municipal councils and their employees were on strike. The Department of Health complained about the high numbers of sick days taken during the disturbances, blaming it on medical officers granting more sick leave than was justifiable on medical grounds. Yet, medical officers were subject to threats and pressure …

... and it is not surprising that symptoms were exaggerated and neuroses were rife, and it is often extremely difficult for a medical officer to send back to work a railway worker, who states that he is suffering from some subjective symptoms, knowing that if the man fails in his duties, he may endanger the lives of others.

According to the Department of Health, in spite of continued disturbances the health picture continued to be satisfactory.

**Long Term Effects**

Malaria eradication programs prior to and during the Mandate period, as well as after World War II in Egypt, were connected to militarization and colonization, with contradictory social and ecological consequences. Scientists and industrialists initiated malaria eradication in order to create large tracts of usable land for single cash crop farming. Britain and America authorized use of pesticides and other toxic chemicals (also used domestically). Parathion, for example, used for malaria eradication, was subsequently found to be a deadly poison that acts on the nervous system. Parathion and DDT were later banned in most industrialized countries. Laborers spreading the toxic substances would have been the first to suffer deleterious effects. Local treatments for malaria, for example, use of herbs that helped to create immunity to the disease, were supplanted by the introduction of new medical treatments.

Increasingly in the twentieth century, the dominant scientific and medical model was a mechanistic model, isolating part from whole. Chemicals (such as DDT) originally developed for use in warfare were later used as pesticides for agricultural use and as drugs to treat diseases, including malaria, without attention to their effect on the population or environment. While customary
land use practices in Palestine placed high value on preserving fertility, cash crop farming places ‘use value’ (defined by profitability) on the land regardless of long term effects.\textsuperscript{65}

A system of shared use and ownership of water rights evolving over many generations in Palestine complicated the task of malaria control: Rockefeller Foundation documents cited in this chapter noted that malaria control would be greatly enhanced if springs could be properly organized and controlled. Private ownership of land facilitated that control and resulted in overuse, and hence reduction in the fertility of land.

Militarism—including manufacture of products of war, as well as mobilization of armed forces overseas – encouraged successful collaboration between science and industry in promoting pesticide use by agribusiness and for malaria control. The Rockefeller Foundation engaged in experimental attempts to eliminate health hazards affecting the military stationed in Europe and the Middle East, using chemicals that had not formerly been used for medical purposes. This alliance of medicine and military led to medical use of modern insecticides when the Allied Military Government eliminated typhus in Italy by dusting with DDT. Destroying the ability of cells to use oxygen, DDT causes mutation of normal cells and can result in cancer and infertility. British officials, assisted by the Rockefeller Foundation, applied more than 1,000 pounds of DDT during the course of a malaria eradication campaign in Egypt. Yet, to enable cash crop production of cotton, the British invested in dams to reroute water and change from basin to perennial irrigation. This increased the incidence of malaria.\textsuperscript{66}

And as late as 1950, the Jordanian Department of Health Annual Report noted that:

In the other districts of the Kingdom the routine work of canalization of Wadies and Springs was carried out with cleaning of edges, drying of stagnant marshes, regular oiling of cisterns and wells. D.D.T. spraying of all villages near the water sources was carried out satisfactorily.\textsuperscript{67}

Although not aware of the harmful effects of DDT in 1919, by 1950 the British and the Egyptian Ministry of Health were at least partially aware of the health dangers posed by use of DDT. For example, in April of 1946, the Rockefeller Foundation, working
for the Egyptian government, issued detailed instructions, including explicit warnings of dangers involved, for the use of DDT-oil application by hand sprayers. The instructions describe the dress and equipment required of the sprayer and how to spray mosquito breeding places with DDT-oil:

When DDT-oil is sprayed on water surfaces in the small quantities here specified, it is a poison only to aquatic insects. It has no effect upon plants, animals, or man, even if the latter drink the water. However, DDT, especially when it is in oil, is a poison to man if it gets on his skin in large quantities. The oil in which the DDT is dissolved is also irritating to the skin of some people. DDT can be absorbed through the intact skin, and the presence of oil favors such absorption.68

The United States Army, believing that the situation in the Nile Valley offered an excellent opportunity to test under controlled conditions the residual effect of DDT insecticide on boats, proposed that 1,000 pounds of DDT be allotted to the Rockefeller Foundation for use there.69 Experimentation extended to use of a special spreading agent developed by Shell Company in London.70 As Assistant Secretary of State G. Howland wrote to Dr. Wilbur A. Sawyer, Director of the Rockefeller Foundation International Health Division, malaria eradication was of great importance to medical progress, to the war effort, and to ‘political enlightenment.’71 In other words, malaria eradication would be useful for developing medical techniques, for safeguarding foreign troops, and to convince the local population of the dictum of Europe’s civilizing mission, justifying the politics of European expansionism.

Those Zionist institutions that supported the British-led malaria eradication program did so not only in an effort to attract Jewish settlers, but also in tandem with acquiring control of water in the region. In an arid region, river systems and groundwater are primary sources for irrigation. The Jordan River, coming from Lake Tiberius and flowing to the Dead Sea, and the Yarmuk River, which meets the Jordan River at the Tiberius Lake, are the principal water sources in the region. In the course of its malaria eradication campaign as noted, the British granted
exclusive rights for seventy years to the Zionist Palestine Electric Corporation to harness the Jordan and Yarmuk waters for hydro-electric power. Pinhas Rutenberg, president of the corporation and a major catalyst in the development of Jewish industry in Palestine before 1948, formed the Jaffa Electric Company under a concession by the Palestine Government in 1921. The British Mandate government gave the company the right to generate, supply, and distribute electricity, as well as develop irrigation facilities from the Auja stream.\textsuperscript{72}

With time, deterioration of water quality of the Jordan River, including high levels of salinity and nitrate concentration, made it unsuitable for agriculture and for daily use. In just forty years groundwater sources had become saline due to overuse. They were also polluted due to insufficient management of domestic and industrial waste, as well as overuse and inappropriate use of pesticides. Wells used for generations had become polluted by leakage from drainage pipes in Jewish settlements built nearby, resulting in ‘irreversible damage to groundwater.’\textsuperscript{73} Over-drilling of wells for development projects caused ‘severe disturbances to environmental equilibrium dynamics, aggravating soil erosion, and spreading desertification, in addition to the loss of resources concerned.’\textsuperscript{74} Further, the malaria carrying mosquito had become resistant to pesticide treatments. After 1948, Israeli policies limited Palestinians’ access to water for survival, a situation compounded in 1967 when the Israeli military took control of the critical aquifers beneath the west bank of the Jordan River. As recent documents note, environmental problems have multiplied the socio-economic problems of all peoples of the region, and have produced increasing health hazards.

**Conclusions: Disease Control and/or the Imposition of Imperial Politics?**

Evidence documented in this chapter demonstrates complexities in the uses of what came to be called ‘modern medicine’ during the Mandate period in Palestine and in Transjordan. Definitions of health and development of health care systems carried gendered and racialized constructions. ‘Modernization’ itself is a paradoxical complex of processes with consequences widely discussed in the twenty-first century. Perhaps discriminating examination of
documents in this period can help us in addressing and resolving such deleterious consequences across the globe. Perhaps reuniting the wisdom of ancient healing practices with the wisdom of ‘modern medicine’ can be facilitated by unraveling colonialist ideologies and practices.

By 1939, the British-led Department of Health, with the support of the Rockefeller Foundation, and Zionist agencies, had instituted a malaria control program making the environment safer for British troops, American industrialists, European Zionist settlers, and the indigenous Palestinian population. In the course of draining swamps, reorganizing patterns of land ownership, tracking and revamping water rights, the policies of the British Mandate carried out through their Department of Health had, for Palestinians, the paradoxical result of contributing to their loss of control over their land base.

British and American documents noted in this chapter draw parallels between reshaping the natural environment and reshaping a mythic and debased ‘Arab nature’. In this sense science was equated with rehabilitation, not only of the environment, but also of a ‘race.’ The masculinist image of the scientist as beneficent conqueror saving the feminized native from ignorance and disease underscored a form of gender politics in the period addressed.

Along with rehabilitation of the environment, one group of Palestinians whose rehabilitation was a focus of British health policies was Palestinian women. British health policies included re-education of Palestinian mothers and Palestinian women healers, or davat. Reorganization of the health system challenged women healers’ base of support and work, and it resulted in further separation of Jews from Muslims and Christians in the area of health care. Women healers responded with a range of strategies in order to continue working and influence the way in which the health system evolved. After 1948, the history of women’s relations to health systems and practices took on new significance in exile.
Figure 9
Figure 10

Figure 11
Figure 12

Figure 13
Figure 14

Figure 15
Figure 16
Figure 17

Chapter 3

BETWEEN DAWA AND DOCTOR:
A FORMIDABLE ABYSS?

This chapter discusses Palestinian women’s interactions with health systems and practices in Palestine and Jordan. In relation both to British reorganization of the health system and as refugees, indigenous women healers experienced changes affecting their ability to work, their relations with women they served, and their customary healing practices.

In July 1937 the Senior Medical Officer of the British-led Department of Health received a petition signed by 11 Palestinian midwives protesting economic hardship resulting from new developments in the area of health care during the Mandate period. The petition was a plea for help:

We, the undersigned, licensed midwives practicing in Jerusalem, wish to draw your attention to the fact that we are faced with poverty, even destitution, due to the number of women going to the hospitals for the birth of their children. Can you help us in some way?

It is surely all wrong that self-supporting women, working to assist their children and homes, should be faced with starvation. We are not young enough to learn other work, we look to you to help us.

We attend many women during the ante-natal period who eventually deliver in a hospital paying us nothing.
If it is impossible to prevent these women going to hospital to deliver, may we be allowed, for our usual fee – to attend them in the hospital.¹

The midwives brought their plight to the attention of the Senior Medical Officer because supervision of midwives had begun under British occupation with Public Health Ordinance No. I of the Occupied Enemy Territory Administration. Midwifery was a central concern of the British Department of Health, which wasted no time in reactivating a system for registration of women who were healers and midwives (dayat). Early in 1918, the British gave midwives temporary registration forms inherited from the Turkish Health Department, and eventually replaced them with forms (later altered again to suit record keeping purposes²) issued by the new Department of Health. Midwives experienced a number of consequences as a result of the new health system. For example, as noted in the petition quoted above, some indigenous midwives were no longer able to be self-supporting. The numbers of women attending hospitals for delivery increased in the Mandate period, and hospital nurses were trained in midwifery. In 1929 the Department of Health issued the Midwives Ordinance, officially making midwifery a part of medical practice under control of the British. Using British records, related literature regarding midwifery, and testimonies of Palestinian midwives, this chapter examines the incorporation of midwifery into the British health system.

In Chapter 2 I examined the relationship between British and American constructs of health and diseases and the constructs of indigenous peoples, for example, conflation of Bedouin with ‘disease’, ‘ignorance’, and ‘misuse of land’. Similar constructs pervade documentation during the Mandate period regarding women and reproduction: midwives and mothers appear as ‘unclean’ and ‘ignorant’. The new medical system introduced definitions of motherhood, along with standards and indicators of women’s health, based on scientific medical models developed in Europe and the United States.

The impact of economic and social changes in the late nineteenth and early twentieth centuries on Palestinian women’s lives included, as Public Health specialist Rita Giacaman puts it, a shift from ‘highly skilled non-wage work such as midwifery or
indigenous medicine', into the sphere of wage labour and training courses whose dictates established new practices regarding health. Giacaman describes the process as it affected Sitti Sa’dieh, a daya practicing in Palestine. Sitti Sa’dieh, ‘mother of the entire village’ had delivered almost everyone. Over the years, however, she and her services to her community as a daya had been marginalized. By 1981, because of old age and changing childbirth patterns, she had hardly any practice.

Sitti Sa’dieh was from a poor background and had taken over her mother’s practice. She considered her skills a gift from God and she trusted that her services would earn her a better life after death. She considered her work a service to her community. Dayat did not charge a specific wage. They were repaid for their services through a bartering system that involved both monetary and other forms of payment. In the early 1900s British and Zionist health services subsumed this system. British, American, and European doctors and nurses inundated the health system. British regulations monitored medical personnel and proscribed practices. By the time of Israeli military occupation (1949), modern medical facilities and drugs predominated, and few women were willing to carry on the daya’s craft.

This chapter begins by examining consequences of specific European and American views of dayat. It asks: what were socio–economic-political consequences for dayat of British policies regarding midwives between 1918 and 1948? Finally, based on testimonies of Palestinian women, this chapter examines the consequences of colonization and population dispersion for specific midwives. How did dayat themselves view and participate in transformations in health systems?

Dangerous Hags and Sanitised Hovels: Midwifery and Modernity

The history of midwifery in Palestine and Transjordan was connected to the history of midwifery in Europe and North America through colonization and importation of medical practices, tools, drugs, and personnel after World War I. In the eyes of some North American and European medical practitioners and travelers to the Middle East, the daya was the quintessential native: she was ‘dirty’, ‘backward’ and ‘ignorant’. Doctors and
their auxiliaries, trained nurses, comprised a core elite sent to remedy the *daya*’s deficiencies.

One such traveler, Ruth Frances Woodsmall (1883–1963), worked for the YMCA in Turkey and Syria and held a fellowship from the Rockefeller Foundation that allowed her to travel to Turkey, Syria, Egypt, Palestine and Transjordan in the post–World War I period. Woodsmall expressed a common view of the village midwife as:

... the greatest hazard that the women of all countries must meet ... untrained, ignorant, old, often blind and half blind, always filthy and always of the lowest class ... the village midwife is for thousands of eastern women and children the harbinger of disease and death.\(^5\)

She depicted the *daya* as jealously guarding her power and exerting a malicious control over the village home: in Woodsmall’s estimation the *daya* was the archetypal conniving woman:

The encroachments of modern science in her special province the midwife bitterly resents and often aggressively opposes. For example, a vigorous midwife in Mosul carried on an active and successful propaganda a few years ago against the hospital there, choosing wisely the one place where harem women gather, the bath, which since privacy is not a requisite of the Oriental bath, fills all the functions of the ladies club, and is the favorite gathering place for gossip and amusement. It also offers as in this case, an unusual opportunity for health or anti-health propaganda.\(^6\)

Woodsmall characterized the midwife with her ‘primitive implements’ as a repository of ignorance, superstition, and fatalism – defining characteristics, according to some Europeans, of an imagined ‘East’. Doctors and nurses lamented that the midwives’ malpractice causes ...

... an inevitable toll of maternal and child mortality, when in fact the mortality or morbidity was frequently unavoidable, arising as it did from social, economic, and medical
conditions. In addition, poverty, bad housing, uncontrolled infectious disease ...

In striking contrast was the newly trained midwife of the modern era ‘in white cap and uniform with shining clean instruments standing beside a bed with clean white covering’. The modern clinic and trained midwife were ‘characteristic of the widespread effort that modern science was making in Asia to overcome this primary danger in the life of Eastern women’.7

Debasement of the midwife was not confined to the Middle Eastern daya. In Europe as well, male doctors often depicted the midwife as a ‘dirty, drink-sodden old hag without skill or conscience’, even though ‘the great majority were clean, knowledgeable old women who took a pride in their office’.8 The struggle of the midwife to supplement her ‘accumulated practical skills gained through observation and experience’, and to benefit from education and technology (thermometers, rubber gloves, syringes, needles and urine testing equipment) spanned several centuries and was intertwined with efforts of the Church, the State, and male medical practitioners to control reproduction.9 Ironically, the number of British women relying on midwives and home birth rose when Great Britain sent many of its doctors into the medical corps during World War I. British doctors in Palestine then became competitors of indigenous dayat.10

New terms set by the British-led Department of Health were introduced through a network of infant welfare and maternity programs, and through laws and regulations pertaining to medical practices, including birth. Infant welfare and maternity programs were introduced in Palestine, beginning in 1921 by the British, the Hadassah Medical organization (primarily for Jews), the Supreme Moslem Council, the American Colony Aid Center in Jerusalem, and private centers and local societies.11 Nurses in hospitals were given midwifery training, and in 1922 a course opened in a government hospital for retraining local midwives. The number of women trained as midwives increased from three in 1922 to 21 in 1928.12 There were, at the end of 1928, 655 doctors, 180 pharmacists, 202 dentists, and 292 midwives licensed to practice their professions in Palestine.13
In Palestine and Transjordan foreign health practitioners complained about mothers and midwives. Nurses complained that native dayat ‘knew nothing of aseptic techniques’, and that:

... the medieval high stool with the hole in the center is still much in vogue for deliveries here. There is no midwife control or supervision. The greater number of native Arab and Jewish women prefer the services of the native midwife to those of the physician or the hospital.14

In addition to such ‘complaints’ (and perhaps in response to their perception of indigenous women’s autonomy regarding medical practices) European and American nurses attempted to ‘westernize the community as soon as possible’:

Nurses exhorted the mothers, ‘And don’t take the advice of your mother or mother-on-law; come to us to ask your questions’. When prizes for ‘Better Babies’ were awarded—clearly one had to pay a price to please the public health nurse ...15

Nonetheless, the success of the nurses in imposing new health practices was mediated by Palestinian women who may have benefited from at least temporarily pleasing the nurses and receiving their prizes:

A glance over the years shows that others did not give in to the nurse, even after several generations had been instructed in ‘modern’ methods. The Oriental population, with its extended families and its own brand of health care, withstood many of the western ideas. To them, western medicine was on the same level as medical practice by the wise man or the wise woman. If the advice of the one did not work, one went to the other for help.16

Attempts to ‘westernize’ resulted in ‘rapid strides in the work of Infant Welfare Centers’, according to a 1927 Department of Health, Annual Report on Palestine. The report quotes at Length Mrs E. Cotching M.D. in charge of the Haifa Infant Welfare Association’s Center. Dr. Catching applauded rapid strides made
in the work of Infant Welfare Centers. She noted the overall purpose of preventive medicine and education of mothers who 'are mere children', as:

The object of the center is to teach these mothers not only how to prevent their children dying, but how to keep them healthy and well, free from such diseases as diarrhoea; how to preserve their eyesight and how to save them unnecessary suffering. When once the mothers of Haifa can be convinced that this is possible and that most diseases and deaths of babies are due to their lack of knowledge, there will be a tremendous fall in infant mortality and also healthier citizens in the future.  

