Cult Med Psychiatry (2008) 32:328–357
DOI 10.1007/s11013-008-9098-y

ORIGINAL PAPER

Building the Infrastructure, Modeling the Nation: The Case of Birth in Palestine

Livia Wick

Published online: 17 June 2008

Abstract This article explores the intersection between the professional politics of medicine and national politics during the second Palestinian uprising, which erupted in 2000. Through an analysis of stories about childbirth from actors in the birth process—obstetricians, midwives and birth mothers—it examines two overlapping movements that contributed to building the public health infrastructure, the movement of *sumud* or steadfastness (1967–87) and the popular health movement (1978–94), as well as their contemporary afterlife. Finally, it deals with relations between medicine and governance through an analysis of the interpenetration of medical and political authority. The birth stories bring to light two contrasting visions of a nation in the context of restrictions on mobility and a ground chopped up by checkpoints. The quasi-postcolonial condition of Palestine as popular construct, institutional protostate organism, and the lived experience of its experts and of its gendered subjects underlie the ethnographic accounts.

Keywords Public health · Nation-building · Palestine · Childbirth

Introduction

This article is intended to clarify the relationship between health and nation-building in Palestine. Based primarily on interviews with professionals and participant observation in hospitals and clinics, it examines two overlapping movements that contributed to building the public health infrastructure in the occupied Palestinian territories, including the West Bank, East Jerusalem and the

L. Wick (✉)
Department of Social and Behavioral Sciences, American University of Beirut, Beirut, Lebanon
e-mail: lw01@aub.edu.lb

Gaza Strip.[1] The first is that of *sumud* (steadfastness), which took shape in the period between the 1967 occupation by Israel of the West Bank and Gaza and the outbreak of the first *intifada* (uprising) in December 1987.[2] The second is that of the popular health movement, which emerged in 1978 and flourished throughout the pre-Oslo period, notably the years of the first *intifada*, lasting until 1994.[3] The oral histories themselves, however, are situated in their moments and places of telling, namely, the second *intifada*, which erupted in 2000,[4] with a ground now chopped up by checkpoints and thus divided into isolated geographical minisections. Through an analysis of the circulation of the oral histories, I show how medicine is a site where political conflicts are played out. The article thus explores the intersection between the professional politics of medicine and national politics in contemporary Palestine.

Understanding the Field

I began my research in 2002, focusing on childbirth and everyday life in the central West Bank (more particularly, the Ramallah and Jerusalem regions). I had come to the field interested in the ways in which the conditions and experiences of birth had changed during the second *intifada*, with its new restrictions on mobility, the closure and a deepened economic crisis. The term "closure," *taskir* in Arabic, requires elucidation. Closure refers to the Israeli policy of separating Palestinian towns from each other. It is a state of geographic isolation imposed over parts or all of the occupied territories. Decreed by public or unannounced military orders, closures may last a few hours, days, months or decades, depending on place. The separation of Palestinian regions from one another is effected through the instrumentality of military checkpoints. The Arabic word for checkpoint is *hajiz* (plural *hawajiz*), although increasingly the Hebrew word *mahsum* (Arabized broken plural *mahasim*) is used in popular parlance. The system thus consists of a policy—closure; a modality—checkpoints; and an effect—isolation. Countervailing resistance strategies have been predicated on *sumud*, or steadfastness, in the face of the policy, argumentation to challenge the modality and ruse to break the isolation. Psychologically and economically, communal agency is directed toward self-reliance.

[1] Israel's internationally recognized borders are those of June 4, 1967, preceding the occupation of Arab lands, including East Jerusalem, the West Bank and the Gaza Strip.

[2] The *intifada*, or so-called revolution of the stones, broke out in Jabalia refugee camp, the largest one in Gaza, and quickly spread to the rest of the occupied territories. It was a mass movement that eschewed the resort to weapons. Within months, Israel and the international community had accepted that there would have to be changes made to the status of the Palestinians.

[3] The "Oslo accords" were signed by Israel and the Palestine Liberation Organization (PLO) on September 13, 1993, on the White House lawn, and the autonomy regime they called for entered into force the following summer.

[4] This uprising, the so-called al-Aqsa *intifada*, differed from the first one in the Palestinians' willingness to resort to violence in their quest for national self-determination.

The process of imposing long-term closures by means of roadblocks began during the 1991 Gulf War when free access to Jerusalem was interrupted, never to be reinstated. Indeed, it was systematized at the very time the government of Prime Minister Yizhak Shamir and the Palestinian delegation headed by Dr. Haidar Abd-al-Shafi began to meet following the Madrid Peace Conference. During the early and mid-1990s, when negotiations with Palestinians appeared to show that they might culminate in the creation of a Palestinian state, it became important for the Israeli government to isolate Jerusalem from the rest of the occupied territories, thus establishing facts on the ground by precluding its consideration for sharing between the parties. Hence the initial importance of checkpoints, which were set up on all main roads leading to Jerusalem and, following a similar logic, then also separated Gaza from Israel and thus the West Bank, mandating special permits to go back and forth. In 1994, after the massacre of Palestinians in the Hebron Ibrahimi mosque and the subsequent first Palestinian suicide bombings in Israel, closures were further strengthened and geographically broadened (to include Jericho, Jenin, Nablus, Ramallah and so on, for varying periods of time). Having begun as the closure of a vital city (Jerusalem), the policy was in a sense inverted, and came to encompass the occupied territories as a whole.

Since September 2000, the Israeli army, intent on crushing the *intifada*, has generalized the use of hundreds of checkpoints throughout the occupied territories, making it as difficult to go from one village to another as it had long been to get to Jerusalem. Types and length of closures vary depending on place and time. But all West Bank roads are dotted with checkpoints. During periods of heightened military activities, closures were accompanied by blanket curfews, imposed and lifted over time and in various places, thus applying the policy to all outside space for Palestinians in the occupied territories (but only rarely in occupied East Jerusalem). During the two major military incursions into Ramallah in 2002, it was risky to stand indoors in front of a window while the city was under curfew. During a July curfew, on the other hand, children could play soccer in the streets. The term closure in Palestinian public discourse, and also in military practice, thus encompasses a graded *set* of measures. Historically they began with the placing of Jerusalem and Israel out of bounds, and were thus closures of destinations. As we have seen, they became, by stages, closures of places of residence, towns or even houses (when curfews were in force). Checkpoints (and, in the case of curfews, mobile military patrols) were the means whereby these policies were carried out.

In this context, it depends very much on the ID or passport one holds, whether, to what extent and at what speed one may pass through the checkpoints and move through the occupied territories. The most effective document is a foreign passport, as long as the family (and, to a lesser extent, the first) name is not an Arabic one, in which case one falls into a less privileged category. After that comes the Jerusalem ID, held by Palestinians officially residing in greater Jerusalem (the area annexed following the 1967 occupation). Next comes the West Bank ID, and finally, Gaza. There is also a fluctuating order of priority, as between West Bank regions, depending on whether and where collective punishment is being imposed for security infractions. Since I held a foreign passport, it remained possible for me, to a certain extent and in the absence of curfews, to move through the maze.

Individuals, Institutions and Networks

When I first started exploring birth and medicine during the closure, people spoke to me about particular social and medical movements that were understood to be at the heart of the health infrastructure in Palestine. I had expected to be confronted more directly with state practices (be it those of the occupation or of the Palestinian Authority [PA]) and the formation of individual subjectivities. Instead, I was struck by the importance people attached to movements as units crucial to understanding the medical component of the ongoing history of Palestinian state- and nation-building.