Cotching added that there were many difficulties still to be overcome, particularly in regard to indigenous views of health and health practices:

There are still many cruel practices carried out by some of the old women in this country as treatment for certain diseases such as burning the skin of the baby here and there and leaving open sores all over the body, putting lemon juice in the babies eyes, giving a male child’s urine as a medicine to those suffering from measles. The practice of wearing charms ‘to keep away the evil eye’ still persists and poor mothers pay as much as a pound for such a charm. Charms are also sold by certain people, which when worn by a woman who is unable to feed her baby in nature’s way are supposed to possess the power to enable her to so ...

Trained nurses, Cotching observed, worked relentlessly, delivering leaflets on infant management, encouraging mothers to attend Infant Welfare Centers, although as yet the benefits had not reached the Arab population in rural areas. But in spite of Cotching’s faith in the ability of the clinics to reduce infant mortality, between 1924 and 1928 infant mortality rates (per 1,000 of the general settled population) fluctuated, rising from 184.8 in 1924 to 188.6 in 1925, falling to 163.0 in 1926, and rising again in 1927:
So far infant welfare work has been limited to the towns and Jewish rural settlements; the large Arab village population of nearly half a million persons remains untouched but efforts were being made to establish, and nurses were being specially trained to conduct, village Centers for infant welfare and health work ... The rise in infantile mortality from 163.03 to 200.46 serves to emphasize the great need that exists in Palestine for organized effort to protect infant life and health.¹⁹

The Transjordan Department of Health had similar goals in regard to establishing Infant Welfare Centers, though progress was slow. In 1928, the Department reported little advance in the important branch of Public Health:

The scheme for the training of a certain number of women in midwifery at the Palestine Government Training School for Midwives at the expense of the Trans-Jordan Government, failed for lack of funds. Only two qualified midwives are licensed to practice their profession; one of them is the Municipal Midwife. All the rest are ‘Dayes’ whom the Department controls by a Registration Certificate. Some of those ‘Dayes’ were receiving from time to time a course of simple lectures by the Medical Officers of Health. The infant mortality rate per 1000 births has been 184.8 compared with 163.27 in 1927 and 131.5 in 1926. 56% of the total deaths during the year has been among children below 5 years of age compared with 47% in 1927.²⁰

Some mothers chose not to attend clinics. A Miss C.A. Lampitt, reporting on the Infant Welfare Center at El-Salt in the same year, offered her explanation:

The work at this Center was commenced in January 1928, by Miss E. Lester, in a room on the Jedda Hill, at first only 2 or 3 mothers could be persuaded to attend, and were afraid of evil happening to their children if they were weighed, but by the end of May there were 8 or more attendances each afternoon twice a week, and some of the homes were
visited. Simple teaching was given, and before Miss Lester left for England the mothers were questioned as to their knowledge, and a prize given for the best answers, also for the cleanest baby.21

Hence began the practice of offering prizes to mothers for ‘better babies’, also used in Palestine as noted above (and initiated by Christian missionaries with Native Americans in North America during the late nineteenth century). Whether for the sake of prizes or from other motivations, gradually women began to attend and eventually to inundate centres. In Palestine and in Transjordan, motherhood was given its due rewards, albeit in new terms.

**Reorganization/Regulation/Specialization**

British regulation of the health system in Palestine and Transjordan, including management of reproduction, was instituted through regulations giving British (and British appointed) administrators control over medical practices, training, fees, work placements, and supervision. Along with the benefits of the imposition of new health standards, training, and job opportunities, Palestinian dayat experienced a range of negative consequences, including poverty, devaluation of their knowledge and experience, and increased competition for, and lack of access to, work.

The British had issued public health and health education regulations in 1918. In 1923 they issued an ordinance regulating the practice of midwifery.22 The ordinance, revised in 1929, stipulated that no person, unless she was authorized under the ordinance, could either practice midwifery or prepare to practice midwifery.

Persons wishing to practice had to be licensed (a fee of 250 mils was charged on grant of a licence), or have their names entered in a registry of unqualified persons practicing midwifery. The latter were allowed to call themselves ‘Registered Dayahs’. Their certificates of registration were valid for one year, after which time renewal had to be sought in person by the holder of the certificate. The daya’s name could be removed from the registry for such offenses as negligence, lack of reasonable skill, or failure to comply with rules and regulations.23
A qualified midwife under the ordinance was allowed to call herself a ‘Licenced Midwife’. Licensed midwives received diplomas from courses enabling them to practice midwifery. They were inspected and supervised in their homes and work places at least twice yearly. They could attend talks and demonstrations at refresher courses given for both dayat and midwives. They could charge higher fees, but could not officially practice outside of assigned locations.

British administrators made a distinction between licensed midwives and registered dayat in regard to literacy. They were less willing to invest in illiterate dayat, who, if they could afford the travel and accommodations, could take refresher courses oriented toward uses of new tools of their trade. Such dayat were excluded from courses requiring reading skills.

By 1929 the Palestine Department of Health had appointed district medical officers to supervise and oversee the appointments and responsibilities of midwives, as well as other health matters. By 1933 there were ten government and 27 non-government hospitals, along with 19 government and 42 non-government dispensaries and clinics. Regulation of health and health practices was well under way. Government regulations of licensed midwives and registered dayat in Palestine and Transjordan stipulated their duties to mother and child, medications they were permitted to dispense, limitations of functions, situations calling for doctor intervention, and notifications required for the medical officer in her district.

The Medical Practitioners Ordinance came into force in February of that year, forbidding the practice of medicine by any except licensed doctors. It prohibited advertising and ‘covering’ (a practice whereby a doctor would take responsibility for a case he did not treat) of unqualified persons by doctors. Contraventions of the ordinance were brought to court. For example, an unqualified man practicing medicine for some years among villagers was fined with the option of six months’ imprisonment. One midwife was fined for conducting a private hospital. A doctor was fined for advertising his practice, and another fined and his license suspended for a month for employing an unqualified assistant. Another doctor was fined for dispensing drugs without authority.

The 1927 Department of Health Annual Report also noted the need for Arab medical women who ‘understand the manners and customs of the Arab population’ and ‘that there are now
Palestinian women studying medicine in Beirut’. Women doctors trained and licensed midwives according to the European practices of the day. These midwives, who sat on a lower rung in the new hierarchy, would facilitate the transition to the new medical and health system. The British picture of the new woman medical practitioner was of a woman with the means to obtain medical education – young, sanitized and morally responsible to colonialists’ expectations.

Sixteen midwives were trained in 1930 in Palestine, and were certified under the Midwives Ordinance of 1929. Their course of instruction was coordinated with the work of the Antenatal Clinic and Infant Welfare Center operating from the Old City. In 1930, midwives carried an average of 27.2 cases each. There were 417 infants cared for by the Infant Welfare Center in Jerusalem. There were 6,649 visits to clinics and 3,414 visits made to infants’ houses.

At the end of 1933, 368 women were licensed midwives and 1,193 untrained dayat practiced in villages in Palestine. The list of medical practitioners and midwives collected by the Palestine Department of Health in 1938 documents 336 licensed midwives whose addresses were known, and 171 whose addresses were unknown. Trained midwives included women who emigrated from Europe and the US, predominantly Jews, as well as Palestinian Jews, Muslims, and Christians.

In Transjordan the Department of Health, addressing the problem of high infant mortality in 1926, included the need for trained midwives in its plea for more staff, including pharmacists and dentists:

All the midwives in the country are unqualified and practically every woman acts as a midwife. The Department started the registration of a limited number of midwives, considering their comparative capabilities, with the object of issuing to them Certificates of Registration for control purposes. The Department is taking up with the Government the matter of employing four municipal qualified midwives for Amman, Irbid, Kerak, and Ma’an Towns, to be paid by those Municipalities until such time as private qualified midwives practice that profession in Transjordan. (Emphasis mine.)
A special sum was put in the 1928–29 public health budget for the training of five midwives, stressing concerns for maternity and child health centres, and for school health services that would be repeated yearly. ‘Ignorant’ mothers and ‘untrained’ midwives, along with impure water and poverty, especially among the Bedouin, were cited by British nurses as major causes of high infant mortality. Midwives would become specialists: delivery should be in the hands of trained experts. Although there were on-going complaints about the inadequate share of the budget allotted to health, the number of hospital beds provided by charitable societies increased from 66 to 99 in 1927. The population only gradually began to use government hospitals and clinics.

Licensing of midwives began in Transjordan in 1931. In 1933 there were two midwives with Department licenses practicing in Amman, one in Salt, and one in Karak. (In addition to medical staff of the Department of Health listed, there were three medical officers and one senior medical officer attached to the Trans-Jordanian Frontier Force, one medical officer of the Royal Air Force, Amman, and two medical officers of the Iraq Petroleum Company. By 1935 four midwives were licensed, in 1936 seven, and in 1937 eleven. In 1936 the Amman Infant Welfare Center was the only center in the country. Cases were registered from 1935, as was the number of attendances, although there was a slight increase in the number of visits to houses of children made by nurses from 2,356 to 2,590. Arrangements were made to train a few women in midwifery at the Palestine Health Department Center at the expense of the municipality, where they would be later appointed as municipal midwives. Transjordan licensed 14 midwives in 1943. In 1948 Jordan licensed 11 midwives in Amman, two in Salt, one in Kerak, one in Ajloun, two in Madaba, and five in Zerka. Those numbers increased in 1950, when 246 unqualified midwives (who had not taken courses) were licensed, with the largest number appointed in Amman, Irbid, Ajloun, and Madaba. In 1950 the wife of the British minister at Amman continued to sponsor the Infant Welfare Center, ‘where lectures were given to mothers on hygiene and care of children’. In addition 175 unqualified practical midwives were licenced by the District Medical Officers all over the country.
Throughout the Mandate period in Palestine, the system put in place to control and regulate midwifery continued to be negotiated. Midwives and others brought concerns regarding appointment or dismissal to the attention of the Senior Medical Officer: often the age of a particular midwife affected that appointment or dismissal. In addition, local village heads raised concerns about who would pay midwives’ or dayat’s fees, and about the level of the fee. For example, in 1946 there was confusion about whether or not three dayat had been assigned to the Hebron subdistrict. Mukhtar (village head) Mussa Imsalim stated that his part of the village paid the major share of the funds from which the dayat’s salaries were taken, and that only two dayat were needed. In addition, the third daya, Handah Ali Mohd Abu Zalata, was of the same family as Fatmi Mohd, already appointed:

It does appear unnecessary for a third Dayah, particularly as the third is an old lady and if permitted to work, the second from one family, trouble will follow.\textsuperscript{41}

In October 1946, the assistant district commissioner at Hebron, Palestine, wrote to the senior medical officer asking for a schedule of village midwives appointed by him and suggesting that the midwives be linked to village clinics and inspected during the monthly visit of the doctor. The commissioner suggested a ratio of one midwife for every 1,000 villagers. Midwives’ salaries would be paid from the village account to the Department of Health. Finally, the commissioner suggested that a Mrs. Rogers give courses annually and that midwives be given bonuses to encourage their attendance.\textsuperscript{42} The senior medical officer confirmed the ‘spirit of the letter’ and pointed out that efforts should be made by mukhtars of different villages to select more intelligent and younger women ‘than the present stock’.\textsuperscript{43}

In addition to being assigned a vigorous workload, midwives generally had to pay for their own equipment and for their licences. Sometimes, however, the department paid for a woman’s licence or equipment because they found her more suitable than the midwife servicing a particular district. Still, mukhtars continued to exert control, assigning midwives to their villages and deciding how many were needed. This occurred at times to the dismay of the superintendent of midwifery and child welfare – for example,
when the *mukhtars* of Kudna village retained a *daya* whom the superintendent considered unsuitable:

> The Mukhtaars [*sic*] of Kudna Village came to me today to say that an aged, blind woman had been replaced by one chosen by me, surely this is against all our endeavors to raise the standard of Midwifery.\(^4^4\)

Midwives thus had to navigate a new and complicated chain of command. One midwife appealed to the law courts petitions writer for help. Khadijah, divorced wife of Ahmad Hamdi Es-Sabed, had applied for and received a licence to act as a professional midwife (‘I am a well qualified Midwife and Nurse’). However, her license was only applicable in a village near Jerusalem named Tour. Khadijah had rejected the license based on the distance of the village from her home in the Old City in Jerusalem, and on the scarcity of clients in the village. Materially and professionally, she was ‘unable to remain unlicensed and workless’:

> ... as I am a lady in loneliness, protectless and hostless, I became sorry for rejecting the Midwife License I applied for, I have to maintain myself and depend on my profession’s work wages ... For obtaining a Midwife’s License. I shall wait, maximum, one week from today, otherwise, I shall be obliged to practice my profession as a Midwife even without a license, whether you license me or not, agree or not. My livelihood obliges me to practice working as a Midwife.\(^4^5\)

In a brief reply from the director of medical services to the *mukhtar* of Bab El Silsilah quarter, Old City, Jerusalem, requesting a permit for Khadijah to practice, Khadijah’s wish to work there was denied. She was thus forced to practice illegally, or to move, which was not an easy task given a woman’s dependence on her local support network.\(^4^6\)

Reports cite increasing poverty in this period among midwives. As noted earlier, midwives complained about decreasing work. Some hospitals had no midwife on staff. When pregnant women who sought antenatal care from midwives went to hospitals for
Between Daya and Doctor

their deliveries, the midwife received no payment. For example, one certified midwife, Labibeh I. Nassir, protested to the superintendent of medicine. Finding herself unable to earn her living in Bethlehem, she had moved to Romema in Jerusalem, where she would have found many clients had it not been for the government hospital accepting maternity admissions. She found that women sought her out for a free examination and then proceeded to the hospital. Nassir noted that she was willing to attend to the women at equal pay or less. The superintendent of midwifery acknowledged that a normal delivery case could be attended to at home. Ten midwives from various quarters in Jerusalem suggested solutions to this problem:

This state of affairs (very few of us are able to gain their [sic] livelihood with great difficulty and suffering) we humbly submit, can only be attributed to and caused by the facilities accorded by the German and French Hospitals, the Bethlehem Hospital, the Hospital of Doctor Rifka and in particular the Government and Italian Hospitals ... It is perhaps also worthwhile to mention the Jewish Hospitals and to submit that there are in them no physicians who work in deliveries, but such duties are entrusted solely to the midwives who carry out their duties properly and efficiently. As an example, we beg to refer to the practice adopted and followed in the German Hospital of Haifa, where in cases of delivery, a midwife is brought from outside for the purpose and the Doctor in charge of the hospital does not participate or intervene in delivery except when abnormal cases arise requiring the presence and assistance of a Doctor ... We wish to refer and lay stress to the fact that the sisters working in most hospitals are not licensed midwives and therefore it is unfair to allow them to carry on this profession and deprive licensed midwives of their means of living.

The midwives added that they incurred large expenses, spent a great deal of energy, and lost much time completing their professional studies and obtaining licences. They protested that when they called for assistance from a private practitioner, he usually ordered the patient to be transferred to his hospital whether or
not this was necessary, thus depriving the midwife of fees expected from delivery.49 In such cases, according to midwives’ testimonies, often the midwife herself paid the fare to transport the patient to the hospital. Further, given that midwives were being called less frequently for deliveries, they often were not in a position to pay the necessary expenses for their tool bags. Since the government maternity hospital charged low fees, they were deprived of their profession and livelihoods. The midwives requested that the authorities take measures to safeguard their interests and ‘protect our rights against such injustice and prejudice’:

May we be allowed to state frankly that unless such measures are taken by Government, we shall be given the impression the Government intends indirectly to stop us from practicing our profession and gaining our livelihood and also deprived [sic] the public from our professional services ... In your deigning to entertain such a destitute poor midwife’s request, you will not only do to humanity a very great favor, but also rescue our children from falling into that formidable abyss – death from starvation.50

Competition between midwives and doctors, competition among women for scarce positions, and competition based on what some midwives perceived as a more beneficial situation for midwives in Jewish hospitals, were all consequences of reorganizing the health system. In addition, while some midwives were coping with poverty as a result of the new health system, others benefited, sometimes in ways that contravened the Midwives Ordinance. In a petition to the Senior Medical Officer in 1945, the British Superintendent of Midwifery and Child Welfare noted that Farideh Ahmad Gheith, Licence No. 540, was violating the Midwives Ordinance, No. 20 of 1929, Paragraph 12, Page 4. Farideh was discovered to be conducting a general and gynaecological clinic, charging for unguents, lotions, medicines, etc., and making a lot of money from ‘these credulous women’:

She is also forbidding the Midwives and Dayahs [sic] of Hebron to attend the Refresher course given by Staff/Nurse Amelia Bandak at the Infant Welfare Center, I gather she frightens them. She is definitely a bad influence apart from
Between *Daya* and Doctor

breaking Rules and Regulations, she is asking for a Prison Sentence ... Bahsur Abdul Hadi, License No. 344 is also conducting a general and gynecological Clinic. Both she and Farideh Ahmad Gheith do internal examinations, in the homes of women. I take a very serious view of this, it means that Hebron is falling back instead of progressing, it is also such a bad example for the Dayahs, it is some years now that an annual course of Talks and demonstrations has been held at the Infant Welfare Center, these two women, who should know better, appear to think they can do as they like and flaunt disrespect and dishonor to the Department of Health, action must be taken.\(^5\)

Whether a form of resistance, of survival, or of caprice, such behaviour on the part of midwives, as well as the many petitions citing cases of hardship, makes clear that women had to become part of the new health system if they wanted to work. Dependence on a wage within the British system made midwives vulnerable to British control in terms of daily survival and medical practices. Midwives attempted to make choices in this process and tried to influence the way in which the system evolved. In many instances, rejection of a licence or of an appointment seems arbitrary: age, intelligence (according to British officials), and literacy, were on-going factors cited. To the extent that successful attempts were made to re-educate mothers and to encourage doctor-assisted deliveries in hospitals, many midwives lost social and economic power, while hospitals and doctors benefited financially.

Undoubtedly British investment in the health sector in Palestine necessitated some return. By charging fees for licences, equipment, and drugs, and a minimal fee for deliveries in government hospitals, the Mandate government used health as a form of economic leverage with the goal of keeping the health budget low. In addition, the British health system became a conduit for foreign drug companies and the sale of medically related technologies from the United States and Europe in the region. Health was fast becoming a commodity to be bought and sold on the market.

The story of one midwife interviewed in Jordan illustrates the manifold effects of the British use of midwives as agents of change. Hadji Anisa Shokar, born in Palestine in 1905, was
conversant with medical practices before, during, and after the British Mandate period. Married at age 11, Hadji Anisa soon after became a midwife because, as she put it, she wanted to run away from her reality – dependence on her husband and pressure to bear children at an early age. She eventually became renowned because she had acquired the honorific title of Hadji after using her dowry to go on the pilgrimage to Mecca and returning many times thereafter.\textsuperscript{52} I interviewed her at her home in Amman.

In 1925, at the age of 20 Hadji Anisa retrained as a midwife in Nablus. Although the Supreme Muslim Council allowed Muslim girls to go to government hospitals in Jerusalem, most Muslims did not want to go to hospitals where they would be treated by predominantly Christian doctors and midwives. The Minister of Health, when he discovered Hadji Anisa’s talents as a midwife, insisted that she accompany other midwives as they went from house to house, so that Muslim families would be receptive to allowing their daughters to visit midwives in hospitals. He encouraged her to supervise the \textit{dayat} as well.

The municipal leader in Khalil (Hebron) heard about Hadji Anisa. His Egyptian wife, from a prominent Muslim family, insisted that the young girl stay with them. Hadji Anisa lived with them for seven years. Everyone thought her much older than her years: she had already been on the \textit{hajj}. This young woman, apparently considered exceptionally beautiful, was encouraged not to veil, and she was spared the trouble of registering at the municipality. She quickly became a well known and highly sought after birth attendant.

Hadji Anisa noted that in the pre-Mandate period fewer women than men went to Turkey for medical education. Training courses for midwives and access to hospitals during the Mandate period gave women more opportunity to enter medical fields. Yet, Hadji Anisa did not trust doctors, and was saddened by the fact that, with modern western medicine, people wanted faster cures and were less respectful of Arabic medicine. While she visited doctors on occasion, she hesitated before going. ‘Before there were machines, pictures, operations, some things were better’, she explained, and added, ‘Midwives never had to cut the vaginal opening, because of the methods they used. Women found it unacceptable to lie down when giving birth. Most preferred to sit
in the chair with a hole in the middle’. In addition, Hadji Anisa objected to traditional methods for attempting to influence the sex of the baby (having intercourse under particular conditions). Hence, she disapproved of modern methods of discovering the sex of the child in utero. When she practiced in Saudi Arabia, she would never discuss the sex of the expected child, but only inquire about the health of the pregnant woman. She did not encourage early marriage. She also did not encourage ‘boy preference’, the prevalent view that boys are easier to raise since girls have more difficult lives, leave when they get married, and come and go.

Hadji Anisa considers herself Palestinian, although when I spoke to her she had been living in Jordan since 1927. Like many midwives I spoke with in refugee camps who had practiced in Palestine before they were exiled in Jordan, she continues to view women’s health against a background of historical and political realities related to Palestine. Although she clearly has her own views on women and reproduction, some of which contradict prevalent views among Palestinian women, her distrust of modern technologies and her faith in what she learned from other midwives as a young girl continued to dominate her practice. She put it this way: ‘I talk Palestinian, my habits are Palestinian.’ And the way in which Hadji Anisa practices her faith carries over to her politics concerning the on-going struggle over control of Palestine. Although she is devout, Hadji Anisa does not judge people by their religion, nor does she believe that people have rights to land: ‘The land is from God, it is all God’s land.’

Everyone I spoke with in Jordan about women and health knew of Hadji Anisa Shokar. She had attended the births of most of Jordan’s officials. Every important family had a story to tell about her participation at a birth. Some told me that when important government officials meet her in the street, they kiss her hand. Not long after I left Jordan, a friend of mine wrote to tell me that a public ceremony had been arranged to honor her. It was striking that the reputation and position of this distinguished woman had in no way been diminished by the forces she herself described as having slowly eroded the meaning and practice of the daya in communal life over the years. For Palestinian midwives residing in refugee camps in Jordan, the situation was even more complex.
A Formidable Journey: 
Midwives in Refugee Camps in Jordan

Changes in socio economic and political structures in Palestine and Transjordan during the Mandate period, with attendant transformations in the health care system, had contradictory effects for women practicing midwifery and healing. Some became impoverished. Some acquired status as they became incorporated into the British system, which meant reduction in status for others. Between 1917 and 1948, all were vulnerable to the increased militarization of the region, to warfare, and to social, economic, and political unrest.

Palestinian women who worked as midwives under British administration were among the many thousands who suffered the consequences of the 1948–49 wars: some were injured, some killed, and many became refugees. A May 1949 report of the League of Red Cross Societies in Lebanon, Syria, and Jordan, estimated that women and children were three quarters of the refugees cared for. Some refugees were among the 150,000 internally displaced in the new state of Israel. According to Palestinian estimates, 849,186 Palestinians became refugees in 1948. War forced 284,324 Palestinians to flee to surrounding countries. Between 1948 and 1967 Palestinian women became refugees through a number of policies of the Israeli government, including refusal to renew family reunification documents (after a Palestinian woman had been out of the country during hostilities, or when she left to visit relatives or friends) and deportation. As a result of the 1967 war, more than a million Palestinians became refugees; 531,198 were going through the experience for the second time. In 1967, 107,000 Palestinians became refugees in Jordan.

In Chapter 4, I offer a detailed discussion of the experience of war and dispersion of Palestinian refugees. In May 1950 the United Nations created a special agency, the United Nations Relief and Works Agency (UNRWA), to provide humanitarian assistance and emergency relief for Palestinian refugees. I leave to Chapter 4 discussion of the traumas of exile and camp life and the creation of UNRWA, focusing on issues of refugee status, the politics of relief and UNRWA’s role in relation to a range of health effects and concerns for Palestinian women in refugee camps in Jordan. For now I view UNRWA from the perspective of the daily
experience of Palestinian dayat, who, as refugees, were incorporated into the UNRWA health system.

In 1995, I interviewed midwives in refugee camps in Jordan in order to see how their war experience and life in the camps had influenced their views of health, health practices, and health systems. In addition, I wanted to understand the effects of on-going transformations in the Mandate period on their ability to work and on their healing practices in Jordan. Midwives and registered dayat were incorporated into the health system under UNRWA through training courses, as they had been under the British Mandate. Hence their work continued to be supervised by doctors, many of whom, however, were Palestinian themselves. Still, midwives’ often critical assessments of UNRWA reflect tensions caused by the imposed hierarchy and other kinds of pressures detailed below. On the other hand, midwives also expressed a willingness to work with doctors and a pride in their updated equipment.59

The training of midwives under UNRWA supervision was carried out according to guidelines established by the World Health Organization (WHO), which directs UNRWA's medical personnel. In the post-1948 period the new terminology and hierarchy of ‘daya–midwife–nurse–doctor’ was further refined when WHO attempted to replace the word daya with the term ‘TBA’, or ‘traditional birth attendant’. The TBA is a midwife trained according to WHO standards, and in this way drawn into a global redefinition of midwives' functions. The use of the term ‘traditional birth attendant’ conceals the social-historical significance of the term ‘daya’. (Because women in the camps still use the term ‘daya’ to refer both to registered dayat and licenced midwives, I will also follow that usage, unless specifying otherwise.) UNRWA instituted a TBA program, identifying dayat, training them in a 12-day initial course and an annual refresher course, and registering them with UNRWA health centers.60

Registered dayat and licenced midwives cannot practice in refugee camps without a certificate from UNRWA, so that one daya interviewed, even with her degree from the hospital course in Nablus, was not able to practice until properly certified. According to this daya, who was a refugee in Baqa’a camp (established in Jordan in 1968), government certification devalued rather than elevated the daya among women in the camp. If dayat
are in need of training, perhaps they were not proficient in the first place. As she put it, ‘now women are more questioning’.

This 61-year-old *daya* had been twice a refugee, first from Jaffa to Nablus in 1948, and then from Nablus to Amman in 1960. She had been in Amman for 35 years. Before the 1947–48 war in Palestine, she lived on a mountain overlooking the sea in an area where bananas and oranges were grown. She was 14 when she left and had been married for two years. When she and her husband resettled in a village near Nablus where villagers grew olive trees, she decided to learn from the villagers how to make ceramic pots. There she met midwives she had known in Jaffa, including one woman from Egypt. In Nablus she studied with these *dayat*, learning how to administer to women in all stages of pregnancy and with various problems associated with birth. It was in Nablus that she was approached by a doctor who, because of her skills, said he wanted to teach her to become a midwife. She stood by the doctor’s side in the hospital and eventually obtained a degree, making her practice official. No doubt the doctor also learned from her during those months of training.

Although *dayat* (TBAs) have one year degrees equivalent to midwife training courses in colleges in the region, and more experience working with pregnant women than most doctors, some doctors ridiculed them. Perhaps this is because the consensus in two refugee camps was that many women prefer midwives to doctors. I asked the *daya* why:

> Women come when they don’t want to get stitched and they don’t want to have the opening … the midwife does not give her medicine to hasten contractions, she gives them all the time they need, and if that doesn’t work, and the position of the baby is not correct she takes them to the hospital. The doctors pressure women, but the midwife does not leave her.

Once I referred a woman in her seventh month to a doctor. She was having dizzy spells. The doctor told her, who do you see, and she told him, that she is seeing a midwife. The doctor told her, what are you crazy to have a midwife take care of you. She told him that the midwife is the one who sent me to you, and if you don’t accept that I will not come to you.
When the *daya* sees a patient, she’s involved even with her social situation, and if there are problems in the family she sits with her and listens to her problems, and interferes if the woman is not happy with her mother-in-law. She talks to the family. She gives advice and recipes as to how improve fertility, or and to have a boy or girl. Sometimes she gives sexual counseling if the woman doesn’t know what to do. Some *dayat* do magic, but I don’t believe in it. My degree is enough to cover what I do.

The doctor has been keeping the woman’s health file during the period and knows what has been happening with her. If she comes to me after she delivers, maybe he did something to her, and why should I take the blame. Maybe the doctor uses bad instruments or not clean ones, so why should I take the responsibility? Once I accepted a woman after she had already delivered the baby because she begged me so much. She kept saying, there’s something inside of me. I put my hand inside and found something very sharp, so I washed up, got all of my tools, and pulled it out with a tweezers. I found all this plastic thread that they use in stitching, and the woman was infected and couldn’t have babies anymore. I treated her and she had a child after six years. She was infected for six years, and then for a month she cleansed herself with water and some baking soda, and she was fine and she had a child. After a woman has a child, she boils some sage and she has water and salt mixed together at a good temperature. She strains the sage in it and then the woman puts it in a big pot and she sits in it and cleanses herself. She does this for seven days and then she is fine and ready and in shape.

Some women, when they go to midwives before they’ll have been on their way to the hospital, and they see the facilities and get scared. The treatment is impersonal. They have to lie on their backs, so they turn around and go back to the midwife. She speaks to them, she reads the Quran and tells them stories until they calm down. Their psychological situation may be bad, they are scared. She needs to make them feel safe. Women need this, and that’s why they need her. Sometimes they come at night and the
child is not sleeping. She brings oil and massages the child, and reads from the Quran until they calm down and sleep. I don’t ask for payment, but they pay me on their own.62

It appears that there are many contexts where midwives are necessary and useful auxiliaries for doctors. According to the women interviewed, many women trust and feel more comfortable with the dayat. They view them as medical practitioners, but also as friends. A daya’s advice is rooted in a historical reality shared with the women she serves.

According to the dayat interviewed, some doctors derived power from maligning midwives and from creating an atmosphere conducive to putting blame on a daya for the doctor’s malpractice. This daya (quoted above) was concerned about harm that doctors can do.

There are additional economic reasons why women prefer midwives to doctors:

If a woman has the time to go to an UNRWA medical center when she is giving birth they will transfer her to a hospital, but she has to pay 12 Jordanian Dinar [equivalent to approximately $20 American dollars], and it takes a long time ... if she doesn’t have time or the money, a higher fee than most can afford, she has the child at home with a midwife.63 Some midwives will return several times a week to see how the child is doing, and after the first two weeks the mother takes the child to the health center to weigh him/her, and to open a file for the baby. Other times the midwife doesn’t do anything except deliver the baby, depending on her personality.64

In Palestine under the British Mandate, government hospital fees for deliveries were low, a factor that enabled many women to choose hospital births. For refugees, the cost of the hospital setting, both literally and in terms of being subjected to unfamiliar practices, inclined women to choose midwives over doctors. Most refugee women live in poverty. And while some women expressed a preference for the hospital (whether because they considered it prestigious or safer) many expressed hesitation because of unfamiliar birthing methods.
Another way in which women have continued indigenous health care practices in refugee camps is through using herbal cures. As mentioned earlier, dayat are conversant with herbs, as well as with midwifery. For example, one daya whom I interviewed had learned from one Palestinian woman 40 types of herbs that can be used as medication for infections. She met with this woman again in Amman and found that the healer still mended bones and treats various ailments, as well as taking care of babies for one week after birth. Another woman interviewed in Jabal al-Hussein camp expressed the general availability of indigenous medical practices still sought by women:

You know my mother knows a lot about medicine. Once her leg was broken and she went to a hospital. For three months she had plaster on it, but it didn’t work. Her leg still hurt and there was still pain in it. So she said, I’ll do what my mother used to do, and she made a mix and put it there, and her leg is perfect. My mother cares for the newborn babies, and she knows if the newborn is suffering from something here or here. She learned this from her grandmother. Women still come to her. Sometimes at night, they knock on the door. I believe in my mother, not because she’s my mother, but I believe they had something. It’s not a matter of doctors, I mean even in Europe in the old ages they didn’t have doctors, so they know a lot about medicine. Also – old people, they know. My mother used to use health services in the camp, but now she doesn’t believe in it. She suffers many things, but she doesn’t believe in doctors. If you feel something bad, but are generally feeling good, they make it into a big thing.⁶⁵

Some women trust their own diagnoses over those of a doctor. Herbal cures may be the preferred treatment based on a woman’s past experience. Another aspect of the question of preferred practitioners and practices in the refugee camps concerns conditions that produce new diseases and ill health. Refugees, for example, suffer from stress-related diseases, malnutrition, and environmental pollution. Traditional healers may not have access to the tools of their trade, such as particular herbs, making women more dependent upon doctors.
Another daya trained in both the ‘old fashion’ and the ‘new’ described a bias among camp officials and doctors against use of the old medicines. Umm Isa left the village near Haifa where she was born in 1948, and lived in towns around Jericho for 20 years. In 1967 she came to Baqa’a camp in Jordan. She studied in Salt through the Ministry of Health to become a midwife. At 35 she had five daughters and three sons. The mother-in-law of her sister was a daya, and she learned from her also and enjoyed delivering babies.

As a refugee in Jordan, Umm Isa received midwifery retraining. In her course in motherhood and childhood in Salt, Umm Isa was given guidelines for differentiating between mothers who deliver at home and those who must go to hospitals. She was taught by staff nurses and midwives who were already trained. Finally she was employed by UNRWA, which had its own set of guidelines.

UNRWA doctors told Umm Isa and other midwives that they were not allowed to practice folk medicine, and that elderly women must not perform massages or treat women with herbs. They explained that what doctors do is better than Arabic medicine. Still, Umm Isa told me that when women came to midwives with bad cases, they gave the women herbs to ovulate and to become pregnant. They gave massages and used hot needles to take out the puss from infections. She also maintained that, even with the doctors’ new medicines, people had been healthier when she lived in Jericho. They had never heard of diabetes or cancer. Umm Isa’s view of health in Palestine, as well as her relation to UNRWA, was mediated by the political conundrum in which she found herself. As with all of the dayat interviewed, her construct of health was permeated with a construct of the past which, while idealized, provide an on-going reference point for her work in the present.

Umm Isa explained that there were 12 women serving as dayat in Baqa’a camp, and that women feared possible loss of honor through exposure to men in hospitals. The reputations of the women were at stake, and doctors were often disrespectful. But the closest hospital, at Salt, had stopped sending midwives to the camp. Further, the new graduates working at the hospital in Salt were very young and didn’t respect Umm Isa’s years of experience, so she stopped going there. Doctors in UNRWA also discounted the skills she had acquired based on experience: they
couldn’t believe that Umm Isa had delivered twins and triplets on her own.

UNRWA doctors also told midwives how many children they would like a woman to have. For example, UNRWA doctors told midwives to encourage a woman who had already had four children not to conceive a fifth. This Umm Isa considered none of their business. She refused to follow UNRWA’s directives, not because she did not believe that women should limit the number of children they have, but because she did not think that this decision should be made by UNRWA. In this case UNRWA directives had contradictory effects since, as a result of the larger political situation, some Palestinian women became wary of UNRWA’s motivations for population control. On the one hand, Israel’s interests were to recognize only a small number of refugees (and that UNRWA keep down births) because of possible claims for compensation. On the other hand, in some of the camps having children became the ultimate patriotic act.

Record keeping was a daily requirement of UNRWA. Daily records provided information about who midwives were serving and about women’s practices connected to birthing and motherhood. Umm Isa began her daily routine with a visit to the UNRWA office to write down the names of women who had delivered, and whom she had visited at home. She wrote down whether or not the woman was breast feeding, the weight of the baby, and its head measurements. All women whom she saw breast-fed. Three to 5 per cent took contraceptive pills or used IUDs. Women used contraceptives, but men did not. Umm Isa explained this by saying (in a matter of fact manner) that their manhood prevented it. She mistrusted IUDs, since, when her daughter used one, it went up into her body, causing her to turn yellow from infection.

Umm Isa’s view of the health system was shaped by her early experience in the camp and on-going negative conditions related to camp life. She stated that ‘malnutrition is high, there is no water, and there is pollution’. She protested that in 1967 there was no housing for women and no clinics, except when Swedish groups came with a van. For these health services, they stood in line. Even more recently, although medicine was available in the clinic for free, anything else needed to be paid for. If women needed an emergency operation, they needed to pay half of the cost, even if they were poor. And the money needed to be paid
up front. Her view of the health situation was inextricably tied to the cynicism she expressed regarding what she and many other women considered a political stalemate. No one, Umm Isa said, was happy with the political situation of the time (the Oslo Accords of 1992, and Jordanian–Israeli agreements of 1994). For the refugees, she asserted, it did not solve anything.

Other dayat whom I interviewed shared with Umm Isa the historical experience of war, exile, relocation, and refugee status. Those in the camps were UNRWA employees, but they had a variety of reasons for having learned their trade. Most had a relative who was a daya. Some became midwives in an effort to find a way to survive.