It is for this reason that I decided to start by engaging with the particular set of social movements and health care. What I present here is ethnographic material regarding two movements that have yet to be written about in any depth. The interviews in this article[5] were gathered at a major hospital in East Jerusalem and at a clinic and homes in the Ramallah area.

These overlapping movements in the Palestinian medical infrastructure, *sumud* and the popular health movement, are remembered as important moments in the history of the resistance against occupation and the process of nation-building (Cousin 2000; Barghouti 2005). While the interviewees were describing moments in the past, their accounts were interspersed with the experience of the situation on the ground at the time of their telling.

Institutionally speaking, I focused on two principal venues, Makassed Hospital and the Union of Palestinian Medical Relief Committees (UPMRC). Whereas Makassed represents an urban, technological model of health, the UPMRC, by contrast, symbolizes a decentralized, grassroots one. They nonetheless present clear parallels in their interpenetration with the political sphere at the ideological level, despite widely differing articulations of the nation, but also in their very structures, hierarchies and even leadership styles.

One of the main themes that the oral histories point to is the relationship between medicine and governance. Most of the literature on this topic has focused on the ways in which medical practices and discourses have produced different regimes of health and control. This scholarship has examined the production of medical knowledge in the construction of differences of race, gender and sexuality (Stoler 1995, 2002), the emergence of medical specializations in the metropolis applied to the study of the colonies (Arnold 1993), medicine as a site involved in the production of a gendered nationalist discourse (Ginsburg and Rapp 1995; Inhorn 1996; Kahn 2000; Kanaaneh 2002) and recourse to the discourse of objectivity and science to justify political leadership (Adams 1998). In this piece, I focus instead on interactions between the medical profession and the Palestinian political authority through the construction of institutions, movements and networks. The presentation

[5] I conducted and taped 56 formal long interviews: with 20 birth mothers, 13 doctors/ public health officials, and 23 midwives/nurses/*dayat*. I also collected about 50 newspaper pieces about birth from two Palestinian daily newspapers, *Al-Quds* and *Al-Ayyam*. Most of the interviews were conducted in peoples' homes and offices. In addition, as part of my participant observation work, I carried out research and interviews at the labor units of Al-Makassed Hospital in Jerusalem and the Red Crescent Hospital in Ramallah. I have used pseudonyms for all the doctors and midwives I interviewed for this piece.

of the two cases reveals the ways in which doctors mobilized politically, and explores the question, "How is it that the figure of the doctor converged with that of the sovereign?"

Some of the answers to this question lead us through the history of governance. Michel Foucault has been the paramount influence in shaping the understanding of ways in which biology, medicine and governance interact. Foucault's (2004) concept of governmentality designates a distinctly modern form of rule that aims to govern more efficiently by rendering individuals capable of augmenting their own welfare. It has three interrelated elements: government, or the management of population; discipline, which concerns practices and techniques of rule; and sovereignty, that is, territory and laws. Building on Foucault's formulation of biopower and focusing on the third of these elements, Giorgio Agamben links the amalgamation of sovereign and medical power in Europe to the "biologized" notion of rights that emerged at the time of the French revolution. He argues that, with the postrevolutionary body becoming the site of rights from the moment of birth—that is, when the body became the ground of sovereign subjects—the sovereign is partially displaced by another figure, the doctor, the one responsible for the care of the body (Agamben 1998).

In his dissertation on doctors and sovereignty in Syria from the mid-19th to the early 20th century, Robert Blecher (2002) shows that in the Middle East, the notion of individual rights has a different genealogy specific to the region's history. Blecher demonstrates first of all that Ottoman governmentality differed from its European equivalent insofar as it departed from the fixation on the individual. The European state appeared to retract itself from certain realms to create seemingly "emancipated zones" where "individual rights" were articulated through "civil society." In the Ottoman Levant, by contrast, which included greater Syria and thus Palestine, Blecher identifies the new "social networks" of the early 20th century as crucial units with historical importance. These urban, civic, gender-based, national and professional *groups* of social actors may have been tied to the state but remained autonomous. Yet, despite this difference in focus, European governmentality, like its Ottoman variety, was mainly designed to protect the interests of the population. In the colonial context, on the other hand, European states used techniques of governmentality as tools of coercion in ways that violated metropolitan norms. Ottoman and post-Ottoman societies thus differ markedly from both Western and colonial models.

This important insight tends to suggest the need to view the Palestinian case (and probably others as well) in a particular light, one differing from standard academic treatment. Ever since Ernest Renan ([1882] 1998:32) and, more recently, Benedict Anderson (1991), the structural relationship that establishes the national entity has been seen as that which links the individual and the state, passing through the workings of print capitalism. While this triangle is relevant, it would seem that in post-Ottoman societies, there are other dimensions to be taken into consideration. In this context, professional corporations emerged from a social context in which, historically, nation building was not on the agenda. The historiography points overwhelmingly in the direction of continued loyalty to the Ottoman state in the Arab East until the outbreak of World War I. Therefore, and although we are

dealing with a simultaneously colonial and postcolonial context in Palestine, very specific, deeply entrenched sociopolitical elements have carried over from an earlier period in the medical sphere among others.

Arguably the most important body of work on colonial and postcolonial subjects has been carried out by the Subaltern Studies Group—whose historians have sought to recover subaltern subjectivity from the various epistemologies that have erased it (Spivak 1988). Building on Foucault's concepts, they pay close attention to the relationship between the state and the subaltern focusing on India (Guha 1988) but, in the process, establishing a model with many applications. In this spirit, Blecher shows that in the Middle East, networks and groups of individuals having similar characteristics (professional, charitable, civic, gender-based) need collectively to be understood as an additional actor not encompassed within the colonial and anticolonial dialectic and, therefore, as a unit of analysis endowed with historical agency.

It is with this specific analytical configuration in mind (neither metropolitan nor colonial) that the present piece explores the slow process whereby deeply rooted affinity groups and networks became an essential element of the still ongoing state- and nation-building process. In the light of these perspectives, and through an analysis of the functioning and role of the two models, I show that the medical profession is deeply intertwined with political authority, from the base to the apex of the pyramid of power.

Two Contrasting Models of the Nation

The first model of the nation is embedded in stories about the medical infrastructure and birth, as represented by Makassed Hospital in Jerusalem, the Palestinian hospital *par excellence*. The hospital can be seen as a microcosm of the successful nation, with its competent leader and spokesperson, the doctor; its hard-working, sacrificing citizens, the nurse, midwife and technician; its modern organization, sophisticated technology, successful operation, clean building and transparent financing.

The envisioned nation is here a classical Jacobin one: a centralized, republican nation in which the elites are chosen by the people and reflect the general will. It is also a positivist vision of the nation, in that technology provides the means for the solution to all social problems. This technocratic construct is based on a Western ideology with science at the apex of the system.

The second series of interviews, those concerned with the UPMRC and its afterlives, presents an alternate microcosm, based on a social-formations concept in which the Palestinian nation cannot be divorced from society and its components. Proponents of this model integrate all of the contradictions—notably those of class—in striving to extend the benefits of primary health care from the single institution of the hospital to the villages, camps and towns of Palestine in the form of clinics. This socially based vision of the nation incorporates the lessons of the socialist model, not as it was, but as it "should" have been practiced. Implicit in this

articulation of the nation through an alternative health system is the effort to save the socialist model by radically restructuring it.

As will be seen, both of these visions engendered internal dissent. In the end, both adopted vertical and paternalistic forms of operation. Implicitly the stories call for a considerable restructuring of the two visions of the nation.