Using ‘sickness’ as a metaphor for their frustration and sense of homelessness, many midwives protested that women got sicker in the camps. In addition, they expressed frustration with their lack of control over reproduction and perhaps disappointment in new technologies, asserting that doctors do not necessarily make childbirth an easier or safer experience. Concentrating less on improvements in women’s reproductive health, the sample of dayat interviewed for this study emphasized tensions and shortcomings in the UNRWA health system related to loss of control over their work. At the same time they expressed satisfaction at what they had learned in training courses and were not averse to cooperating with doctors, although they were reluctant to let doctors interfere in their relationships with the women who sought their help. They also expressed a tacit approval of UNRWA health services by expressing criticism when the system did not function as it was set up to function. All were politically astute, aware of current developments, clear about their support for the Intifada, disappointed with Abu Ammar (Arafat) and limited self rule, and all were of the opinion that the people who had worked from the inside for freedom were being shortchanged.

The daya has always had a central role in consolidating communal mores. Dayat can preserve historical traditions in ways that are beneficial to women’s health, or in ways that proscribe women’s limitations and possibilities. They might, for example, serve as keepers of customs which limit women’s abilities to define themselves beyond the spheres of motherhood and reproduction. Or they might support women in limiting the customary number of children they have by advising them on contraception.
without the participation of the husband. As trained midwives in their new settings (clinics, hospitals, refugee camps) they have had to compete with other women and men for control of health practices.

Although imported medical practitioners characterized the daya as representing ‘tradition’, and therefore ‘backwardness’, in fact, in the nineteenth- and twentieth-century colonial Middle East, the daya became an agent of change, combining the old with the new, becoming the carrier of new medical practices and regulations. Her work was subsumed under new medical practices and beliefs established by a medical system which had no connection to her roots.

Conclusions:

Doctors Training Dayat or Dayat Training Doctors?

During the Mandate period, dayat in Palestine, Transjordan, and later in refugee camps in Jordan continued indigenous practices and mores – incorporating new information, mediating paternalistic treatment, and negotiating imposed regulations. From this perspective, dayat acted as agents of accommodation to changes, making it possible for women to adjust to a health system regulating motherhood according to standards that were defined by foreign intervention.

Combining customary methods with new technologies, the health care that dayat offered was characterized by a view of health shaped by history, politics, economics, and social mores. Women’s work as healers was standardized by their medical training and state regulations, and women worked with and contributed to doctors’ knowledge bases. But women also went outside of the new system to continue less formalized practices.

Although officially British and American medical practitioners privileged concepts of disease based on purely biological factors, the Palestinian women interviewed continued to view disease as a function of social–environmental–spiritual factors, as well as of biological factors. Rita Giacaman has demonstrated that, even with the introduction of western scientific medicine and the social and economic changes associated with it, indigenous treatments have survived. Palestinians incorporated new and old concepts of disease, and sought a mixture of treatments. The situation of
the dayat illustrates these points, since dayat are both incorporated into the imported medical system and, at the same time, continue to practice in ways connected to their geographic and historical experience. They continue to serve women on a level that cannot be replicated by the newly introduced doctor–patient model and, in this sense, are ‘keepers’ of history. From my sampling, dayat have not attempted to indoctrinate women into a view of medicine and health that shatters existing mores.

Given the customary focus among Palestinians on disease causation as social, environmental, and spiritual, and given the health effects of political developments in the region of Bilad al-Sham in the interwar period and beyond, it is not surprising that the most politically active women I encountered in the refugee camps were health practitioners. Through the Mandate and post-1948 period dayat have had a central role in mediating the relationship between women and the new health system, and hence in maintaining control of definitions of health. Dayat maintain their attachment to Palestine through their relationships with other women, using the vehicle of women’s health.

The difficulties dayat faced as they were becoming incorporated into a health system based on a narrowly focused definition of disease causation, on a hierarchical chain of authority, and on propositional knowledge at the expense of practical knowledge, reflected the gender politics of state building in the period addressed. Midwives had functioned in Palestine with a range of knowledge bases available to them. Midwives learned their trade predominantly through oral transmission and hands-on experience. The defamation of midwives by many European medical practitioners (male and female) was connected to a struggle for authority and control of knowledge, as well as for control of land. Health became a vehicle for imperial politics as the British health system appropriated the sphere of women’s health, particularly through medicalizing reproduction. In this process the medical profession delegitimized the historically based knowledge and experience of midwives.

Oral histories of midwives are important both as they represent indigenous historical perspectives and as validation of women’s knowledge. Authorization of women’s knowledge by women is kept alive through networks of women health practitioners in refugee camps in Jordan. For these women, health is a vehicle
for ‘socially sanctioned dissent expressed in a medical idiom’. Health is also embedded in social relations of power and in the political environment. The narratives of the dayat cited in this chapter represent core beliefs and ethics of the dayat’s community. Hence, when Umm Isa and others protested that health was better in Palestine, they were creating the present and future by invoking a collective past. Further, these narratives make clear that practical knowledge rooted in experience and observation is critical to these women in overcoming what can be life-threatening obstacles to their health, such as a particular doctor’s malpractice, or adverse conditions in the camps.

Control of women and reproduction was a critical aspect of imperial rule in Palestine and Jordan. The economic benefits for the medical establishment accrued to colonialist and, to a lesser extent, to indigenous male and sometimes female doctors. Some of the Palestinians suffering from and protesting those benefits to the medical establishment were impoverished midwives. As in the sphere of agriculture, new medical technologies and practices replaced customary practices associated with women – practices that supported women’s survival, and that validated women’s importance within their families and community. If the midwife stood in the way of the development of modern institutional medicine, doctor dependent hospital births were one way to displace her.

Another way of displacing the midwife was through socialization of mothers according to a new set of standards based on the disparagement of both women and Arabs. Some ‘Western’ nurses and health practitioners, though by no means all, contributed to the racist literature of the times. Through erroneous accounts and interpretations of Palestinian women’s lives and customs, as noted earlier in this chapter, many of these health practitioners perhaps unintentionally, underscored the association of Arab women, and of Arabs in general, with ignorance and disease. Some European and North American nurses were constructed as carriers of a sanitized and moral approach to health. Women from Europe and North America who were installed as health practitioners under the colonialist Mandate participated in inscribing new health norms and in doing so, in some instances took work away from indigenous women. Hence, in this way, the colonial health system exacerbated geographic divisions between women.
Yet, Palestinian women did attend and benefit from clinics. In Arab villages where clinics were scarce, foreign nurses complained about the impossibility of treating the volume of women seeking help. Palestinian mothers used services to improve their situations. Many valued new forms of knowledge disseminated by western doctors and complained about uneven distribution of public health services. From the perspective of one British woman who took an active role in implementing health policies during the interwar period in Jordan, in some instances Palestinian women forged important and on-going friendships with nurses and doctors. In such instances Palestinian and British women revived the historical syncretic relationship between regions in the areas of medicine and health that had been disrupted by various aspects of the colonial effort.

The documentation and testimonies of *dayat* in this chapter show that Palestinian women have consistently advocated for their rights. A network of friendship, support, and learning among Palestinian women persisted and became politicized, as women in the camps increasingly insisted on taking an active role in the major political developments of their times. Included in those rights was not only the ability to practice their profession, but also the ability to practice in Palestine, where healing practices were closely associated with nature and with women’s relationships to the land. Palestinian refugee women connect politics to health, linking their well being with their ability to go home.
Chapter 4


Tuesday afternoon, returning from my first visit to Jabal al-Hussein refugee camp, I stood for a moment in the doorway, feeling the February chill. The sky was a dusky blue. Yesterday’s snowfall, covering tiny purple flowers with a heavy wet mass, had already melted. Plaintive calls to prayer were reverberating over the hills.

Earlier in the week I had shared in festivities at a lavish party in one of the wealthier areas of Amman. Women in traditional dress and the latest Italian fashions enjoyed dancing and eating long into the night. Some of these women were ‘Jordanian-Jordanian,’ as they would say; some were Palestinians whose families had come to Transjordan before 1948 and had helped to build the new state. And some were from families who had been driven out of Palestine in the 1948–49 wars leading to declaration of the Zionist state of Israel, but they had left with some resources and had prospered in their new environment.

War had driven most Palestinian refugees from their homes with no more than the clothes on their backs, and their lives bore little resemblance to the lives of the women I mingled with that night. They had few liquid assets. Whatever wealth they had in land and other immoveable property was left behind. Initially
they established make-shift homes in refugee camps, until gradually the tents of the early years gave way to cinderblock and plaster houses.

This chapter focuses on Palestinian refugees living in refugee camps in Jordan. In the first two sections I address the following questions: What is the significance of the particular health effects of war and exile for women? Who was considered a refugee, and how did camp officials define and address the health needs of refugees? What is the particular significance of those definitions and health practices for women? In the final section, centered on oral histories, I ask how Palestinian women in camps in Jordan construct and address health. What influence does gender have on the politics of Palestinian refugee status and on the possibility for resolution of the refugee tragedy?

In 1995, of the world’s more than 20 million refugees, approximately 80% were women and their dependent children.\(^1\) (The number of refugees worldwide has doubled in the last ten years.) Among those 20 million refugees the largest number, estimated at 80 per cent, were Muslim, including Palestinians.\(^2\) And approximately 75 per cent of these refugees were Muslim women and children.\(^3\)

In 1995 there were more than 200,000 Palestinians registered with UNRWA as refugees living in ten official camps in Jordan established since 1948.\(^4\) After 1967, three unofficial camps were created. This was the largest number of Palestinian refugees living in camps outside of the Gaza Strip. (By June 30, 1994, over 3 million Palestinians were registered refugees in UNRWA’s five fields of operation).\(^5\) The total number of Palestinian refugees in Jordan was more than 1 million.\(^6\)

Jordan was the only country to grant refugees citizenship rights under the 1954 Jordanian Nationality Law. After 1988, when Jordan renounced legal claim to the West Bank, refugees in the West Bank received a Jordanian passport valid for five years. Palestinians who had come to Jordan from Gaza after the 1967 war were not considered citizens (Gaza had been under Egyptian administration), and Gazans who returned to Jordan, expelled from Kuwait after the Gulf War, were not entitled to citizenship, property, or the right to work.\(^7\)

Although granted citizenship, women refugees were subject to the same disabilities as other Jordanian women in the realm of
citizenship in the time period addressed. The language of the law speaks to the citizen as male. For example, Jordanian women could not apply for passports on their own. (This restriction has subsequently been revoked.) A mother could not pass on her nationality to her child. Only a male head of household could get insurance for his sons and daughters.

In addition, if a woman harmed or killed a man who had been harming her and threatening her life, the law did not take her motivation into consideration. The government maintained that honor crimes (when, for example, a brother or husband murders a woman who has been raped), were a tribal matter, so that if a man found his sister or wife sleeping with someone and killed her, he was not convicted. (see Rana Husseini, Murder in the Name of Honour, One World Publications, 1994.) Women were expected to tolerate domestic violence rather than shame their families by disclosing their situations. Nor did the government stop mechanisms supporting trafficking in women. Hence, as is true throughout the globe, the benefits of citizenship are not always the same for women as for men. Later in this chapter, refugee women describe the ways they cope with some of these disparities in their struggle for self determination.

Refugee or Freedom Fighter?
Identity Politics and Health in Exile

The following two sections provide an overview of the critical problems facing the Palestinian refugees who found themselves cordoned off from the mainstream of international refugee law. Beginning with the question of who is a refugee, the sections survey relief efforts and look at the specific problems posed by these developments for women.

The response of the international community in meeting the survival needs of Palestinians was complicated by the capitulation of the United Nations (and specifically, the primary donor of refugee relief, the United States) to the intransigence of the new Israeli government regarding compensation to, and return of, Palestinian refugees.

In December of 1948 the United Nations Security Council passed Resolution 194 granting Palestinian refugees the right to return to their homeland. Section 11 states that the refugees
wishing to return to their homes and live at peace with their neighbors should be permitted to do so at the earliest practicable date, and that compensation should be paid for the property of those choosing not to return and for loss of or damage to property which, under principles of international law or in equity, should be made good by the governments or authorities responsible. Israel became a member of the United Nations although refusing to adhere to Resolution 194. Reinforced in new resolutions after the 1967 war, Palestinian refugees’ rights continued to be systematically denied.\textsuperscript{10}

The survival of Palestinians in exile depended upon how they were defined. In 1948, the international community had not yet decided whether Palestinians fit the definition of, and thereby were entitled to the rations of, refugees.\textsuperscript{11} The League of Nations had appointed the first high commissioner for Refugees in 1921, and over the next ten years instituted several organizations to take on provision of food, shelter, clothing, and medical and other services, for victims of war.\textsuperscript{12} The term ‘refugee’ was defined in December 1946 by the International Refugee Organization created to deal with the refugee problem in Europe, with a focus on issues of compensation, resettlement, and protection if refugees choose to return to countries of persecution.\textsuperscript{13} After the 1948 Arab-Israeli War, the United Nations created the United Nations Relief for Palestine Refugees (UNRPR) organization to support voluntary relief organizations providing emergency care for the Palestinian refugees.

In August 1949, a United Nations Economic Survey Mission, called the Clapp Mission,\textsuperscript{14} examined the effects of the 1948–49 war and recommended the establishment of a new organization to handle the Palestinian refugee population.\textsuperscript{15} Named after Gordon Clapp, chairman of the Tennessee Valley Authority who led the inquiry, the Clapp Commission’s assignment reflected the United States’ larger goal of regional development. When it seemed that the parties involved (Israel and the Arab League) were intransigent regarding their respective positions on the fate of the refugees, the Clapp Commission capitulated. The refugees, as political scientist Benjamin Schiff puts it, could then be seen as regional assets for development.\textsuperscript{16}

In December 1950, the United Nations General Assembly created an Office of the United Nations High Commissioner for
Refugees. However, the UNHCR mandate did not include the Palestinians. Instead, a special agency, the United Nations Relief and Works Agency, began operations in May 1950 providing humanitarian assistance and emergency relief to more than 910,000 Palestine refugees. A drawback of making the refugees the sole responsibility of UNRWA was that they were then excluded from human rights protection granted to refugees by the UNHCR and other international bodies. UNRWA developed its own definition of a Palestine refugee, since Palestinians were excluded from the definition of refugee established by the UNHCR. While it was not unusual for regional organizations to develop their own definitions of refugees, in this particular case the implications were particularly far reaching. This is because the emphasis in the case of the Palestinian refugees differed from that of most European refugees who were concerned about resettlement, rather than repatriation. The collective sentiment of Palestinian refugees was that justice meant repatriation, even while the conditions that had fostered their dispersion remained.

At first UNRWA defined a Palestinian refugee as a person normally resident in Palestine who has lost his home and his livelihood as a result of the hostilities and who is in need. By 1952, UNRWA considered a refugee to be a person whose normal residence had been Palestine for a minimum of two years preceding the 1948 conflict and who, as a result, had lost both his home and his means of livelihood.

Because of the wide range of situations among Palestinians, UNRWA’s definition of refugee was confusing and inadequate. Some Palestinians had lost homes, but not livelihoods, or were Bedouin who lost markets and grazing areas, but since they were nomadic, had technically not lost their homes. The definition of refugee did not take into account the many ways in which newly imposed borders destroyed a way of life that depended upon geographic continuity:

Were bedouin about 100,000 persons who used to move perpetually between Sinai, Palestine and Jordan – refugees and entitled to relief if they were cut off from their grazing lands in South Palestine? Were the fellahin refugees if they were no longer able to get a livelihood from migration to Palestine? Were villagers, still living in their own homes
but separated from their land by mines, barbed wire, or artificial demarcation lines, refugees? And finally, were indigenous inhabitants of an area now destitute because of the economic consequences of war entitled to relief? Approximately 160,000 Palestinians did not qualify for UNRWA assistance but were separated from their productive land by armistice lines. Disruption of commerce and transport by new and hostile frontiers left many unemployed and without assets.

Elia Zureik points out that UNRWA’s definition excluded many displaced persons who fell outside UNRWA’s responsibility and definition. These included Palestinians who ended up in areas outside UNRWA’s area of operations: internally displaced people whose needs were supposed to be addressed by Israel; residents of Gaza, the West Bank, and East Jerusalem displaced for the first time in 1967; individuals deported after 1967; those who left the occupied territories and were prevented from returning; those outside British Mandatory Palestine when the 1948 or 1967 wars took place; well-off Palestinians who had not registered with UNRWA.

In 1950, UNRWA attempted to conduct a census of the ‘genuinely destitute’ in Lebanon, Jordan, and the Arab part of Palestine, where political scientist Rony Gabbay asserts, ‘the number of false declarations and fraud were expected to be the highest’. UNRWA found the task impossible. The question of who was lying and who telling the truth became intertwined with what bordered on international agency officials’ criminalization of the population, now subject to continuous investigation. Frequently repeated characterizations of Arab refugees as ‘primitive,’ ‘poor,’ ‘miserable,’ ‘mysterious,’ ‘unpredictable,’ and ‘untrustworthy’ replicates the descriptions of dayat discussed earlier.

Introducing her discussion of Palestinian identity in camps in Lebanon, Rosemary Sayigh notes that the term ‘Arab refugees’ gives the impression of an undifferentiated mass, just as the term ‘Arab world’ or ‘Arab countries’ diverts attention from the specific social/sectarian features of each country. Yet, refugees responded in diverse ways to their circumstances, and to the challenges of daily survival. In historian Avi Plascov’s study of refugees in camps in Jordan between 1948 and 1957, refugees are differentiated: as camp leaders and committee members; as objects of
political struggles internally and externally; as recruits to various political parties and positions; as deceiving UNRWA to obtain ration cards; as victims of policies designed by UNRWA to deceive them into resettlement. Palestinians would respond in ways that were relevant to their interests, life experience, and goals: those with resources and those living in poverty, those living in what would become ‘frontier’ or border areas, those who had been regular travelers between Transjordan and Palestine, and those who made their living from their herds, or from farming. With their contradictory and diverse aspects, these people and their stories comprise al-ghurbah (the exile). Yet, as welfare recipients and participants in various work programs, Palestinian refugees became homogenized, at least in the public mind.

A comprehensive analysis of Palestinian refugee history requires research on women refugees. Issues central to the historical experience of Palestinian refugees include those of sexual abuse and rape endemic to war and exile, gendered aspects of ‘the right of return’ (United Nations Resolution 194), conditions on the ground for women, women’s resistance during war, women’s activism in the camps, and women’s goals in terms of social, economic, political organization. Historical developments are played out differently for women given the various ways women are situated within indigenous societies, as well as the ways in which women are situated in the lexicon of international politics.