Sumud at Makassed Hospital in Jerusalem

Genealogies of Sumud

Makassed sits on the Mount of Olives in Jerusalem. It has a capacity of 250 beds, about 45 percent of the hospital beds in East Jerusalem, and is staffed by 560 employees. It has nine departments of medicine. The department of obstetrics and gynecology is known throughout Palestine. In addition to normal and high-risk obstetric care, it provides gynecological surgery and has a well-known infertility and perinatology clinic. It is the main teaching hospital for doctors, specialists, midwives and nurses. It is affiliated with the first Palestinian medical school, established in 1994 at Al-Quds University. Prior to that time, all medical students were obliged to study and train outside of the country. Since 1988 Makassed also has provided a 4-year specialization program in obstetrics, where general practitioners train to be obstetricians and to pass the Jordanian Board Certification exam. Whereas up until the 1990s Makassed received patients from all over the occupied territories, with the tight closure[6] of Jerusalem, most Palestinians from the West Bank no longer have access to this referral hospital, and it mainly serves Palestinians from the immediate area. Since it is a nongovernmental, albeit charitable, hospital, the cost of treatment is considerably higher than at government institutions (which have been free of charge for childbirth services since the outbreak of the second *intifada*) but cheaper than equivalent services in the private sector. In addition, Makassed offers reduced costs according to household income. Many members of the professional elite obtain treatment there, as do poorer people. With its impressive technologies, its interest in medical education, its diverse clientele and its universalist aspirations, it is a working symbol of the Palestinian national movement's dreams.

In the early days of my research, I went to speak with a prominent obstetrician at Makassed, Dr. Rami. When I asked him what Makassed Hospital was like, he described its history as being intimately linked with that of *sumud*. The *sumud* policy of the PLO promoted a type of nonviolent resistance whereby Palestinians under occupation received material support from external sources as they endured difficult military and political measures and a harsh economic situation for the sake of their national future. The PLO and Arab governments sent funds to support local industries and services, thereby sustaining living conditions in the occupied

[6] The issue of the progressive closure imposed on the occupied territories, whose nature, intent and phases are sketched out above, has never been treated in a systematic fashion, although it is, yet today, arguably the most visible element of everyday life in Palestine.

territories. This was a response and challenge to the poor government services offered by the Israeli military's "civil administration," which controlled governmental health and educational institutions, in addition to various other offices.[7]

The *sumud* approach was rooted in Arab and Palestinian nationalism, which understood colonialism and military rule to be the major causes of poverty and the major obstacle to development. *Sumud*-linked donations were supposed to alleviate poverty and encourage Palestinians to stay put. In 1978 Arab leaders officially started the pan-Arab fund, *amwal al-sumud*, to be administered jointly by Jordan and the PLO, and called on Palestinians in the occupied territories to be *samidin* (steadfast).

Dr. Rami and other physicians, when discussing the genealogy of funding sources (well known throughout the country but regarding which there are very few records due to the illegal status of the PLO prior to 1993), were signaling the institution's connection to *sumud*, a source of prestige. The Arab states, through the *sumud* fund, had, they believed, been infusing the body social and thus the body politic with the means to survive, while different forms of resistance would hasten the demise of the occupation. Like the PLO itself, then, the hospital had seen a succession of donors in keeping with the ebb and flow of international politics. With its leadership and departments, Makassed was a microcosm of the "virtual state" and would someday fuse with it.

Makassed was one of the Palestinian hospitals considered financially stable. Dr. Rami explained that it had large debts but managed to cover salaries every month through received donations (another demonstration of *sumud*). At the time of our initial encounter in 2002, employees of the hospital had in fact not received salaries for a few months. According to Dr. Rami, this was a problem of liquidity, based simply on the delays caused by Israel and the PA in clearing the donations and passing them on to the hospital. The institution's continued limited resources and liquidity problems, however, suggested that it was not as stable financially as some portrayed it. It continued, nonetheless, with the payment of salaries, even when these were late in coming, something very few large institutions such as the universities could claim (World Bank 2003:45). Furthermore, the symbolic and historical importance of the hospital in Palestinian national thinking made it difficult to imagine that it may in fact have been in financial crisis or teetering on the edge of bankruptcy, just as the permanence of the PLO had, through thick and thin, been deemed axiomatic. Unlike the private hospitals that started to sprout in the mid-1990s and were then subject to the whims of economic and political changes, Makassed, it appeared, had the stability of a national infrastructure. In fact, while it had indeed managed to stay afloat over the years, the multiple changes in sources of funding illustrated the unstable political conditions with which Palestinian institutions had to cope. Describing the source of *sumud* funds, Dr. Rami noted:

[7] Between 1967 and 1994, the Palestinian health system was under the control of Israel's defense ministry, with the Officer for Health playing the role of minister. At public institutions, his prerogatives included the payment of salaries and the hiring and firing of Palestinian medical personnel, as well as the setting of health policies. The actual health providers were Palestinians.

> It has been funded regularly since its beginnings in 1968. Before the Gulf War, most of the funding came from Kuwait and Saudi Arabia. After 1991, it had to depend more on other Gulf countries like the United Arab Emirates and Qatar. Since the Palestinian leadership sided against the US and its allies during the Gulf War, Kuwait and Saudi Arabia took away their funding. But other Gulf countries replaced them.

Makassed thus managed to weather the 1991 Gulf War and had had clear sailing through the 1993–2000 Oslo period, thanks to *sumud* funds.

The majority of nationalists had, for some time prior to Oslo, espoused the politics of *sumud* across political and professional sectors. According to the ideology of the time, real and lasting solutions to health problems could only be achieved with a just and durable resolution of the political crisis. In the meantime, however, the development of a Palestinian infrastructure within the limits imposed by Israeli military laws and practices was the aim. Palestinian administrators thus agreed to fight for permits and licenses in the offices of the Israeli military governor, for the renewal or inception of each project. Some applications were denied, others granted. But an inherent principle of the politics of *sumud* was to act in the open, and thus, with the toleration of the occupier, department after department were created and staffed.

Leaders and activists thus set up the basic infrastructure of Palestinian curative services in the occupied territories. They bought medical technologies and developed expertise. Other Palestinian hospitals also tended to be large, bureaucratic and located in urban areas; although most of them did not possess the means to do so, they aspired to sophisticated technologies and specialized services. Makassed was "as good and advanced as Israeli hospitals," Dr. Rami said with pride.

Practices of Sumud

Arab leaders gave the concept of *sumud* a prominent place in political discourse regarding Palestine, even as Palestinians in the occupied territories were reading new meanings into it, thus carving a niche for themselves in official politics. In fact, Palestinians in the territories (occupied in 1967) and in Israel had been speaking of *sumud* as a form of daily politics for a much longer time. Its purpose was to enable them to endure, clinging to their homes, their lands and their activities. In his published journal *The Third Way*, Raja Shehadeh (1982:viii),[8] author and human rights lawyer, writes of the everyday practices of *sumud*:

> Long before Arab politicians outside defined *sumud* as a pan-Arab objective, it had been practiced by every man, woman and child here struggling on his or her own to learn to cope with, and resist, the pressures of living as a member of a conquered people. *Sumud* is watching your home turned into a prison.

[8] The distinction between "static *sumud*" and "resistance *sumud*" (*sumud muqawim*) is found here and there in the literature (Farsoun and Landis 1990:28).

> You, *Samid*, choose to stay in that prison, because it is your home, and because you fear that if you leave, your jailer will not allow you to return. Living like this, you must constantly resist the twin temptations of either acquiescing in the jailer's plan in numb despair, or becoming crazed by consuming hatred for your jailer and yourself, the prisoner. It is from this personal basis that *sumud* for us, in contrast with politicians outside, is developing from an all-encompassing form of life into a form of resistance that unites the Palestinians living under Israeli occupation.

For many people like Dr. Rami in Palestine, *sumud* is "practiced" in everyday life.

Dr. Rami's description of Makassed as a *sumud* institution not only classified it as a PLO-related organization, but described practices of everyday life under occupation.[9] Dealing with obstacles on the road and at work was seen as living the politics of *sumud*. The hospital partook of *sumud* whether with regard to its links, roots and funding or in terms of the everyday practices of doctors and employees.

Perseverance in the face of difficulties in getting to work around roadblocks and despite the discontinuity of care due to the closure exemplified practices of *sumud*. While Makassed always had patients, it was difficult for doctors to anticipate where these would be coming from, and whether there would be an avalanche or a dearth thereof. Since the beginning of the prolonged closure in the early 1990s, patients from the Gaza Strip had been extremely rare because they were not given permits to travel. But even from the West Bank, the numbers fluctuated. The first phase of closure targeted Jerusalem, so patients started going to hospitals in other towns. After Ramallah was reoccupied by the Israeli military in 2002, those who could do so returned to Jerusalem. People living in surrounding villages such as Hizma, Anata and Abu Dis, and some in the Ramallah and Bethlehem areas, found it easier to get to Jerusalem than to the nearest town.[10] Everything seemed to depend on the constellation of the closure. "We always have patients, but the question is from where and how many?" I would have added to Dr. Rami's question: What effect did this repeated reshuffling of patient populations and staff have on the quality and continuity of care?

Dr. Rami continued:

> My patient from Ras Karkar [a village close to Ramallah], she comes here like many because she has high-risk pregnancies. She had two previous cesareans and suffers from diabetes. She thought it would be easier to drive 40 km to Jerusalem than to get to Ramallah. We set up an appointment for the C-section. She was unable to cross the checkpoint that day. She arrived knocking at my door four days later. I had to stop everything, because her case was getting dangerous.

[9] Women in Lebanon used the PLO's *sumud* discourse to give political value to their daily activities of housework and child-rearing (Peteet 1991).

[10] In the meantime, with the near-completion of the high wall around and within Jerusalem, the lines of communication have shifted once again, and it is very hard even for Palestinians from the immediate surroundings to get in, if they come from the "wrong" side of the separation wall.

My ongoing observations indicated that this was the precarious way in which much medical care had to be dispensed and many births assisted in Palestinian hospitals. The medical practices learned as routines were no longer practicable in this unpredictable situation. Only rarely had medical providers seen a particular woman prior to her arrival, already in labor. Now they barely had time to get background information about the mother. It was difficult to know who would come to work and who wouldn't, which patient would arrive and which one wouldn't, but the hospital continued to function and to adapt. Working and managing a hospital under these conditions was experienced as part of the living politics of *sumud*.

Employees were never sure they would reach the hospital. A resident in the anesthesia department whom Dr. Rami drove to and from Ramallah first had to take a five-hour drive from Tulkarem. And Dr. Rami himself was not much better off. "For two weeks I could not come to work. A doctor here took my place during that time. But it is still a mess. And can you imagine the road every day?"

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

Closure stories have become a communal account that refugees, returnees,[11] urban and rural people, men and women, poor and wealthy all share. This is not to say that the effects of the closure are the same for all Palestinians regardless of class. However, the politics of the closure, the delays, standing in line, waiting, surveillance, being refused entry and being under curfew in your home, as well as breaking the closure regulation, bypassing the checkpoint on winding dirt roads or slipping out after sunset during curfew days, are lived, told and remembered as communal, as the story of a whole people, and are part of the discourse of *sumud*, especially when the destination is the hospital that symbolizes a lifeline of the nation.

Beginnings

The very creation of Makassed Hospital represented a victory for the Palestinian national movement and is emblematic of remaining steadfast. "There are two events

[11] The term "returnees" designates Palestinians from the diaspora, usually belonging to the PLO in exile, who came to the occupied territories with Yasser Arafat in 1994 or thereafter.

in the hospital's history that single it out as the most important hospital in the occupied territories," Dr. Rami remarked.

> In 1964, the Al-Makassed Foundation started building a hospital on the Mount of Olives in Jerusalem…. In 1967, when Israel occupied the West Bank and Gaza, the hospital was being built on land owned by the Islamic *Awqaf* [religious endowment fund]. Right after the occupation of Jerusalem, the Israeli army decided to expropriate the still empty hospital building and transform it into a police station. Hundreds of doctors and nurses mobilized. They moved beds, equipment and even patients from private clinics and homes into Makassed premises and stayed in the hospital. The Israeli authorities gave up control of the building.[12]

The Makassed Foundation had just finished building the hospital at the time of the occupation. By filling the building with beds and equipment, doctors and nurses unofficially inaugurated the hospital at the beginning of occupation, and this takes on foundational importance. The official inauguration was not until 1968. Its initial movement against occupation, according to Dr. Rami, made a name for Makassed right from the start.

The 1987 *intifada* secured the hospital's position as an emblem of Palestinian nationalism.

> By early 1988, government hospitals were inundated with injured persons. These were controlled by the Israeli so-called "Civil Administration," under the aegis of the ministry of defense. Their services were not sufficient. So the injured from all over the occupied territories, from Gaza in the south to Jenin in the north, flocked to Makassed. There were no checkpoints at that time. The roads were easy. Furthermore, the hospital specializes in high-tech, complicated, emergency surgery. And, like many other hospitals, *intifada* injuries were treated free of charge. Makassed became the most prominent Palestinian hospital.

The hospital's foundation story in 1967 resembles popular stories about what happened to the entire country when it came under occupation. It is a story about waking up to the necessity of joining the struggle, an impulsive awakening. It is the year the PLO opted for Fatah's historical insistence on steering clear of Arab nationalism of any stripe and concentrating on the Palestinian project. The decisive victory of the Palestinian over the Arab nationalist program resulted from the battle of Karameh of March 1968, in which Israeli forces withdrew after an onslaught onto a Fatah military camp in Jordan, suffering relatively heavy casualties. Yasir Arafat had personally, and against the advice of many of his peers, insisted on standing firm rather than opting for a tactical withdrawal. For the Palestinians and the Arabs, the battle of Karameh was the beginning of a comeback after the humiliating defeat of the Six-Day War of June 1967 (Sayigh 1997).

Nineteen sixty-seven is usually narrated as the quintessential story of loss followed by an awakening and then civil disobedience. Makassed's successful sit-in was the nonviolent Karameh. Furthermore, since it was carried out by the

[12] For another account of this event, see Barghouthi and Giacaman (1990).

Palestinians under occupation and without resort to arms, it is part of the history of the everyday practices of *sumud*.

The late Palestinian author Ghassan Kanafani wrote his novel *Returning to Haifa* (1969) about the events and psychological/political effects of 1967. It is about Said S., originally from Haifa, who is a refugee in Ramallah. He lives comfortably in a nice house, forbids his children to become fighters and waits for the day he can return to the home he was expelled from in 1948. In the rush to flee Haifa in 1948, this man and his wife were unable to take their first child with them. Suddenly, 19 years later, when Israel occupied the West Bank, Said S. had the opportunity to travel to Israel, visit the house and inquire about his firstborn, Khaled. In the house, he found an Israeli couple living with their 20-year-old son, Dov. The couple had found Khaled/Dov and adopted him. Said realized that his son was an Israeli, served in the army and did not want to have anything to do with his Arab or Palestinian identity. On his car drive back to Ramallah, he realizes that he must renounce even blood ties for the sake of the struggle and wishes that his other son had joined the resistance. Kanafani's novel is about a middle-aged man's awakening to the need to struggle, the common experience of the inhabitants of the West Bank and Gaza after the June 1967 occupation.[13]

Makassed's foundation story of 1967 is also about an awakening and the impulse to join the struggle against occupation. The doctors and nurses joined the resistance by bringing their equipment and sitting in on the hospital grounds. They, like Shehadeh's *samid*, chose "to stay in that prison." Makassed is here a microcosm of Palestine. For Dr. Rami, the story about childbirth in Palestine started with the history of the medical system, and the medical system conveyed his worldview. As will be seen later, the midwives and nurses, on the other hand, rarely recounted this history without being asked about it specifically. They usually began by talking about issues of work, labor relations and everyday life.