Women refugees shared the experience of disruptions of households, and of losing sisters, mothers, husbands, children, brothers, male and female friends, and other relatives. And undoubtedly women shared among themselves war experiences that they were reluctant to recount at the time.

For example, one of the most egregious, yet least acknowledged, war experiences of Palestinian women was rape. Most academic and popular literature has not addressed rape as a major health issue for women in relation to the Palestinian refugee crisis.

It hardly needs to be said that rape carried out by male soldiers is endemic to war (both within and outside of the military). The targets are both men and women with far higher incidences of rape of women. A gendered analysis of war bringing into the foreground socialization of men vs. women across geography is one way in which to examine this phenomenon. Extensive literature on this subject points to the rape of women as a way of humiliating
‘conquered’ men. Rape challenges the masculinity of ‘the subjugated’ and control over ‘their’ women. For the purposes of the following comments, it is important to situate the testimony of Palestinian women within this larger reality. Israeli and Jordanian soldiers who raped, did so with impunity because of global historical processes linking war and ‘justifying’ rape of women, rape of land, rape of ‘nature’, and linking nationalism to war and concomitant rape of women and of ‘nature’, themes explored in this text. Through a long historical process of speaking out and writing on the cruelty of rape, it has finally been recognized as a crime against humanity and a war crime under the Geneva Conventions. While difficult to implement, the importance of this new statute cannot be overestimated, because if rape in war is prohibited, war itself may one day also be prohibited as violating the sacredness of life.

Women living in a village called Safsaf, were raped in 1948 after witnessing the massacre of male villagers. A former head of the Haganah National Staff listed crimes committed by Israeli soldiers:

52 men tied with a rope and dropped into a well and shot. 10 were killed. Women pleaded for mercy. 3 cases of rape ... a girl aged 14 was raped. Another 4 were killed.²⁸

In interviews by historian Nefaz Nazzal and anthropologist Rosemary Sayigh, women’s accounts of devastation, of watching relatives and friends bleed to death, also include rape.²⁹ Women and children were injured by gunshot, shrapnel, or mines – and by rape.

One of Nazzal’s interviewees, Umm Shahadah al-Salih, described what would become a familiar tragedy:

As we lined up, a few soldiers ordered four girls to accompany them to carry water for the soldiers. Instead, they took them to our empty houses and raped them.³⁰

There were commanders and politicians who knew of rape and reported it to Ben-Gurion, Israel’s first prime minister.³¹

What laid the groundwork for rape of Palestinian women? Escalating militarization in the region was one factor. As noted
earlier, the British stationed soldiers in Palestine during World War I, and continued to maintain a military presence until they left in 1947–48. In 1926 the British created the Transjordan Frontier Force as part of their Imperial Forces in Palestine.\textsuperscript{32} The Haganah, or Israel Defense Force, was officially organized in 1920. Arms and armed men (armed women also fought in the Haganah) proliferated in the region. Rape is not only a product of war, but it is also an aspect of colonization.\textsuperscript{33} The parents of one 37 year old woman born in the camps told her about British killing and rape of Palestinians:

The British collaborated and conspired against the Arabs and they kicked them out of the land, and they killed a lot of Arabs. So when they left it was the British who were shooting them, and they had cannons all over the place ... women were so scared they forgot their babies behind them. Some of them took their keys because they thought they were coming back the next day. The English and the Jew were fighting and killing the people. The \textit{fedayeen} resisted, but at the end they won and people ran away. The British got mercenaries, the people they got were Jewish people, and they fought together, and they raped women.\textsuperscript{34}

Palestinian women were raped not only by British and Israeli soldiers, but also by Jordanian soldiers. In times of war, violence against women rises within both subjugated groups and among the winners (for example, Israeli Jews report rising levels of violence against women by men returning from serving in the occupied territories.). Women’s health and well being are at risk as long as men’s access to women’s bodies is sanctioned as an inevitable consequence of male biology, and/or on the basis of political and military objectives. A case in point is the rape of women by Jordanian soldiers in refugee camps in Jordan, in September 1970.

‘Black September’ refers to the Jordanian military destruction of the Palestinian nationalist movement within Jordan’s refugee camps. It was one of the events that have become an indelible part of Palestinian refugees’ nationalist history – another is the Battle of Karamah in 1968. The two battles were related. The success of the Battle of Karamah, when Palestinians in the
Karamah camp on the east bank of the Jordan River were able to drive back Israeli tanks (sent to cleanse the camp of nationalist activity), spurred nationalist enthusiasm among Palestinians and Palestinian organizing including weapons training in the camps, but this activity was eradicated by King Hussein in 1970 (remembered as Black September). Clashes between the Jordanian army and Palestinian commandos had been going on in and around Amman. In one incident in 1970, Jordanians shelled a refugee camp at Wandat, housing 15,000 Palestinians. Each camp was a separate base of operations. Jordanian tanks surrounded and attacked Jabal al-Hussein camp. Al-Fatah (the name of the Palestinian nationalist organization that became a mass movement in the 1960s) claimed that a hospital was shelled at El Rumman. Al-Wandat was almost entirely destroyed by shells. Thousands of refugees fled Baqa’a camp to escape Jordanian fire. Inhabitants became refugees once again, as they fled to the Israeli-occupied West Bank. One resident of Jabal al-Hussein camp described the consequences for women during this period:

If the girls stayed in their houses they used to get raped by the army. Because the resistance had a base here this was a very vital place for the army to take down. So the deaths that occurred at that time were very big. Twenty thousand people died. The army wanted to break down the resistance. Women were raped, and after they raped them, they killed them. They found their corpses there. This went on for one month. Then the resistance went underground.36

Palestinian women were active in resistance in the camps, one reason for retaliation against them. But the form of retaliation was related to their vulnerability as women who behaved improperly:

If resistance remained now, we wouldn’t be here. The woman played a vital role. The boys were the cubs and the girls blossoms, and they were all part of these groups. They used to gather money and ammunition for the people, arms training, all of them, women and men, only after 1970s this stopped. It’s the war with the Jordanian government.
If men went out they wouldn’t come back. Others would be disappearing in Jordanian jails and nobody knew anything about them. With all camps surrounded by the Jordanian army, people were trying to stay in shelters. With all their family in one place, women would sneak out and go to get food and to get water and go to their houses to get stuff for different families. Women were killed.

Yes, the Jordanian army used to be scared of the women because women were very strong and they used to have arguments with them, used to spit in their face and say: I’m Arab like you, what are you doing? And my mother once shoved one of them.37

Another factor contributing to increased incidences of rape was debasement of women expressed through European and American constructs of Arabs discussed in Chapters Two and Three. Such constructs underpinned policies of land reclamation and underpinned health policies targeting mothers and midwives as ‘ignorant’ and ‘unclean women’. ‘Diseased foreigners’ and ‘primitive women’ fuse in the rhetoric of some imperialists and medical practitioners. Dehumanization and a desire to change the nature of the ‘native’ creates a dangerous atmosphere for women, deemed ‘bearers of the race,’ and customarily defined as conveyors of mores. Such views were also held by some Arab men.

A third development that may have contributed to an atmosphere that was potentially threatening for women was that state regulation of health to control women’s bodies (as practitioners and as mothers) took power away from women and put it in the hands of a chain of male command. In so far as women benefited from access to useful medical techniques and technologies, they also paid a price.

The United Nations High Commission for Refugees (UNHCR) is one of many international organizations that currently acknowledge that international law is not sufficient to protect women refugees. UNHCR Guidelines point out that women who are unable to feed, clothe, shelter themselves and children ‘are more vulnerable to manipulation and physical and sexual abuse to obtain such necessities,’38 and that, where traditional social systems break up, traditional forms of social protection for women also collapse. It gives the example of women who had means of expressing their views
in their communities, but who found themselves unable to do so in camp management committees established by assistance organizations. And food was often passed out to men before women.  

The UNHCR Report acknowledges that one problem with the 1951 Convention’s definition of refugee is that it does not include issues related to gender. In the form of a recommendation left to the discretion of countries, it proposes that women who are persecuted because of having transgressed societal laws and mores as women (for example, in cases of honor murder as noted earlier) be protected under international law:

As a UNHCR legal advisor has noted, transgressing social mores is not reflected in the universal refugee definition. Yet, examples can be found of violence against women who are accused of violating social mores in a number of countries. The offence can range from adultery to wearing lipstick, and the penalty can be death. The Executive Committee of UNHCR has encouraged States to consider women so persecuted as a social group to ensure their coverage, but it is left to the discretion of countries to follow this recommendation.

Furthermore, according to international declarations and conventions:

... women who are attacked by military personnel may find difficulty in showing that they are victims of rape rather than random violence. Even victims of rape by military forces face difficulties in obtaining refugee status when the adjudicators of their refugee claim view such attacks as a normal part of warfare.

The 1950 United Nations Relief and Works Agency definition of a supposedly gender-neutral refugee had a particular salience for women: with no legally defined identity, and hence no access to assistance to meet their particular needs, women had narrower options (fewer job opportunities, more physical vulnerability) than men. The international community responded to the needs of refugee women as mothers: this concern came in the form of a plea for funds for food and shelter, and in the form of nutritional
programs for pregnant women and for children. (And even then, food and other supplies were distributed to heads of households, typically men.) It was not until the 1980s that advocacy on the part of women’s organizations raised awareness globally about the needs and rights of women, who comprise the largest number of poor and of single-headed households, that UNRWA began emphasizing programs for women. The range of consequences during the early period for all Palestinian women, whether they were mothers at the time of their exile or not, has yet to be documented. For example, UNRWA officials found that refugees in Lebanon in 1951 ‘felt “forsaken and abandoned” by political organizations, international institutions, and the big powers … The disintegration of their society was shown by the fact that prostitution was becoming noticeable among a village population that had not known it before.’ Women had few options for economic survival. In the early years, UNRWA programs to retrain men for possible employment were far more common than training programs for women. These were limited to women’s traditional work, such as sewing.

The Political Economy of Refugee Health

During October 1948, United Nations mediator, Count Bernadotte, assessed the situation of approximately 95,000 refugees, many of whom were without blankets and clothing: ‘every week’s delay will mean a progressive death-roll from exposure.’ He appealed to the United Nations International Children’s Emergency Fund (UNICEF) for aid in the name of children, pregnant women, and nursing mothers. Fifty three states, many international organizations, and some oil companies responded. The League of Red Cross Societies took responsibility for medical inspections in Lebanon, Syria, Transjordan, Egypt, and Iraq. The International Committee of the Red Cross aided the Israeli- and Jordanian-occupied area of former British Mandate Palestine; and the American Friends Service Committee held responsibility for Egyptian-occupied Gaza and the town of Acre in Israel. Transjordan contributed $933,481 until April 1950 to UNRPR’s (United Nations Relief for Palestine Refugees) relief fund. Palestinians were living in tents in makeshift camps with communal latrines and washing facilities, with little or no privacy. As one Palestinian interviewee put it in our discussion about the
history of Jabal al-Hussein camp, ‘the toilets were shared by all of the people of the camps because we were living in tents, and also the water resources were shared by all the people of the camp.’ Many women felt exposed because they had fled without headscarves.

Malnutrition, inadequate housing and living conditions, lack of sufficient clothing, the consequences of which were borne primarily by women, were endemic. Women and men, especially those who traveled on foot, suffered ongoing health problems. Some women had given birth at road sides en route. Many bled from miscarriages. Women were in need of health services staffed by women practitioners who were aware that many of their clients had been raped. Women needed treatment for infections, sexually transmitted diseases, and trauma. As Rosemary Sayigh notes about refugees in Lebanon’s camps, many died because they could not adjust to the severe conditions in the camps, particularly if they were used to urban life.

By the time UNRWA had set up its medical clinics, official definitions of what was necessary to maintain health (defined primarily in terms of nutrition and immunization) were those of international voluntary and governmental organizations and were driven by questions of cost and the international politics of relief. A United Nations Resolution approved $29.5 million for direct relief for a monthly average of 500,000 refugees for nine months from December 1, 1948 to August 1949, as well as $2.5 million for administrative and local operational expenses. The United Nations Disaster Relief Project coordinated relief, beginning in September, 1948. The staff included a chief medical officer of the World Health Organization. A senior medical officer of WHO in Beirut directed the medical program. As noted, the United Nations Relief for Palestine Refugees (UNRPR) took over the Disaster Relief Project until the founding of UNRWA. The immediate tasks of UNRPR were to provide food and water for a million people, to prevent epidemic diseases by inoculation, and to provide hospital services on an emergency basis. The Disaster Relief Project inoculated refugees in cases of threats or actual outbreaks of epidemic disease. UNICEF’s distribution of milk and cod liver oil for mothers and children accounted for approximately one fourth of commodities delivered under United Nations auspices. Jordan agreed to allow in all refugee supplies
duty free, without inspection, giving UNRWA full control as well as privileges and immunities while fulfilling its tasks.\textsuperscript{54}

International politics determined the amount and delivery of relief supplies. Once supplied, refugees depended on distribution agencies and on agreements between states. In April 1949, for example, the League of Red Cross Societies was not able to deliver supplies because Lebanon refused to pay the private company loading and unloading supplies until Syria and Jordan contributed their share of the costs.\textsuperscript{55}

Early on, UNRPR reduced the caloric value of rations delivered. This was their solution to the fact that more Palestinians were registered as refugees than the number of rations received by agencies. Since more than half of refugee children were under 15 and most adult males were not regularly working, UNRPR considered reduced rations adequate nourishment. Given the differential value that UNRPR placed on men and women, and the fact that girls typically had a higher rate of malnutrition than boys,\textsuperscript{56} women were more vulnerable to rationing. Girls might go hungry in order that their brothers and fathers were fed. And since the predominant medical model utilized by WHO and other international organizations was a male model, specific health effects for women for a range of health issues, including their physical safety as noted above, were overlooked. For example, asbestos shelters (also jeopardizing men’s health) may be a factor in incidences of breast cancer in the camps, which women note is on the rise.

In addition to the politics of distribution and the problems of obtaining an identity card, refugees were aware that a major portion of UNRWA’s funding came from the United States. Many camp residents saw UNRWA as an agent of imperialism.\textsuperscript{57} Further, UNRWA’s relief effort was tied to development in Jordan. What would be the function of the refugees in this process? The bulk of UNRWA’s staff were from among the refugee population. UNRWA brought in much needed funds for infrastructure and for development programs that utilized refugees as a labor force. Refugees were often told that entry into a work program was a pre-requisite for an identity card.\textsuperscript{58} Other work projects required cancellation of identity cards, which were Palestinians’ insurance on lost property.\textsuperscript{59} Attempts at resettlement by UNRWA, and implicitly by the Jordanian government, were viewed with great mistrust and rejected; so much so, that many were willing
to move from tents to more permanent shelters only when they faced untenably harsh weather conditions.

In his study of UNRWA, 1950–91, Benjamin Schiff characterizes four phases of UNRWA’s development. Between 1950 and 1957, UNRWA was a vehicle for regional development plans, much along the lines of those described in Chapter Two of this text. With its new ‘superpower status and technological prowess,’ the United States visualized a Middle East Tennessee Valley Authority ‘sowing seeds of cooperation among nations, absorbing refugee creativity and labor in a transformed Jordan Valley region.’ Schiff contends that one reason why the United States supported UNRWA was because refugees who were healthier and happier were less likely to become Communists or terrorists.

During its second phase, 1957–June 1967, when it became apparent that ‘grandiose plans for regional development’ had to be abandoned, UNRWA focused its resources on health (effectively reducing infectious diseases, implementing mass immunization, reducing mortality rates, and reducing malnutrition) and education, expanding its bureaucracy, and becoming, in the eyes of many, a model in the Middle East in both areas. After the 1967 War and through the Intifada period (phases three and four), with increased international support for Palestinian self-determination, and at the same time, faced with mounting resistance against the Palestinian struggle, UNRWA once again had to supply emergency relief services. It needed to do so in Jordan during the period of Black September, and in the occupied territories in 1987. UNRWA finally became what many Palestinians had advocated for, ‘an agency involved in the protection as well as relief of the refugees.’

During this latter phase, UNRWA began emphasizing programs for women. The agency established women’s centers and skills programs enabling more women to find employment. Refugee women played a major role in this phase, deciding what kinds of training they wanted and following up on projects.

From its inception UNRWA became the vehicle for a range of political objectives of its donors and of those it was servicing. It represented the stalemate produced by political developments in relation to Israel since UNRWA was the product of Israel’s refusal to comply with international law. Refugees found employment through UNRWA (more than 20,000 Palestinian administrators,
managers, teachers, nurses and doctors, but they were drawn into a paternalistic bureaucracy which often left them without decision making power. Some viewed UNRWA as a welfare agency contributing to refugees’ dependency, hence dampening their politicization. Israel, on the other hand, accused UNRWA of politicizing Palestinians. Host governments depended on UNRWA to provide resources for refugees, and they used incoming funds to make improvements in their own countries. Refugees obtained homes through UNRWA, but wanted primarily to return to their former homes. Refugees were able to continue a tradition of high levels of education, and UNRWA provided literacy training, which was particularly beneficial for women. At the same time, there were many complicating factors in regard to both education and health, for example, control of the curriculum, overcrowded health clinics, and other issues related to health services and practices, discussed below.

Admittedly this study does not present a comprehensive view of the goals and achievements of UNRWA, as this would require testimony from policy makers, field workers and staffers, as well as from refugees. The goal here is to document the experience of a select group of women refugees whose lives were influenced by UNRWA in a variety of ways, and to analyze these women’s testimonies in the context of their relation to constructs of health, health systems, and medical practices over time.

Officials and refugees used health issues both as a means of control and as a political statement. Refugees organized to oppose attempted vaccination against tuberculosis, unless given by local staff who could be trusted to conceal the exact number of refugees. The politics of relations between UNRWA and the refugees, between the Jordanian government and UNRWA, and between the powers involved in the Israeli–Palestinian conflict have complicated the exemplary work of UNRWA in providing relief and ensuring the survival of hundreds of thousands of Palestinians.