The Midwife: Rebellious Intermediary

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

In the interviews midwives granted me,[14] they wanted to make sure that their working conditions would be part of the story I would write. The discussion of

[13] For a discussion of Kanafani in the culture of Palestinian resistance, see Harlow (1996).

[14] I conducted 23 formal interviews with midwives (*qabilat*), traditional birth attendants (*dayat*) and labor unit nurses (*mumarridat*).

hospital practices shifted from the treatment of the histories and practices of *sumud*, human and financial, to that of *sumud* and intra- or interprofessional struggle. From their perspective, the hospital is far from being the ideal nation and the doctor far from being the competent leader and spokesperson. One midwife told me that if I wanted to learn about childbirth in this hospital, I needed to know how many hours they worked per week, how much money they made and how often they got to see their families. Through telling their own version of the childbirth story, they readjusted the version they correctly presumed I had gotten from the doctor a few days earlier.

Samia explained to me:

> Makassed is late in paying its employees. It has happened before. But this time we have not been paid for 3 months. It is the longest time without pay I can remember. Today, they paid us. We get more or less 1000 NIS [New Israeli Shekels; about $250] per month. So they should not do this to us. We cannot afford to wait 3 months for our wages. We have bills to pay and children to raise. This makes it impossible for us to live regular and stable lives.

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

Samia gave an additional explanation for the rise in births at Makassed: "Palestinians from Jerusalem are now afraid to go to Jewish hospitals. Many people with blue [Jerusalem] IDs[15] used to deliver in Hadassah or other Israeli hospitals. But many women now tell me they don't want to go there. There are rumors that Arabs receive different treatment than Jews." Ruba, the midwife, talked about the same suspicions: "Because of the political situation, [Palestinian] women from Jerusalem are now afraid to go to Israeli hospitals. They say, 'You don't know what they will do to me. Will they take revenge on me or my newborn? We don't know how we'll be treated.'" These stories were clearly specific to the residents of Jerusalem, where women could choose to go to hospitals across the "Green Line"[16] into West Jerusalem. In fact, the increase in hospital births in 2002 was specific to the city of Jerusalem. In other West Bank cities, such as Ramallah, staff at some hospitals spoke of a radical decrease in the number of births, even of empty labor rooms during the curfews (conversation with midwives at Ramallah and Hebron hospitals).

[15] Palestinians from Jerusalem have blue identification cards, like Israelis and Palestinians born within the pre-1967 borders of Israel. Palestinians from the occupied territories (excluding Jerusalem) hold orange or green IDs. The difference in the color of the Israeli ID cards is in itself a statement about which future nation Jerusalem (with, or for, the occupier, preferably without its blue ID-holding Palestinians) should belong to.

[16] The borders of Israel prior to the occupation of 1967.

In addition to an increase in the number of births, the labor room at Makassed had fewer staff. There were usually 16 midwives. Two had recently resigned. "With so few midwives and so many births we can no longer work the way we used to. Now we cannot attend to many of the important aspects of midwifery care." Sometimes, they didn't have time to shower women after delivery or to show them how to breastfeed. They went on rounds from one woman to the next, doing no more than the basic medical checkup.

Their stories about the closure intersected with those of the doctors. However, unlike the doctor, midwives saw working conditions as the most important feature of their professional existence. The actual *doing* of birth assistance constitutes the major part of the professional identity of midwifery. They take pride in assisting births and contrast this with the doctor, who "walks in the delivery room when the work is all over" (communication with a midwife at another hospital). The doctor had here been identified as belonging to a privileged elite whose self-ascribed role is based on the labor of others. It was important for the midwives to emphasize that the hospital was not the ideal entity it presented itself to be. All was not organized, rational and smoothly productive. *Sumud* was a recurring theme among midwives, but it had acquired a new, social and subaltern tonality in addition to the nationalist slant taken for granted. They too felt that their steadfastness was directed toward the political predicament in which the occupation in general, and the system of closures in particular, had placed them. But they also felt that it was a matter of continuing to work in the face of conditions for which the Palestinian employer was also responsible. This form of *sumud* paralleled the combined national and social objectives of the 2000 *intifada* as a whole, directed as it was against the occupation and against a ruling clique by whom they felt exploited (Heacock 2008).

Another difference midwives pointed to between their profession and that of doctors was their closeness to a Palestinian social base and women's apparent preference for female birth attendants.[17] Describing her previous job in Ramallah, Samia explained how birth mothers demanded that midwives rather than obstetricians assist their births. Opening in the mid-1990s, the hospital in question was part of the expanding private sector that emerged amid the hopes of looming peace and a rising economy. It vaunted its specialized, personalized and luxurious services, targeting women who could afford the fees. The novelty of this maternity hospital was that obstetricians assisted normal births instead of midwives.

According to Samia,[18] midwives were dissatisfied with their secondary role despite the good salary, as they could not provide midwifery care according to their vision of the profession. She for one decided to leave and go to Makassed. However, this Ramallah hospital was soon forced to change its policy due to lack of clientele, and permitted midwives to attend normal births upon a woman's request. Her story points to one of the main arguments midwives continue to make to the ministry of health: unlike doctors' assistance at births, their work is grounded in popular demand.

[17] According to the Palestinian Association of Obstetricians/Gynecologists, less than 10 percent of obstetricians working in West Bank hospitals are females.

[18] This story was repeated to me by a few midwives, including the head midwife at the hospital in question.

These stories reflect an increasingly visible tension between obstetricians and midwives in Palestine. As is the case in many other parts of the world, the professions of midwifery and obstetrics compete for the control of childbirth. However, in contrast to other Arab countries in the Middle East (Egypt, Lebanon and Jordan, for example), midwives in the West Bank assist almost all complication-free hospital births.[19] While they do not have their own union (they belong to the nurses' union, headed by a male nurse) and are relatively low in the hierarchy of the hospital staff, they exercise a certain power because of the shortage of midwives in Palestine.

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

In another interview, an obstetrician exclaimed, while he was explaining the division of labor: "Midwives are mutinous! It is not like Europe and America.[20] Here, midwives fight to get what they want. But the biggest problem for us is that in the end, we are responsible for everything that goes on in the labor room. If there is a problem or a mistake, the obstetricians are held accountable for it."

The doctor spoke of mutiny, of fighting, of responsibility and accountability. While it has been noted by many that the language of medicine and birth is full of metaphors from state and economic terminology, the wording in this simple exchange on the workings of the labor room was very strong and reflected an exacerbation of class tensions among different categories of health providers.

Thus, midwives' narratives about work revolved around concepts of an everyday struggle contained in the notion of *sumud*. However, they integrated into the idea of *sumud* a critique of unacknowledged labor. Mirroring the political objectives of the second *intifada*, they directed their critique at the occupation and at a ruling class.

Topographies of Sumud

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

[19] For a comparative description of policies and practices in Egypt, Palestine, Lebanon and Syria, see Choices and Challenges for Changing Childbirth Research Network (2005).

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

> "Hello, I have contractions. I am afraid. I can't go to a hospital. We are under curfew," the woman said. "How many contractions per minute?" I asked. "OK, take a shower and an Acamol [tylenol] and try to sleep until morning, maybe you can find a way to come in the morning in daylight. But don't worry. Just don't be afraid. If worst comes to worst I'll guide you and your family through delivery." In another conversation the birthing woman says, "I have pain. I feel contractions. I can't wait anymore. The closure … I can't come. Help us!" So I got the birthing woman's mother on the phone and tried to take them through delivery. I explained how to clamp the umbilical cord, to tie a string, to boil a pair of scissors and then cut the cord.

The phone birth was unexpected in a hospital in Jerusalem. It became relatively common in areas under prolonged curfew. Through her accounts of phone-births, Samia linked Jerusalem and the West Bank, which have been separated by the closure. In her story, assisting phone-births challenged the closure,[21] connected her work to a resistant form of *sumud* and bound her and her profession to people in the rest of Palestine.

These stories illuminate a tension between, on the one hand, the institutional, imposed and, to a certain extent, lived separation of Jerusalem from the rest of Palestine and, on the other hand, its unity and oneness with it, which is imagined and willed, but also lived. The administrative and physical partition of Jerusalem from the West Bank affected one of the centers of the midwives' lives, their families. Except for those few residents of Jerusalem, they now slept in the nurses' quarters at the hospitals. In this way they avoided the difficult roads. But they were unable to live with their families. They got one day off a week. And in order to accumulate a few days' leave, they worked for four weeks without a break. They then went back to their hometown for four or five days.

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

The closure separated many midwives from their families. Phone-births and medical assistance over the phone not only were a form of *sumud* but also re-united

[21] One should note that other health professionals argue that coping mechanisms such as birth assistance by phone serve the closure policies by minimizing pressure to end them.

them with the people they left behind in the West Bank for a week while they came to their workplaces.

In the above discussion I have illustrated the articulation of a particular vision of the nation through the institution and the functioning of a Palestinian hospital, Makassed, in Jerusalem. The nation is projected as a territorially unified entity despite all measures taken to remove an essential portion of it, its capital. We have here the first type of a nation, the unified, Jacobin, technocratic one, as envisaged by the doctor and contested by the midwife in the name of the people. What the midwives contested was the assertion by the doctor that this particular national paradigm functioned smoothly and without major contradictions. Theirs were stories of unpaid, malrespected labor, carried out essentially by women, whose critiques combined a gender and class perspective. We are still within the first paradigm of the centralized nation. Within this paradigm, the various categories of health professionals live their daily travails as *sumud*, but with the nuance described above. And, it has been seen, the term *sumud* is rather adaptable, depending on the category of those within the national movement who apply it. Nonetheless, it fit into a system in which the various actors bore their hardships and carried out their responsibilities, not uncomplainingly, but without hesitation. Central authority may be questioned openly, but within this model rebellion never means revolt. In the section that follows, in which the popular health movement is discussed, the notion of *sumud* is virtually absent, It was discarded in favor of a more proactive and agential type of action in the face of occupation and then military assault during the 2000 *intifada*.

The Popular Health Movement: A Decentralizing Vision

Networking

The streets were empty. The stores were closed. The people were indoors. The only sound the city made was the roaring of passing tanks. Ramallah was silent. Since March 29, 2002, the Israeli army had imposed a curfew on Ramallah. For the first 2 months it was very strict. People never broke it. Every few days, the army lifted the curfew for a few hours so that people could stock up on food. Later, the curfew was less strict and was lifted more often. People sat on their verandas. Children played in the streets. But at the intrusive sound of the tank, everyone went running inside.

On the morning of July 4, 2002, Ramallah was bustling. The whole city was in the streets. Vegetable vendors, sandal and shoe sellers, shoppers and strollers mingled in the middle of town. Political leaders and prisoners—Marwan al-Barghouti,[22] Ahmad Saadat[23]—as well as *intifada* martyrs—Wafa' Idris,[24]

[22] A home-grown, popular, elected West Bank leader sentenced to life imprisonment by Israel, head of the militant *Tanzim* within Fatah, which contested the bureaucratic and corrupt leadership as well as the occupation.

[23] Leader of the Popular Front for the Liberation of Palestine (PFLP).

[24] The first Palestinian woman suicide bomber.

Muhammad al-Durra[25]—looked down from posters on the walls. There was not a soldier in sight. Cell phones were ringing everywhere. Horns were honking. Radios were blasting. Ramallah was loud; the curfew had been lifted.

In an office building at the center of town, Dr. Siham, an obstetrician, shared a private clinic with a few other health professionals. The building was empty, the door barely open. She was alone in her clinic, on the phone: "You'll be fine. The curfew is lifted until 2 P.M. You can stop by the clinic if you want, before then. But I don't think it's necessary. Call me at home if you feel pain." Dr. Siham turned to me and said:

> I would never have imagined that I would practice medicine by phone…. I never thought I would wake up at 2 A.M. to phone calls from women in labor and instruct the husband how to assist his wife in childbirth. I have never heard of a time in history when even health providers were restricted in their movements. But the thing is, life goes on. Women still become sick. Women still become pregnant. They can impose a curfew, restrict mobility, but it does not stop labor from starting. This is dangerous. This is frightening….

The phone rang again. It was another patient.

In between periods of medical advice given on the phone to her patients, Dr. Siham told me stories about assisting birth by phone during curfew nights. She explained that this instrument had become a crucial medium of medical assistance. Since many women thought it better to give birth at home than to brave the curfew, they would telephone health providers to get counseling during childbirth.

Dr. Siham's stories centered around a movement of health professionals who had mobilized to provide services to women who went into labor during curfews. "Sort of naturally," she said:

> by the first days of the curfew, many health providers in the Ramallah area would converse, share stories and give each other advice. Quickly and spontaneously, we had a system working. Health providers would tell people in need to call such and such a person to follow up on something. Those with no experience with childbirth in a village under siege would call me so I could give them training by phone…. Since the beginning of the long invasion we have created a hotline to provide this network of medical services and advice, so we can take many midwives, nurses and lay people through childbirth on the phone.

The phone rang again and a few patients had come to her clinic. She talked to the phone patient; then saw her clinic patients. In the midst of this chaos, expecting the curfew to be reimposed any minute, she told me stories of an effective and active "childbirth network." Here, stories traveled by phone and into my interviews to construct the basis for what she called a network.

[25] A child killed by Israeli gunfire in his father's arms at the beginning of the second *intifada*, on September 30, 2000.

However, Dr. Siham's use of the word "network" suggested that it had long-term and administrative functions: "With this hotline and network," Dr. Siham explained:

> we are also trying to convince women to have natural childbirth[26] at home or close to the woman's home. That way, we can avoid the fear, humiliation and danger of the road…. So, I try to convince women to forget about the hospital. That it is safer for them to give birth close to where they live…. If we create a system where women can give birth close to their homes, that is what I mean by natural childbirth, then we would have succeeded in something extraordinary for our political aspirations.

She wanted women to relocate their births from the urban hospital to their villages in order to build a lasting decentralized infrastructure and make each neighborhood self-sufficient.

After my initial interview with Dr. Siham, I talked to numerous doctors who had assisted births during the closure. I asked whether they were part of the network she had described and several responded clearly that they were not part of a network or movement, that they were simply part of the infrastructure, doing their duty. They distanced themselves from the term because of their disenchantment with political movements, and perhaps because they disapproved of some of the personalities involved in its leadership. By identifying themselves as part of the infrastructure, they were telling me that the network as described was getting too much recognition; that they, just as much as the people who said they were part of it, were movers and shakers in the medical sector but not recognized in the same way. This group of alienated doctors told stories with a plaintive tone about disrespected or unrecognized labor and demand for change reminiscent of the midwives in the hospital.