If health was tied to a complex web of international and local politics, it was also tied to derogatory views of Arabs as noted, and to a tendency to blame refugees for whatever went wrong. For example, refugees got no credit for the fact that, as tents in makeshift camps gave way to asbestos shelters, then to mud huts, and eventually to one or two room houses of concrete block, in
spite of unsanitary and overcrowded conditions, there were no serious outbreaks of disease. International organizations, proud of their relief efforts, felt the recipients spoiled the effects of their efforts. Reports often asserted that poor standards of refugee health were endemic to poor classes in the Middle East, rather than a consequence of war.\textsuperscript{66} A mythology developed flattening the health of Palestinian peasants, farmers, and villagers into a one-dimensional picture of ‘ignorant’, ‘underfed’, and ‘impoverished’ women, men, and children. Did Palestinian women know how to cook? Were shops and bazaars dens of filth? Investigations were carried out, reports written.

These reports reached contradictory conclusions. One such report found Palestinians on the whole to be in reasonable nutritional shape, ‘considering their previous circumstances and those of the population among whom they are at present living. In Trans-Jordan and the Gaza Strip, they appear to be in better nutritional state than the local population.’\textsuperscript{67} While UNRPR, WHO, and UNRWA reports praised health and nutritional standards, a YMCA report of January 1950 cited fair standards of food, clothing, shelter, and medical care, but low morale from poverty and inactivity.\textsuperscript{68}

Refugees protested the quality of medical care, and were ‘further unsettled by sometimes groundless or exaggerated Press reports about them.’\textsuperscript{69} In the eyes of some Palestinians medical care was a means to control the refugees; others saw medical neglect as a way of ‘solving the refugee problem.’\textsuperscript{70} Refugees protested that low caloric value and stale food caused malnutrition and disease, that foods were mismanaged and had to be destroyed, that food was differentially distributed between unemployed and employed.\textsuperscript{71} When camp residents found that a miller in Amman sold inferior quality flour to UNRWA in order to make larger profits, it was a cause for a mass reassertion of their right to return to farms, orchards, and local customs.\textsuperscript{72} In the eyes of many refugees, as Rosemary Sayigh concludes after discussions with refugees in camps in Lebanon, medical services available to refugees were not much in advance over those in Palestine.\textsuperscript{73} Given the complexity of the politics of relief, it is no wonder that many refugees assert that people were healthier in Palestine.
Women Talk About Health: Al-Ghurbah – The Disaster

As noted earlier, Palestinian women experienced wartime hardships of 1948 in various ways given their particular situations (access to resources, urban or rural origins, age), and they experienced particular hardships because they were women (such as rape). Pregnant women faced multiple dangers, as one interviewee notes of her pregnant mother. This Palestinian–Jordanian woman told me that her mother had both a Jewish doctor and an Arab doctor during her pregnancy. During the Mandate period, her mother had taken advantage of multiple knowledge bases relevant to her health care. She described how she took her mother and her aunt to Hadassah hospital, ‘owned by the Jews … this was 1945, before the war … things were starting to get tense.’ But when her mother’s panic precipitated an early delivery, her mother turned to the daya to save her child:

In 1948 my mother was pregnant … in the market there were bombs, people were being killed like flies. From the window we could see all the dead people. My mother was pregnant with her third child, so she sent the children. She refused to leave. Her husband said, if you’re staying I’m staying with you … she was registered in a hospital to have the child … but at night the bombs were exploding and you could see dead bodies all around and a bullet came into the kitchen and then she decided she’s not going to the hospital and she started having contractions from being scared from the bullets. At 2 a.m. when she started bleeding they got her the daya and she delivered her. They went by car and then they reached the bridge and then put a block of wood under their feet. They were soaked with water and all through the day they were reciting verses from the Koran to protect them. She got the checks and knitted them into the diaper of the baby … and you could see the soldiers so she was closing her eyes all the time because she didn’t want to see what was going to happen when she began the crossing … 74

Hardship was not unfamiliar to this woman who delivered under dangerous conditions. She was from Safed where, as her daughter described to me, under the British Mandate, soldiers
... used to go into the house ... they used to strip search all the houses and anybody they used to take in they used to go to jail for five years. They hanged my cousin ... the first martyr ... they used to get people of the towns into the big yards and then they used to spoil everything in the house, and then they go to the houses and search the houses and spill the rice [and] sugar.\textsuperscript{75}

A Palestinian refugee originally from Haifa, and now a nurse who organizes women in Jabal al-Hussein refugee camp, experienced similar hardships and became politicized as a result of her experiences during trying times of war and exile. She has since devoted herself to improving the situation of refugee women. In a matter of fact manner, she described her instinct for relieving suffering and for attention to the collective rather than the personal. Stepping outside of prescribed norms regarding motherhood, she had displayed a loyalty to her people that transcended her particular situation. She was in Karamah refugee camp in Jordan for the historic battle that happened there in 1968, and described her contributions to the victory that Palestinians remember with pride:

When Karamah happened I had two daughters; one was only one month old. I forgot them and left them and went to work as a nurse in a hospital for the wounded and disappeared for three days and they didn’t know what happened to me. Due to circumstances the human instinct in me made me just put my children aside and go and help the wounded. I left them with my aunt and went to work. I used to live with her, but I went to Karamah.

For three days my family didn’t know whether I was alive or dead. I worked in the Karamah camp where the first and the only battle Arabs won happened. I was there – that was a true war. Women took care of the wounded. I used to work in the center and my family didn’t know if I was alive – and I stayed there all of the time where I was working – and this is what made me continue to work on the grassroots level. All the suffering that I saw.\textsuperscript{76}

Forging a place for women such as herself, this woman put public before personal needs. She did not hesitate to take control
in a crisis, even when it meant leaving small children for a time. Following the 1948 defeat, a resurgence of nationalist sentiment gave Palestinians hope that they still might positively affect the course of history. She was among those women who saw themselves as movers in the process of winning liberation:

At that time a person used to work and put in all her energy because the hope was so much that there was something on the horizon that can be done and can be changed, so that was the priority.

And the cause was not a personal cause; it was a public cause; people need me, so it’s not a private matter; public needs were more important than personal needs at that point. The circumstances and the suffering that they saw made us ... no people suffered as much. This is the minimal that I can do now that part of my life is just for that cause and that’s a minimum thing. I wish that all the women would raise their children in a manner that they would have these feelings toward their country.77

The Palestinian Liberation Movement emphasized the critical role of women as bearers and educators of the race. Umm Abdullah saw women as liberation fighters who would carry the national cause into child rearing. She chose her tools as a nationalist, for a time putting motherhood on hold, and at the same time she fused women’s biological and historical roles.

Umm Abdullah was resolute when she described her sister-in-law’s experience in Gaza, that of her friends, and her own, beginning in 1948. One friend had lost her husband from heart failure and she had lost her son in a car accident. Her remaining sons went to school, one to become a mechanic, the other a hairdresser.

Her daughter studies child education at the National College in Amman. This woman described a history of resistance informed not only by external events such as war, but also by the necessity to survive when her father-in-law and husband left her on her own.

My sister-in-law was two years old, from Saba. Her village resisted. She went to Gaza. The women used to carry bombs in their dresses and they used to give them to the
resistance, and they fought and fought until they lost – this was in ’48. And people when they lost they had to leave only with their clothes on their backs, even the women who need to wear scarves, they couldn’t put their scarves on … My grandmother was very very old – her brothers, her uncles could not carry her away from the village, so they had to leave her and go back to get her. People were just running for their lives.78

As noted earlier, this woman and many others witnessed, as did many children, the slaughter of men of her village. They endured the on-going state of war as Zionist leaders, threatened by the growing strength of Arab nationalists, joined forces with Britain and France to regain control of the Gulf of Aqaba and of the Suez Canal, nationalized by Nasser in the summer of 1956:

When the occupation came we left from Haifa79 and went to Jenin. When Deir Yassin80 happened, Umm Ramsey was two years old. The people got really scared and ran away. So Jenin was the closest town.

In 1956, Umm Ramzi was ten years old, and when they came to the town they called from the speakers, and they asked all the young men from 16 to 40 to go to a certain school. Everyone was sleeping, and she said in this house next to them there were seven men and their families. They lived here, they searched in the house, they took them out, they asked them to line up. She remembers this, and she was looking. They killed all of them. And she said what they used to do they used to take them in lines, and they said, we’ll kill this line … in 1956 they killed more people than in 1948.81

In 1967, Umm Abdullah was deserted by her husband. She had married as soon as she was capable of conceiving, but her father-in-law, more concerned for his only son than for her welfare, took his son away with him. He then refused to let Umm Abdullah return to Jenin after she had her first child. At the intersection of sexual politics and war, Umm Abdullah cast her fate with her mother-in-law as they left for Jordan with only the clothes on their backs:
We both remember the war of ’67. I left, while my family stayed in Jenin. In my family, I’m the one who left. When the Israelis came the first town they entered was Jenin, and I was working and my father-in-law was very scared for my husband because he was his only son. So he took his son and they went away, and left me. I could work in UNRWA (United Nations Relief and Works Agency) in Jenin, but I left Jenin and went to Kabatya. Then I had my first child. I was only 14, and I tried to return to Jenin, but my husband and father-in-law refused to let me return.

During the war of 1967, women didn’t leave when the war started until they saw people killed in front of them. Every time when any soldier sees anybody, they can kill them on sight. My mother-in-law when she saw this killing of people on sight, said, let’s run away to Jordan. She had only two sons. They only came here with the clothes on their backs.82

Umm Abdullah’s sadness in describing the disruption and violence of war, coupled with her resilience, were characteristic of many Palestinian women whose life histories led them to focus on nationalist activities and on the collective welfare, and particularly on the welfare of women. Her experiences and those of Umm Ramzi typify the kinds of events that have left women with a legacy of health issues related to stress, overwork, injuries, and male ill-treatment of women in times of military conflict.

Umm Abdullah was twice driven from her home, first from Haifa to Jenin in northern Palestine, and then in 1967, from Jenin to Kabra. In 1968 she was fourteen, and though quite young at the time, was on her own. She left her child and told no one where she was going.

Trained by UNRWA in a Jenin refugee camp, Umm Abdullah became a nurse and worked in women’s health centers. After 1967 she worked in emergency camps set up in Jordan, among them Karamneh Camp. She was then transferred to another camp where she worked for thirteen years, until she was moved to the central clinic for refugees in Amman. Eventually she was rewarded by UNRWA with a medal for being the youngest employee to work for them for 31 years.
Women from the neighborhood on the periphery of Jabal al-Hussein camp started the Women’s Collaborative and Rehabilitation Society in 1973, to address issues of women’s poverty. A leader in forming the society, Umm Abdullah told me how it functions:

Women ... started the society in 1973, and they’ve been in touch with families in the camp [Jabal al-Hussein] ever since. The Union [Jordanian Women’s Union] at that time was not working, was not active, because of the politics of the country. So we worked with women from this neighborhood and outside the camp. This is the first women’s society in the whole area. Fifty five women are involved from the ages of 18 to 45. We run a productive kitchen, handiworks, health lectures in cooperation with UNICEF. There is another institution that markets our products. The government and NGOs do not give us funds, so we have to rely on donations. We have 980 women who graduated with skills from courses that we teach. Forty five graduated from the different workshops we have.\(^{83}\)

Umm Abdullah had brought these women together to take matters into their own hands. They created a society to address specific health issues of refugee women in order to give women some control over their lives. They approached women’s groups as well as non-governmental organizations for resources.

In 1974 Umm Abdullah became a member of the Jordanian Women’s Union and Director of the Women’s Rehabilitation Organization, located near Jabal al-Hussein camp. Since 1993 she has been a member of the Royal Organization for Environmental Protection. Finally, she was nominated by Princess Basma to be on the Board of the National Committee for Women’s Issues.

Asserting her belief that women working together within and across geographic boundaries can solve problems of poverty and unemployment, Umm Abdullah has kept alive a tradition of networking among women caring for the health needs of women by organizing within and outside of the state sponsored refugee support system. When state policies closed down the activities of the Jordanian Women’s Union in 1955 (reopened
in 1974, dissolved again in 1981, and reconstituted in 1989), Umm Abdullah created an alternative society not subject to state regulation.

Umm Abdullah described ways that she uses customary practices to solve problems without state interference. For example, practicing Muslims are obligated to give to those in need, especially on religious holidays. Thus, on the Eid Umm Abdullah distributes what is contributed through her organization. Job training is a priority of the Society. With jobs, Umm Abdullah concludes, women are less likely to have as many children. Umm Abdullah’s definition of what is necessary to maintain health is touched by the wider political-economic-social nexus. Some women, then, in the face of the trials of war and dislocation, took their skills into the arena of political organizing and turned to other women for solidarity.

From Jabal al-Hussein Camp to the Ministry: Poverty/Reproductive Health/Resistance

When I asked Umm Abdullah, Rema, a woman in her early twenties living with her mother, father, and brothers in Jabal al-Hussein camp, and Kitam, a mother of eight from Baqa’a camp, to describe women’s major health concerns in the camps, both responded identically – ‘poverty.’ Kitam talked about problems created by unemployment. Poverty made it difficult for some to take advantage of opportunities in the area of education described earlier:

All are living in debt, waiting for donations. Families who own houses are better off ... those who are financially O.K. are the merchants who have shops. Some of them brought some money so they bought. Other people, employees in any other type of institution, can’t afford houses.

Most of the children here finish sixth grade and then they drop out of school and work for their families. They work as carpenters, mechanics, electricians, so they drop out of school to help their families. They go around and ask for leftovers, food, clothes. UNRWA only covers education to the ninth grade ... after that it’s on our own expenses ... we have to pay the government, we have to pay for the books ... now my daughter is in the tenth grade, and I
don’t know how to buy books … UNRWA doesn’t give support, only the basics.84

Poverty was a critical health issue for all refugees, particularly for women, and has been the lot of most Palestinian refugees in camps since their arrival in Jordan. Economic crisis in Jordan has had the greatest impact on Palestinian refugees inside camps and in low income areas surrounding greater Amman. Programs initiated by NGOs and charitable societies maintain unpredictable levels of assistance.

While some refugees live on the outskirts of the camps, where housing is more substantial and less crowded, most live with large families in one or two rooms. Low rents in refugee camps draw Jordanians, Egyptians, Syrians, Sri Lankans, and others whose incomes are meager, in addition to Palestinians. UNICEF reports noted that population density in camps was highest in Jordan.85 Nonetheless, the camps did not have legal status as villages or towns. They were administered by the Palestinian Affairs Department of the Jordanian Ministry of Foreign Affairs.86

I was in Jordan on the heels of the October 1994 Israeli-Jordanian treaty.87 While some I spoke to viewed the agreements as positive for the economy, women interviewed in the camps consistently maintained that the agreements had been negotiated at their expense because their status has not been resolved. As one woman put it, “Nothing has changed. The conditions are the same … A person who is poor is always lost in these situations.”88

In the course of my talks with Rema, she explained that Jabal al-Hussein camp residents were from different areas in Palestine and that most were refugees of the 1947–48 war. Jabal al-Hussein refugee camp was established in 1952, in northern Amman. By June 1994, there were approximately 29,000 Palestinians living in Jabal al-Hussein camp registered with UNRWA. Rema noted that because of its central location in northern Amman, conditions were better than in camps remote from the capital.

In 1948, the youth in the camp wanted it to be called the Camp of Return, but the government wouldn’t allow it because the camp is situated in the area of Jebel al-Hussein, Mount Hussein. To name their new living situation Camp of Return was an attempt to name themselves. At the center of their self-definition was the
praxis of resistance that, for some of the camp population at least, would inform camp life.

Describing the early period of the camp, Rema noted that some Palestinians came to the camps organized to resist resettlement. Their national representative, the Palestine Liberation Organization, would not allow people to build more than one level, called building Type A. By building the minimum living space, Palestinians demonstrated that their stay was not permanent. People who could afford to do so left the camp and tried to exist on the outside.  

Rema connected women’s lack of economic status in the camps with a lack of services for women and related to gender relations:

The atmosphere for women in the camps is very negative. It limits women from developing in all aspects. This is related to the services that are offered to women in the camp. The services are limited, so women’s development is limited, and it’s related to the low economic status and also to the relationship between women and men in the camp. And the relationship between the man and the woman is always affected by the economic background which is always related to the man’s economic power, and also educational background, and therefore controls the woman from progressing.

The economic situation for men in the camp was not much better. With a high level of unemployment of men, women suffered, since most were dependent upon husband’s, father’s and son’s incomes:

The elderly are mostly labor workers and owners of shops. The youth are either helpers for their fathers, or they are students, or are unemployed. Apprentices are very scarce. You can find someone who is a carpenter, or a mechanic, but it’s a limited percentage. UNRWA made a center to offer men certain apprenticeships, but it’s not situated in the camp. It’s in a place called Wadi Seer, and they learn there how to become electricians, mechanics, carpenters, iron-smiths, blacksmiths – but not everyone can get into that center. There are certain requirements for a person to
apply to the center. He has to be from the territories of ’48, and he has to have a ninth-grade degree, and also none of the people in his immediate family can be working for any of the agencies of UNRWA. His financial situation must be bad. If these conditions are fulfilled, then they are allowed to apply.  

Training for women is especially critical, since strategies for dealing with poverty are not dependable:

We depend on religious holidays for donations … During that time many people come and ask. But local agencies didn’t give any money this year. The National Treasury for poor families helps women find jobs- the ones who graduate from the programs work in factories … in needlework factories.

Job training for women, sponsored by NGOs in Jordan and by UNRWA, was in areas traditionally defined as women’s work. Rema noted that one of the positive roles of UNRWA was that they opened a center for women for training in …

... small apprenticeships, like embroidery, wool, sewing machines. Charges to learn these skills are very minimal. The government didn’t do anything like that. Younger women are more likely to take advantage of such programs. Most employed women are teachers.

But Kitam has not had the benefit of vocational training and struggles with poverty and consequent health problems:

Ten people live in these two rooms, five boys and three girls, my husband and myself. Life is very bad in the camp. My husband has diabetes and we really need services. He’s unemployed right now. We get money from the treasury of the camp which is Islamic … and sometimes from UNRWA.

We live on the services of UNRWA, and if they stop we can’t live. People have kidney problems, high blood pressure; half the camp population has diabetes. One of my sons has a problem with his leg, as his bone came out … and his eyesight. UNRWA will give you two pills to cover everything.
My daughter was hit by a car, and didn’t get help during the Gulf War. She has a rod in her thigh. The doctor charged 1,200 JD. The hospital is owned by the PLO and they don’t give free services. She had to have her intestines repaired after the accident, so they paid 900 JD. I asked the doctor to do it for free. He said he can’t afford it … although he has a very big house. When the school heard she had an operation, they wouldn’t accept her.