The Genealogy of Popular Health

By her use of the term "network" and reference to bringing "childbirth close to women's homes" or "into women's neighborhoods," Dr. Siham was placing the childbirth network in the framework of an ideology, program and movement intended to counter that of the PLO's centralizing politics of *sumud*. She positioned the childbirth network in the wake of the "popular health movement" that emerged in the late 1970s.

Upon its establishment in the occupied territories in 1994, the PA continued Israel's and the PLO's policies of supporting large, urban hospitals over community clinics. And in terms of childbirth, the PA's ministry of health instituted practices designed to encourage women to give birth in hospitals. It reduced the costs of a

[26] It became clear as her story proceeded that the meanings of "natural childbirth" for her were different from the meanings attached to it in the West. Natural childbirth is not so much about giving birth without technologies and drugs as about locating the birth in women's neighborhoods rather than in large, urban hospitals. Also, in the context of the Middle East, the term natural childbirth does not carry the same history of a feminist movement attached to it elsewhere.

normal birth in government hospitals to 100 NIS (approximately $40 at the time). It also supervised the *dayat* (midwives with no formal certification who assist home births) and permitted them to practice their profession but refused to license any new midwives who wanted to assist home births. This resulted in the situation whereby the *dayat* (who are for the most part old and will not be practicing much longer) were licensed to attend home births, while *qabilat*, younger midwives with formal training from midwifery schools, could only practice in hospitals. Through these multiple strategies, the PA developed a strong, centralized system of hospitals and discouraged women from giving birth in their homes or neighborhoods.[27]

The popular health movement emerged more than a decade before the arrival of the PA, in the late 1970s. Dr. Siham explained that it had taken shape quite spontaneously, in a manner reminiscent of the childbirth network she now saw emerging. She had started in the movement by offering a few hours a week of voluntary work in mobile clinics, treating patients for free. She and a group of physicians would drive around in their cars to villages providing consultations, with equipment and medication donated by local pharmacies and companies. Later, villagers offered them a room in the village to set up a permanent clinic. The physicians would rotate, offering one day a week of voluntary service. Very soon Dr. Siham became a leading figure in the movement.

I asked another doctor who had been involved in the popular health movement, Dr. Othman, to tell me about its beginnings. He told me that most of the doctors involved in the movement had just finished medical school in the Eastern bloc and had been impressed by certain local public health programs in regions of the Soviet Union. Upon their return to the occupied territories, Dr. Othman explained, the ideology of the emergent popular health movement was still malleable and had not yet crystallized. The leading ideas that held the group together were very popular and not very original. They shared "a national objective and a belief in justice." "We had energy," he said. "We wanted to do something for our country. We had all studied in the USSR or in other socialist countries during that period, and seen that health care was free of charge, whereas back home, people had to pay unaffordable prices for it. This was unjust. So justice was our goal." His story about the popular health movement's beginnings emphasized its spontaneity, popularity and grass-roots base and distanced the emergence of the group from the work of a political party. At the same time, Dr. Othman's account of the rapid and spontaneous mobilization of people around health also described popular health as mapping itself onto an existing social movement in the Occupied Territories. Their "entry points to the communities" in the rural areas were the activists in the women's movement, which had existed since the beginning of the 20th century. By the 1970s, the women's movement had become very active in social services and community organizing and "was more powerful than us [the health movement]. We had little access to the communities we were targeting. They gave us the connections and the communities began to work with us." Dr. Othman thus inserts popular health into a genealogy of mass-based social movements in the occupied territories. In his narrative, the women's organizations gave rise to and coexisted with popular health

[27] For further discussion of the PA's childbirth policy, see Giacaman et al. (2005).

(as well as similar trends in education, agriculture and the very important youth movement), which spurred the outbreak of the first *intifada* and its "neighborhood committees," which in turn solidified the second *intifada* when it erupted; all of these movements and phases finally engendered the childbirth network.

It must be noted here that Dr. Othman's reference to the origins of popular health in the women's movement shows an unusually humble reverence to a more senior popular movement (especially one of women). In addition, at a time of disenchantment with party politics, it also positions health within a genealogy of popular, mass-based movements rather than ideologies of parties and governments. The final point regarding this story is that Dr. Othman's reference to "entry points into the communities" reveals a consciousness of the class division separating the doctors who then became leaders of the movement from the people they were trying to mobilize through health care. "We believed in health, social justice and the participation of people in health care. The idea was that comprehensive primary health care pushes people to revolution. It would permit them to take power."

With time the vision became more specific to the context of Palestine. What made the movement instantly popular, Dr. Othman said, was that people saw it as a means of resistance to occupation. "Health was controlled by the Israeli authorities. They decided whom to hire, whom not to hire, whom to treat, whom not to treat, what to do, what not to do. So, developing health services without the permission of the authorities was a challenge to occupation." In Dr. Othman's stories, the illegal status of the popular health movement was essential to the creation of its popular base. In their published chapter on the emergence of the popular health movement, Mustafa Barghouti and Rita Giacaman (1990)—two of its leading figures—also talk about the commitment to developing health services without getting legal permission from the military authorities. What can already be derived from Dr. Othman's account becomes explicit in Barghouti and Giacaman's analysis: the illegality of the popular health movement stood in contrast to the politics of health of the *sumud*-based charitable hospitals. They position the movement in stark and proactive opposition to the Israeli politics of health in the occupied territories, but also to the centralizing and legalistic politics of health of the PLO.

Dr. Othman went on to recount the bureaucratization of the movement about a decade after its emergence and the role the political parties played in this process. The movement, he noted, created an umbrella organization, called the Union of Palestinian Medical Relief Committees, over which political parties sought control. In the UPMRC, disagreements started to emerge. Members from Fatah[28] and the Popular Front[29] seceded and created similar organizations, but close to their own parties. UPMRC was left to the Communist Party.[30] Dr. Othman thus inserted the history of the political parties into a second phase of the history of the popular health movement, a phase now dominated by institutional history. In his story, the first

[28] Fatah is the hegemonic Palestinian nationalist party, headed by Yasser Arafat until his death in November 2005, and then by Mahmud Abbas (Abu Mazen), elected to succeed him as president of the PA.

[29] The PFLP is a Marxist, pan-Arab party considered more intransigent than Fatah.

[30] The Palestinian Communist Party (now renamed Palestinian People's Party), unlike Fatah and the PFLP, had always favored a two-state solution for Palestine.

decade of the movement was exciting and popular, whereas the second phase was tainted by the politics of bureaucracies, internal power struggles and political parties.

Dr. Siham, for her part, was clearly accustomed to being a spokesperson for the childbirth network. She had long been a leading person in the popular health movement and politically involved. Her interview had the aura of a political speech. After leaving the UPMRC, she joined a practice in downtown Ramallah. But when the closure started, she said, the childbirth network re-energized her. It brought back the memories and passion she had found in her initial work with the UPMRC. Like Dr. Siham, Dr. Othman was speaking from the perspective of someone who had been very active in the former health movement but now worked in the post-Oslo nongovernmental organization sector, which had become established and donor-driven. They took pride in their past involvement in the health movement. Bringing back the glorious past and seeing a network in the present reinstated some of their lost status.