UNRWA’s dental clinic wanted to take out all of my teeth, but I said no, because they said it’s going to cost 200 JD. The government doesn’t take care of teeth and they don’t clean teeth. My day is spent always working, always cleaning house. The roof is made of zinc, metal, nylon with rocks to keep water from getting in, but it is very damp. We can’t afford inhalers for asthma.94

Both Rema and Umm Abdullah agreed with Kitam that UNRWA’s health services were useful for children’s minor illnesses and vaccinations, but otherwise were limited:

Refugees from 1967 go to the Ministry of Health and they give them something minimal-financial aid that doesn’t cover everything. UNRWA is only general practice … they give everyone the same medication … they give aspirin for everything … it’s very general … it’s good for children. But for somebody like me, there is no specialization.95

Umm Abdullah explained further:

UNRWA gives basic general health care, but let’s say if someone has a need to go to the hospital, they pay only 50% for emergency cases. If the refugee doesn’t have a card given to refugees in 1948, and has to go to hospital, UNRWA will not pay. Refugees from 1967 don’t have them. They used to have two cards, one for food, but they don’t do this anymore. Now they’re giving food cards only in severe cases when no-one is working, below the poverty line.96
In addition, Umm Abdullah pointed out that the number of doctors available through UNRWA was not sufficient to meet the needs of the camp population. Doctors were overworked, therefore the people were shortchanged. And only 1% were women. Another problem for women was that they may not be able to afford hospitalization.

Not all doctors are sincere. They see 100 patients a day. Not all of them give the same care because they have so many people coming. Doctors in general are good and sympathetic, because they are Palestinians themselves and have been refugees. But sometimes they do things more quickly, seeing so many people. They work from 7:30 a.m. until 2 p.m. and they have to see 70 patients. Women prefer women doctors, but there are very few, only 1%.

If a woman has time when she is going to deliver she can go to the UNRWA medical centers and they will pay for her transfer to a hospital, but she has to pay 12 JD … and then it takes a long time … and if she doesn’t she will have the child at home with a midwife.\(^{97}\)

Rema concurred, explaining that only women refugees from 1948 qualified for prenatal and antenatal care. In addition, midwives who worked for UNRWA varied in their delivery of services:

It depends on humanitarian sense … she would sometimes pass by twice a week, see how the child is doing … all of these midwives belong to UNRWA. After two weeks, the first two weeks, the mother takes the child to the health center, and they will weigh him and open a file for him. But sometimes the midwife doesn’t do anything besides delivering the baby … it depends on her personality.\(^{98}\)

UNRWA doctors saw more than 100 persons in clinics in a day. UNICEF reports that in 1985 there were 22 physicians in the camps per 100,000 population, and 12 nurses/100,000 population. Sixty eight percent of the camp population went first to an UNRWA clinic when ill; 25% went to private doctors; 7% went to a Jordanian government hospital and clinic where they had
to pay a fee. Services for the disabled, initiated in the late 1980s, were minimal.

Women refugees had access to specialized health care only insofar as it related to reproductive health. Even with UNRWA’s focus on reproductive health, women described inadequate access to services, expenses beyond their means, and limitations because of an overburdened health system. In addition, their options for treatment and diagnosis were limited by the drugs and technologies available.

In modern scientific terms, a woman’s health is measured by her ability to deliver a healthy child. A standard indicator of the success of western medical practices in colonized countries is reduction of infant mortality rates. The rate of infant mortality for Palestinians in refugee camps was 151 per 1,000 live births in 1961, 80 per 1,000 in 1976, 55 per 1,000 in 1986, and 35 per 1,000 live births in 1989. In 1995, the infant mortality rate in the camps was 35 per 1,000. The under five mortality rate in Palestinian camps in 1989 was 45 per 1,000 live births. Girls suffered higher mortality rates than boys, and major causes of infant mortality included prematurity, diarrheal disease and gastroenteritis, and respiratory infections. Maternal mortality among Palestinian women in general was estimated in 1989 by UNICEF and the Ministry of Health at 40 per 100,000 births, while the United Nations Economic and Social Commission for Western Asia (ESCWA) indicators show a rate of 200 per 100,000 births in 1988 for Jordanian women as a whole.

Estimated demographic indicators for Jordan and selected groups of developing and developed countries (1991) show that developing countries had much higher rates of infant mortality, and maternal mortality, and that Jordan’s figures were closer to the level of developed countries than Arab countries as a whole. However, these figures are deceptive. There are significant large disparities among developed countries; for example, nineteen industrialized countries have lower infant mortality rates than the United States. Infant mortality in the United States, Greece, and Spain was 11 per 1,000 in 1989. (Other figures for the same year include 5 per 1,000 in Japan, 7 per 1,000 in Canada, Denmark, The Netherlands, West Germany, 20 per 1,000 in Hungary and Poland, 25 per 1,000 in Romania and the Soviet Union, 32 per 1,000 in North Korea).

Furthermore, low birth weight, the main cause of infant mortality, occurs predominantly among mothers who are
adolescents, poor, or women of color, so that in the United States, African-Americans are twice as likely as white American infants to die before reaching their first birthday. Just as minorities within the United States suffer higher infant mortality rates and maternal mortality rates, so refugees suffer higher rates than the general population in Jordan. The role of medicalization in furthering the transition to capitalist economies has uneven implications for women depending upon their histories and subsequent access to centers of power. Thus infant mortality rates for Palestinians in low income squatter areas, 40 per 1,000 according to a 1992 UNICEF report, exceeded even those of refugee camps, and were much higher than the rate for Jordanian women in higher income areas. Under five mortality in low income squatter areas was 46 per 1,000 for males and 78 per 1,000 for females. Increasing numbers of children were working in the streets. Palestinian babies in Jordan had the highest low birth weight of all Palestinian communities, a fact which was not reflected in figures comparing Jordan’s health picture with that of other Arab and developed countries.

Rema and Umm Abdullah detailed a range of women’s concerns related to reproductive health. Many women were concerned about congenital diseases, especially after marrying relatives. Umm Abdullah worked with her Society to raise awareness about the dangers of marrying relatives, of marrying young, and of having many children. Women started marrying at 16 and have, on average, eight or nine children. Many expressed that the more children they had, the more they felt in control of their husbands. But frequent pregnancy took a toll, and women were concerned about infections from available contraception, such as the IUD:

As a result, women suffer from anemia. Their teeth fall out, they have genital problems, women’s diseases, osteoporosis, bone disease. They have problems during pregnancy. There are many miscarriages. She has one pregnancy after another – there is no planning, all her body weight is destroyed. She cannot travel the distance to mother and child health centers, so she must rely on UNRWA. UNRWA gives out free contraception, but many women do not think it’s good for them.
Another area of concern for refugee women has been the impact of the camp environment on women’s health (as noted by Kitam above). Older women suffered from rheumatism and arthritis. Living spaces were damp, roofs leaked, and many had no source of heat. Public sewage was exposed and open: there were garbage dumps which generated foul smells, insects and disease. If UNRWA had a holiday for three days, the camp became very dirty:

The stones here play a role because the streets are dirty in spreading diseases. They throw things into the street. There is no planning, no disposal, so it accumulates.

The situation here now is really bad, the humidity, the garbage … all of this can lead to cancer … Three years ago the sewage was open … we had to gather money and give it to the people from City Hall to bribe them to give us a sewage system. Before that we had to go down to where the water was flowing and throw it there.

The Ministry of Social Development divided the camp into two areas, higher and lower. At the lower end of the camp there is a stream of water, and they have problems from trash in the stream, flies, mosquitos. In the winter, when it rains, it floods into the houses, polluted water, wrecking houses and destroying furniture. The government didn’t do anything, UNRWA didn’t do anything – only gave us blankets and sandbags. Only last year the government made pavements and they don’t flood.109

A national housing survey showed 66.7% of all camp households had water piped into their homes; 13% used public water taps, 17% brought water from commercial tankers, 2% used other sources. The average per capita daily supply of water was 8.96 liters, less than the average 24 liters for Palestinians in the region, and far below the Jordanian average of 98–110 liters. Camps were not well lit, a problem especially for women who worked outside the camp and returned after dark. Sewage systems were installed in some camps in the late 1970s, but, as several women interviewed remarked, they were not adequate. Contractual arrangements with municipalities and private firms had improved refuse collection and disposal, but, again,
according to the women interviewed, these services were not adequate, and stench was a problem:

The city has control over the water system and sewage ... the government was really very lazy in giving these services so they only gave the water system in the seventies, and the sewage system in the eighties.\textsuperscript{110}

In spite of on-going conditions in the camps negatively impacting women’s health, over the 30 years she had worked as a nurse in the camp, Umm Abdullah had seen a decrease in some diseases, for example blood diseases. While she pointed to a high rate of malnutrition among women, she noted that fewer children died of malnutrition because of UNRWA.

The ambivalent attitude of most refugees toward UNRWA, inevitable given the complex politics supporting and threatening UNRWA’s relief efforts for refugees, became heightened after the Oslo Accords of September, 1993. These Accords included a provision that the work of UNRWA be turned over within five years to the Palestine Authority, the governing body of newly defined areas of Palestinian autonomy in the West Bank and Gaza. Given the uncertain future, Umm Abdullah was concerned about UNRWA services decreasing in Jordan. Once again, women emphatically took a stand, joined by UNRWA employees:

There was a sit-in for women a week ago, they were demonstrating against cutting the services. Nearly 100 women were involved in the demonstration. The government can’t take over health services, because even for the people the government is serving it’s not able to cover their basic needs.

The sit-in took place at the United Nations, headquarters of UNRWA, in Shmaysani. Women will plan another one if they start cutting funds. Minimal services are not being given to people due to the political situation. Women are connected to the Jordanian Women’s Union – I am on the Board of Directors of the Union as well as connected to women’s organizations of political parties.

And employers who work within UNRWA in charge of employees called a sit-in. Committees within UNRWA who
are in charge of the employers – they called for a sit-in. They did this before when they said they were not going to get any raise, because usually they do. They are joining forces with the employees of UNRWA because UNRWA offers services and within the camp at the same time that they cut the budget it affects the workers and the people who benefit from the services.\textsuperscript{111}

Rema’s and Umm Abdullah’s discussions of the involvement of women in resistance work, within and outside of prescribed gender roles, portrayed women as political actors in the course of historical events leading up to Black September and after. Women have defined political objectives in their own formal organizations, and as ‘arms’ of official male bureaucracies. Although never recognized in Jordan, the General Union of Palestinian Women (of the PLO), founded in 1965 in Jerusalem, created chapters and offered services in refugee camps, including literacy classes and military training.\textsuperscript{112}

Literacy is another factor affecting women’s health. As described earlier, a noteworthy achievement of UNRWA has been education for the generation coming into the camps as children and born in the camps. In addition, women themselves have organized to provide literacy training. Umm Abdullah was knowledgeable in describing the situation in the camp:

This generation is all educated, that’s one thing. The dropout rate within Amman is very low, but outside the city it is higher. This generation has much awareness about their right to education – that they have the right to be educated. Outside the city the families prefer to educate their sons

From grades one to six, which is considered the basic that they have to learn, 80\% are educated. As the camp population gets older it goes to 50 percent. Only 25\% have a basic high school education. Umm Ramzi is 47, she finished grade six when she first came here. Five percent of older women go back to school.

There are literacy campaigns, and they are done by the government during the summer, in the afternoon. It is very important for them because ... one woman 60 years old went back to school in order to read the Koran. And
they want to learn to read street signs. To know the names of the streets. The [literacy] class is given for 40 students every summer, every summer they [the students] change.\textsuperscript{113}

When I asked Umm Abdullah if literacy would give women options for leaving unhappy marriages, when, for example, they suffered from domestic violence, she noted:

In this area there are problems of domestic violence, father, brother. People are in close contact with each other – and I’ve been working in this area for thirty years, so people have this grassroots connection with each other, so if there is a family problem everybody helps.\textsuperscript{114}

Another refugee, Umm Ramzi, concurred, presenting another example of the efficacy of women’s networking:

Sometimes when there is a family problem, Umm Mohammed herself comes, she knows the family and she intervenes, she talks to the man of the house and she discusses it without going to the law, especially if there are children – so people maintain social bonds, if they can solve the problem.\textsuperscript{115}

The history of women’s organizing in Jabal al-Hussein camp was described by another woman, Nahid. Although some of her brothers discouraged her activism, others supported it. She went to demonstrations and sit-ins, spreading awareness, creating literacy classes, involving women in International Women’s Day events. Nahid dated women’s political involvement to Black September, after so many men had been jailed or killed:

What I’ve heard is that from the beginning the situation was very difficult for everyone. And there were some specific groups that the government was not happy with, and was not happy with them being in the camps. The Palestinians have different political affiliations, and they were also involved in the movement of the \textit{fedayeen} regardless of what affiliation they had, so they had certain groupings within the camp that this belonged to this group, or
that group, and they had weapons at that time. They had tensions and they used weapons against each other. The women might have been an indirect support, but not seen. Women began to organize in the camp after that period. Even before that they could be a part of anything they wanted ... they just went there, even for training camps so they could learn how to use weapons. They had tunnels dug and they had places where they used to teach you how to fight, self defense.

The shebab (young men) tried to enroll women in the clubs, but the women were always cursed with resentment from the social surroundings and also the political situation with the government. After Black September, the men started to involve their sisters and wives due to circumstances. Social tradition would stand in the way and illiteracy. Even now the society does not accept a woman to go around and work in the camp, either on social issues or political issues.\textsuperscript{116}

The political involvement of Palestinian refugee women has taken many forms. Some women joined the fedayeen (freedom fighters) in Palestine, and many lost their lives. Others had to struggle for years to convince family members that their activities were necessary to the nationalist struggle. Organizing through the medium of health care is effective, because women healers have always been respected members of their communities. Many women in the camps are too concerned with their own problems to support other women, but when it comes to a collective issue in the camps, they take a stand together, as Kitam describes:

The legal boundary of the camp is the upper side. This piece of land belongs to a man, and people when they came after the war there just stayed in different houses without regulations. So this man found out that the government is interested in retaining this land and came to the people and wanted to get them out of here, so he can sell it and make a profit. And the government doesn’t want to pay any compensation to the families here. So that was one of the incidents when all the families stuck together. After the Gulf War the women got together and went to the Palace
... to the Parliament. He took us to court, took papers, telling us you either buy the land or you leave. And we went to the Parliament, and nobody helped us. He keeps coming and giving the papers from the court, but we just tear them up and ignore it.

Women organize by word of mouth. All of them said he came to the houses and knocked and said you all have to leave, so everybody was upset. They were telling him wait a couple of years and we are going to the West Bank, we’re going back home, and you’ll get your land back, and he said, no – you’re not going back home and I know. Nothing has changed. The conditions are the same. There would be a solution if we bought our house or if they give us material compensation, but nothing.¹¹⁷

**Conclusions: The Necessity for Cooperation Among Women Worldwide**

Palestinian refugees, women and men, living in camps in Jordan, have deployed a wide range of resources, politics, and strategies for survival. Nonetheless, most comprise a new proletariat.¹¹⁸ They experience limited work options, high levels of unemployment, and restrictions on available vocational centers. Most men are laborers, and women are confined to low paying work or are unemployed while performing unpaid labor of maintaining daily life and health. The majority of refugees subsist on welfare services.

UNRWA health services have been effective in controlling epidemic diseases, including those caused by the 1948 Arab–Israeli War, which precipitated the creation of UNRWA. The Agency is a major source of employment for Palestinian refugees, education for refugee children, and the provision of vocational training. UNRWA programs facilitate transition to a new social, economic, and political system in a period of institutional change characterized by imperialism and state building in the region. Definitions or redefinitions of health based on modern scientific indicators, and the development of health systems, are central to these processes.

Defined in gender-neutral terms, the designation ‘refugee’ conceals the problems that women describe in their stories. It
conceals the particular relationship of women to historical processes of war, citizenship in the modern nation state, relief efforts, work, land, and development processes.

Historian Rashid Khalidi explains Palestinian’s objections to the term ‘refugee,’ preferring the term ‘returnee,’ symbolically affirming the right of return to Palestine. Most women I spoke with in refugee camps said that the right of return was the single most critical factor affecting their health. But if return to Palestine is to signal an end to a life of poverty, environmental degradation, and loss of control over health practices, then the meaning of the right of return itself must be reconceptualized from the perspective of women’s historical experience.

The historical experience of women refugees is unique because of the many ways that women already fit the definition of the refugee. Palestinian women were subject to violence through customary practices and foreign intervention because they are women. The right of return is embedded in a system of gender relations that disadvantages women. Women refugees in Jordan’s camps, coping with poverty and frustration, stand as a living symbol of the critical need to address women’s health in the context of the gender, race, and class politics dominating the globe. Aspects of those politics were defined by Palestinian women refugees when asked to talk about women and health. They spoke about poverty, about lack of control over reproductive health, about rape, and about resistance.

All women interviewed for this study constructed the present through remembering the past. Remembering became an affirmation of group cohesion and of resisting and overcoming obstacles in the present. Health was a metaphor for homecoming, a confirmation of the intersection of personal and political realities.

The Palestinian women interviewed defined health as being shaped by economic, political, and social factors. Their model of health moved beyond the biological to emphasize interconnections between disease factors and history. They addressed health issues within the larger context of Palestinian women’s social subordination, both exacerbated and in some ways overcome in their new setting. As they defined health, they defined a set of ethics about ruler and ruled, about sharing resources, about the right of shelter, nutrition, and work – about Palestinian women’s right to self-determination. Their knowledge base was constitutive.
of community as it was constructed by community in the struggle for survival. And some connected their struggle for survival with the necessity for cooperation among women worldwide:

Through societies, unions, committees, through cooperation with women from abroad, women can contribute to solving the problems of the present situation, addressing and having the right of return. We would like to get names of such organizations from other countries, so we can explain what women in the camps want, the needs of women and children, to solve problems of poverty in the area. And we want to have communication between women to have an exchange of opinions of how they can work together to achieve this goal.
NOTES

Preface

2 See Young, *Keepers of the History*, Chapters two and three.
3 See, for example, Aaron Glantz, ‘Jordan’s Sweatshops: The Carrot or the Stick of US Policy.’ Special to Corpwatch, February 26, 2003 (http://www.corpwatch.org).
4 SAWA, *All the Women Together Today and Tomorrow*. June 2008. That this report was published at all was groundbreaking.
6 Griot (masculine) and griotte (feminine) (with origins in West Africa, and spreading to incorporate itself in the tradition of many other societies are ‘keepers of the history’, delivering history in the form of poems, psalms, songs of praise, as oral history recitation. See Thomas A. Hale, *Griots and Griottes: Masters of Words and Music* (Indiana: Indiana University Press, 1998).

Chapter 1: Introduction

1 Dr. Salwa Najjab-Khatib, ‘Notes on Women in Occupied Palestine’. (1989), unpublished paper.
5 Ibid., 6.
6 Ibid., 9.
7 Ibid., 23–4.
9 Rahman, ‘Islam and Health/Medicine,’ 149.
12 I interviewed Hajj Anisa Shokar in her home in Amman, Jordan, in March, 1995, for this study. See also Gabbay, *A Political Study*, 115.
16 Morsy, *Gender, Sickness, and Healing*, 18.
17 Morsy, *Gender, Sickness, and Healing*, 18–19.
20 Ibid., 86.
21 Ibid., 56.
22 Ibid., 81.
23 Ibid., 57.
24 Ibid., 81–2.
25 Ibid., 82.
26 Ibid., 91.
28 Morsy, *Gender, Sickness and Healing*, 157.
29 See Ibid., 204.
31 Morsy, *Gender and Sickness*, 18–19.
33 Ibid., 50.
34 Ibid., 51–2.
35 For one such study with a comprehensive bibliography, see Linda Alcoff and Elizabeth Potter, eds., *Feminist Epistemologies* (New York: Routledge, 1993).
37 Ibid., 222.
38 Ibid., 222.
39 Ibid., 223.
40 Ibid., 223.
41 Ibid., 224.
42 Ibid., 226.
44 Rosemary Sayigh, ‘Roles and Functions of Arab Women: A Reappraisal,’ *Arab Studies Quarterly* 3 (3):258.
46 Feminist philosopher Lynn Hankinson Nelson points out that agents of epistemology are not isolated, and she develops a typology asserting that communities are the primary generators and repositories of knowledge. See Lynn Hankinson Nelson, ‘Epistemological Communities,’ in Alcoff and Potter, 1993.
49 Ibid., xxviii.
50 Ibid., xxviii.
51 Ibid., xxvi.
52 Ibid., 6.
53 Ibid., xxx.
Chapter 2: Imperialism and Health

4 Ibid., 1.
7 Ibid., 9–10.
9 Ibid., 48.
12 For example: ‘Native use was non-use, native lands were empty and “void,” and could be defined as valueless, free, “nature,” to be “justly” appropriated. New colonies are now being created, carved out by reductionist thought, capital and profit, controlled by patriarchal might.’ (Mies, 1993: 32)
A Department of Health annual report on Palestine in 1926 notes that The Dentists Ordinance of 1926 ‘supersedes the previously existing but inadequate Ottoman laws and the clauses in Public Health Ordinance No.1 of May 1918, with regard to the practice of dentistry in Palestine.’ The Ordinance was concerned with regulating the practice of dentistry and limited grants of licenses to persons who had studied for a period of at least three academic years in a recognized dental or medical school, and it allowed grant of permits at the discretion of the Department of Health. (Department of Health, Annual Report: Palestine 1926, 44). The Ordinance, mimicking the age old practice of hisbah (by means of which charlatans were eliminated from medical practice) was clearly a vehicle for British control of medical practices. It is possible that, as with other Ottoman laws, the British utilized an already existing practice to their benefit.

Palestinian doctors (and their patients) also benefited from association with the new Department of Health given availability of medical supplies (drugs, disinfectants, dental, surgical and medical appliances and apparatus; optical appliances and surgical and dental dressings) exempted from customs duties by Ordinance in 1924. (Department of Health, Annual Report: Palestine 1926), 44.


Ibid., 12.


Interview with author, Amman, Jordan, April, 1995.

Swedenburg, *Memories of Revolt*, 147.


Hammami, ‘Between Heaven and Earth,’ 245.


Ibid., 30.

Ibid., 31.

Ibid., 9.

Ibid., 9.

Ibid., 9.

Ibid., 10.

Ibid., 10.

Ibid., 11.

Ibid., 12.

Ibid., 59.

Ibid., 59.

Ibid., 59.

Ibid., 59.

Ibid., 59.

Ibid., 58.

Ecologist Rosina Hassoun, discussing environmental issues in the Israeli–Palestinian conflict, maintains that differences in agricultural practices between Israelis and Palestinians are due to differing paradigms of nature: ‘The differences in the paradigms between the Palestinians and Israelis can be traced through their treatment of natural resources. It influences their actions towards nature and each other. In some ways their dueling paradigms parallel worldwide conflicts between developed and developing countries.’ (Hassoun,
Hassoun notes that: ‘Palestinians have followed historical patterns of crop rotation, collective and private land ownership, share cropping, and multicropping (more than one use or one crop per land area) like grazing animals or planting vegetables between olive trees. These traditional patterns represent deeply ingrained generational practices … ’ (Hassoun, 1993:5).

Rachel Carson noted that ‘resistance of the anopheline group of mosquitoes to insecticides created by the thoroughness of the programs designed to eliminate malaria … surged upward at an astounding rate … in dangerous malaria vectors such as the Middle East’ (Carson, 1962: 269).

Chapter 3: Between Daya and Doctor

1 ‘Petition to the Senior Medical Officer,’ (Israel State Archives, Department of Health Office, Jerusalem, July 12, 1937).
2 ‘The inspection and supervision of Midwives,’ (Israel State Archives, Department of Health Office, Jerusalem, July 12, 1937) 1–2.
4 Ibid., 74–5.
5 Ruth Frances Woodsmall, *Moslem Women Enter a New World* (New York; Round Table Press, 1936), 287.
6 Ibid., 287.
7 Ibid., 288.
9 Bramall and Towler, *Midwives in History*, 44.
10 For a detailed discussion on the history of midwifery in England, see Ibid.
15 Development of Public Health Nursing practice as related to the health needs of the Jewish population in Palestine, 1913-1948, Tel Aviv University, Sackler School of Medicine, 1977.
16 Ibid., 138–9.
24 ‘The inspection and supervision of Midwives,’ (Israel State Archives, Department of Health Office, Jerusalem, July 12, 1937).
25 Woodsmall, Moslem Women, 329fn.
26 Stockler, ‘Development of Public Health Nursing,’ 76.
27 Department of Health, Annual Report: Palestine 1928, 64.
28 Department of Health, Annual Report: Palestine 1928, 64.
30 Woodsmall, Moslem Women, 331.
36 Ibid., 15.
42 Office of the Assistant District Commissioner, Hebron (Israel State Archives, Jerusalem, October 31, 1946, No. VW/39/1).
Notes

43 Letter from the Senior Medical Officer to Assistant District Commissioner, Hebron (Israel State Archives, District Health Office, Jerusalem, November 1946).


46 Letter to Mukhtar of Bab El Silsilah Qts., Old City, Jerusalem, from Director of Medical Services (Israel State Archives, Jerusalem, April 1947).

47 Petition to Superintendent of Medicine, Jerusalem, from Labibeh I. Nassir, Certified Midwife, Romema, (Israel State Archives, Jerusalem, September 26, 1935).

48 Department of Health, Government of Palestine (Israel State Archives, Jerusalem, June 1927).

49 Ibid.

50 Ibid.


52 Hajj is the pilgrimage to Mecca, the holy city of Islam in western Arabia. Pilgrimage is the last of the five pillars of Islam, and fulfillment of religious obligation.


56 Ibid., 17.

57 Ibid., 21.

58 Ibid., 21.

59 It is important for the reader to know that when interviewed, the Director of UNRWA Health Services in Baqa’a camp spoke in glowing terms of the training program for midwives, but refused to allow me to interview dayat. He also discouraged me from pursuing my interest in informal health practices initiated by lay women in the camp, denying that any such practices existed. It was through the Jordanian Women’s Union that I was able to contact and interview dayat in Baqa’a and Jabal al-Hussein camps.


61 Conversation with daya, Baqa’a refugee camp, April, 1995.

62 Conversation with daya, Baqa’a refugee camp, April, 1995.

Chapter 4: ‘The Camp of Return’

2 Ibid.
3 Ibid.
7 Elia Zureik, Palestinian Refugees, 32–3.
9 Ibid.
11 Ronald Gabbay, A Political Study, 115.
13 Gabbay, A Political Study, 115.
14 R. Hammami notes that the Clapp Commission, headed by Gordon Clapp of the Tennessee Valley Authority, became known among Palestinians as Lajnet Kilaab, ‘Committee of the Dogs’. It was supposed to redress the economic situation of the refugees when repatriation seemed unlikely (Hammami, 1994, 257).
20 Ibid.
21 Ibid.
23 Brand, *Palestinians in the Arab World*, 149.
36 Conversation with 42 year old Palestinian woman refugee born in Jabal al-Hussein refugee camp (who prefers to remain anonymous), Jabal al-Hussein refugee camp, March 1995.
37 Ibid.
39 Ibid., 9.
40 Ibid., 36.
41 Ibid., 36.
42 Ibid., 47.
44 In Palestine women were highly respected for their expertise in sewing, but in refugee camps women lost control over their labor power. This may change as more programs are established in Jordan by NGOs granting loans to women to produce traditional embroidery.
46 These included the Near East Foundation, American Medical Relief, Save the Children, UNESCO, American Friends Service Committee,
Church World Services, American-Arabian Oil Company, and Iraq Petroleum Company.


50 Sayigh, *Too Many Enemies*.

51 Ibid.


53 One Palestinian woman interviewed, Kitam, told me that milk and cod liver oil reached the schools in Jabal al-Hussein camp once or twice a week.


55 Ibid., 134.


58 Ibid., 62.

59 Ibid., 71–111.


61 Ibid., 8.

62 Ibid., 9.

63 Ibid., 57–9.

64 Zureik, *Palestinian Refugees*, 126.


66 Ibid., 149.

67 Ibid., 150.

68 Ibid., 150.

69 Ibid., 149.

70 Ibid., 149.

71 Ibid., 150–1.


73 Rosemary Sayigh, ‘Palestinian Identity.’

74 Interview with author, April 1995, Amman, Jordan. From a conversation with a refugee of 1948, now living in the upper class sector of Jordanian society.

75 Ibid.

76 Personal communication, March 1995, Jabal al-Hussein refugee camp. From a conversation on the outskirts of Jabal al-Hussein.


78 Interview with author, March 1995, Jabal al-Hussein refugee camp.

79 A harbor city on the eastern Mediterranean coast of Palestine with a heterogeneous population.
The village of Deir Yassin was located near Jerusalem. On April 9, 1948, a massacre of its Palestinian civilians was carried out there by soldiers of Irgun and LEHI, both Jewish underground militia organizations.

Interview with author, March 1995, Jabal al-Hussein refugee camp.

Ibid.

Ibid., from a conversation with a mother of eight from Baqa’a camp.

As of this writing, Jordan has a population of 5,439,000, (2,653,000 girls and women), and a population density of 55.6 km.


Israel and Jordan, Treaty of Peace Between the State of Israel and the Hashemite Kingdom of Jordan, signed on the Israeli–Jordanian border, October 26, 1994. Regarding health, the Treaty states: ‘... The Parties will cooperate in the area of health and shall negotiate with a view to the conclusion of ratification of this Treaty.’


Ibid.

Ibid.

Ibid.

Ibid.

Ibid.

Interview with author, April, 1995, Baqa’a refugee camp, Amman, Jordan. From a conversation with a Palestinian woman, 44 years old, refugee of 1967, living in Baqa’a refugee camp on the outskirts of Amman, Jordan.


Ibid.

Ibid.

Ibid.

Ibid.


Mona Khalidi notes that historically the data on infant mortality in Jordan has been ‘the most sloppily recorded demographic indicator of the country,’ and ‘estimations have been far from complete.’ (Khalidi, 1992, 73).


106 Ibid., 2.

107 Ibid., 5.


109 Ibid., from a conversation with a mother of eight from Baqa’a camp.

110 Ibid.

111 Ibid.


113 Interview with author, March 1995, Jabal al-Hussein refugee camp.

114 Interview with author, March 1995, on the outskirts of Jabal al-Hussein refugee camp.

115 Ibid.


117 Interview with author, April 1995, Jabal al-Hussein refugee camp. From a conversation with a mother of eight from Baq’a camp.

118 Sayigh, ‘Palestinian Identity.’


120 The third article of the Oslo Agreement upholds the right of Palestinian return, but the refugee issue has been deferred to the final status talks.

121 Interview with author, March 1995, Jabal al-Hussein refugee camp.
ADDITIONAL RESOURCES

The following is a set of additional resources on women, health, and refugees available at the time of publication.


—. 2006. ‘Are They Human Children or Just Border Rats?’ *Boston University Public Interest Law Journal* 187.


Hear, Nicholas Van, and University of Oxford International Development Centre. 1995. ‘The Impact of the involuntary mass ‘repatriation’ of
Palestinians to Jordan in the wake of the Gulf crisis.’ Centro studi luca
d’agliano: Queen Elizabeth House Development Studies Working
Papers, no. 84.
Khawaja, Marwan. 2004. ‘The extraordinary decline of infant and child-
hood mortality among Palestinian Refugees.’ Social Science &
Medicine 58, no. 3 :463, http://search.ebscohost.com
——. 2003. ‘The fertility of Palestinian women in Gaza, the West Bank,
libaccess.sjlibrary.org/
Khawaja, Marwan, and Rana Barazi. 2005. ‘Prevalence of wife beating
in Jordanian refugee camps: Reports by men and women.’ Journal
ebscohost.com
‘Attitudes of men and women towards wife beating: Findings from
Palestinian refugee camps in Jordan.’ Journal of Family Violence 23,
no. 3: 211–18, http://search.ebscohost.com
ebscohost.com
Pappagallo, S., and D. L. Bull. 1996. ‘Operational problems of an iron
supplementation programme for pregnant women: An assessment of
UNRWA experience.’ Bulletin of the World Health Organization 74 (1),
no. 01: 25–33, http://search.ebscohost.com
Pommier, Sophie. 1994. ‘Jordanie: Sur le fil de la paix.’ Politique interna-
and the Palestinians: The fateful triangle / Jordan in transition / seeds
of hate: How America’s flawed Mideast policy ignited the jihad / the
Jordanian-Israeli war: 1948–1951 / the Levant: A fractured mosaic / the
Palestinian impasse in Lebanon: The politics of refugee integration.’ The
Qutaishat A. and Mahmoud, L. 1993. Palestinian Refugee Camps in
Jordan, Status Report and Data Base. Amman: UNICEF.
Rees, Gareth. 2001. ‘A personal experience of the Israeli-Palestinian
ebscohost.com
Sabatinelli, Guido, Stefania Pace-Shanklin, Flavia Riccardo, and Yousef
Shahin. 2009. ‘Palestinian refugees outside the occupied Palestinian
territory.’ Lancet 373, no. 9669 (03/28): 1063–5, http://search.ebsco-
host.com


BIBLIOGRAPHY


——. Draft Regional Plan of Action for Advancement of Arab Women to the Year 2005.

——. El-Sohl, Camillia. Women and Poverty in the ESCWA Region, Issues and Concerns.


——. ‘Women and the State in Jordan: Inclusion or Exclusion?’ Unpublished ms.


Davis, Uri. 1995. ‘Jinsiyya versus Muwatana.’ *Arab Studies Quarterly* 17, nos. 1 and 2: 19–50.


Hassoun, R. ‘Save the Musht (and the Land of Palestine).’ The Link, 26, No. 4, October/November 1993: 1–12.


Keizer, B. 1989. ‘Women in Black.’ *The Other Israel* 38, no. 9.
Bibliography


Bibliography


United Nations Relief and Works Agency for Palestine Refugees in the Near East:


—. UNRWA, An Investment in People.

—. UNRWA in Jordan.

—. UNRWA in Figures.


Archival Sources


Rockefeller Foundation Archives, Tarrytown, N.Y. (RFA) RG Series 8251.

New York Public Library


—. CO 83143 77103, 1937, no. 77103, no. 14A66.
—. Despatch no. 116, Reference no. T/292/34.
—. Despatch no. 87, Reference no. T/479/34.

Protestant Episcopal Church, U.S.A., Conference of the Mediterranean and Middle East Bishops, Lambeth Palace, July 2–5, 1951.

Interviews by author, January 1995–April 1996

Abdullah, Umm. In Jabal al-Hussein refugee Camp, Amman, Jordan.
Canaan, Dr. Taber. Historian, in Amman, Jordan.
Dayat (3) (anonymous) in Jabal al-Hussein refugee camp, Amman, Jordan.
Dayat (3) (anonymous) in Ba’qa refugee camp, on the outskirts of Amman, Jordan.
Director of Health Service, UNRWA, Baqa’a refugee camp, on the outskirts of Amman, Jordan.
Hammad, Rana. Director of Hospice, Amman, Jordan.
Hamzeh, Dr. Zeid. Physician, former Minister of Health, in his office in Amman, Jordan.
Hijazi, Safia. Director, Save the Children, in her office in Amman, Jordan.
Ida. In the offices of the Jordanian Women’s Union, Amman, Jordan.
Khatib, Maha. In her office at UNIFEM, Amman, Jordan.
Nusseir, Shadia. Chief Coordinator, Coordinating Office for the Beijing Conference, in her office in Amman, Jordan.
Sabbagh, Amal. CADRE, Regional Centre on Agrarian Reform, in her office in Amman, Jordan.
Saleh, Firial. Hai Nazal Development Center, Amman, Jordan.
Salibi, Dr. Kamal. Historian, Amman, Jordan.
Shaheed, Maha. In her office at UNICEF.
Sharbeh, Baraster Zahra. In her office in Amman, Jordan.
Shokar, Hajj Anisa. In her home in Amman, Jordan.
Staff, Queen Alia Social Welfare Fund, Amman, Jordan.
Staff, Queen Nur Foundation, Amman, Jordan.
Staff, Sweileh Development Center, Sweileh, Jordan.
Tell, Ruth. Public health specialist, in her home in Amman, Jordan.
Tujuni, Dr. Nevin. Physician, in her home in Amman, Jordan.
Ramzi, Umm. In Jabal al-Hussein refugee Camp, Amman, Jordan.
Zuabi, Raeda al–. In her office at UNICEF, Amman, Jordan.
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