In addition to their importance from the point of view of the researcher seeking a multidimensional perspective on capital historical processes, these two interviews illustrate perfectly the existence of a second paradigmatic vision of the idea of the nation, as exemplified by the dispersed clinics, the popular health movement and, more recently, the so-called network. In this paradigm, the traditional monolithic vision of the first image is broken down and replaced by a socially based model, in which the nation emerges out of a web of social relations dedicated to national but also social struggle, and seeking agency for the subaltern. The health system is a microcosm of this socially based vision. The administration of health should be decentralized. The primacy of the ministry of health should be questioned. The village health worker, introduced by the UPMRC in the late 1980s, has become a significant figure. The system is looser, broader and, in theory, less subject to vertical control. It should be noted that this vision too is contested, on the one hand, by those who refuse the notion of a health network and, on the other hand, by those who contest its authenticity in this particular context.

Physicians: Glorification and Vilification

Doctors as Statesmen

This article has a number of doctor-as-strategist stories. The successful strategist is a politician and, potentially, a statesperson. The lines between doctor and statesman are blurred in the occupied territories because of the considerable number of doctors in key positions within Palestinian political parties. To speak only of top leadership, Dr. Fathi Arafat, brother of Yasser Arafat, was head of the Palestinian Red Crescent Society until his death. The founder and historic leader of the Popular Front for the Liberation of Palestine (PFLP), George Habash, was a physician. In the internal leadership,[31] Dr. Haidar Abd-al-Shafi, now deceased, was close to the Communist

[31] From inside the occupied territories, as opposed to the external leadership, which until the 1990s was headquartered in Amman, Beirut and, finally, Tunis.

Party and the former head of the Red Crescent Society in Gaza. Dr. Mustafa Barghouti heads an opposition movement, the Palestinian National Initiative (*al-mubadara al-wataniyya al-filistiniyya*). Finally, two of the founders and leaders of Hamas, Drs. Mahmud Zahhar and Abd-el-Aziz Rantisi, were physicians. The near-hegemony of engineers among the founding members of Fatah in the 1950s has been discussed by historians as the result of these young men becoming politically active even as they worked in the oil economies of the Gulf. The presence of numerous doctors in the leadership, especially in the internal leadership has, however, not yet been explained. In contrast to the Indian movement for independence, with its many lawyers, in Palestine doctors are associated with leadership. The medical profession is heavily represented in the protostate, whether in power or in opposition. The presence of doctors in the leadership makes for a scenario where what is at stake is not simply laws and organization, but the preservation of collective life itself, in the deepest biopolitical sense intended by Foucault (2003). As a result of doctors' association with power, social but also political, doctors are sometimes the target of vilification and rumor, as the following stories show.

The Birth Mother: A Protesting Citizen

Maha had arranged to give birth at the Red Crescent hospital in Ramallah. In early April 2002, however, the severe curfew made it highly unlikely that she could make it there and back. She wondered, "If I got to the hospital, how long would it take me before I could come back? What about my husband and children alone at home? I was afraid the soldiers might come to arrest my husband…. So, I was afraid the kids might be alone. I thought about it a hundred times." Maha had heard from a neighbor that a doctor who lived in her neighborhood was assisting births in her home. Eventually, she decided to give birth with this doctor.

> At 6:30 PM, on the 14th of April, I went to [the doctor's] house with my neighbor. My cervix was dilated 3.5 cm. The doctor said, "In about two hours you will give birth." So she did things to facilitate my birth. At 9:30, I gave birth to my daughter. Quickly, she cleaned me up. I had a tear, but she did not stitch me up…. She made me understand that we were bothering her. She kicked us out!

Maha and her neighbor consequently picked up the newborn and walked home. On the way, they heard a tank approaching, so they knocked at the door of a house to ask for cover.

> The people did not just open the door for us. They had us sit down and made us some tea, and we started talking. "How did the doctor let you leave when you had barely given birth?" Even though I had a tear. See how lowly of the doctor! The doctor has no principles…. Then our hosts telephoned the houses along the main road. Young men were placed on the lookout from their roofs. If a tank came, they would whistle. This way we got home.

One element of Maha's story was part of a collective narrative about life under curfew. She, her neighbor and her newborn baby dodged tanks in the middle of the night. She hid in the house of someone she did not even know. This family was extremely hospitable. And the young men in the neighborhood worked out a system of watching and whistling for them to run safely to their home. It is the story of neighborhood cooperation, one reminiscent of popular movement stories from the first *intifada*. The perspective is that of the villagers, dealing at once with the overweening occupation and the unfeeling, authoritarian doctor.

In her story, the doctor (whom, incidentally, Dr. Siham would probably consider as belonging to the childbirth network) was not part of the popular movement. Maha's tone was one of anger. She kept on repeating that the doctor was greedy, inhospitable and, in the end, did not have the morals a doctor should have and the politics someone under curfew should have. She had paid for the service, and expected assistance during and for a few hours after birth in return. Doctors, she commented, should have humanistic values and political principles. Within the narration of a communal story of her giving birth under curfew, Maha integrated a staunch critique of the medical care she received, and contributed to a potentially systematic critique of the doctor as mandarin.

I first heard of Maha's birth story as a rumor, through the friend of one of her neighbors. The story in the rumor was similar in structure (although told with much less detail): she broke the curfew during the night, and was helped by the neighborhood to get back and forth from the doctor's house, but the doctor was inhumane and did not tend to Maha's tear. The rumors and our interview became, in the eyes of those who participated in recounting them, instruments for the propagation of a critique of doctors.

Clearly, some stories from women who had given birth at home during the curfew did not contain such a harsh critique of the medical assistance they received. However, those that did were interesting because of the demand for a different type of care within the context of limited options. There were in fact many instances of critiques of doctors and sometimes of midwives (some of whom, people claimed, pretended to be doctors). In one village, closed off from its neighboring city, a doctor had transformed the vaccination clinic into a space for birthing. She was a gynecologist and had not assisted births in years. All of a sudden, during the month of April, the doctor assisted about 40 births.

During one of these births, assisted by the doctor at the vaccination clinic-turned-birthing clinic, a villager's newborn died. "The whole village is talking about a problem we had," the director of the clinic told me. "But what could we do? We were ill-equipped and unprepared to assist births in our clinic." According to the director and to some people in the village, the villagers blamed the doctor for the newborn's death. Eventually, they told me, the doctor had to leave the village.

Tamara, one of the women who gave birth to a healthy baby in the village during this period of closure, voiced further criticism of this doctor. She had given birth in her home, unexpectedly early. Her husband called the doctor right away and "it took a whole hour for the doctor to come and cut the umbilical cord. And she lives close by," Tamara told me with a tone of reproach. She was bitter about the childbirth assistance her village was offered, and blamed the doctor personally.

My recounting of Tamara's and Maha's stories is by no means intended to discredit the childbirth network. The health providers worked under difficult conditions. Birth assistants were under pressure from the community and, on the basis of their own political engagement, assisted births during curfews. They had very little equipment and it was highly probable that they would not be able to manage transport to the hospital in cases of emergency. Thus, as a listener to Tamara's and Maha's stories, I shared their feelings of anger at a system of closures as well as a system of medicine that allowed, and perhaps even systematically produced, poor care during their births. However, in the end, I cannot blame the doctors individually for this system of childbirth assistance. The demands made of these health professionals, the pressures to which they were subjected, the conditions under which they had to work, all combined to erase the individual blame a story such as Maha's carried.

During times of conflict, there is no legal system through which to deal with malpractice in the occupied territories. Under the PA's regulations regarding childbirth, only *dayat* are permitted to assist home births on a regular basis. However, by the time of the events narrated by these women, the legal and executive system of the PA had crumbled. There was no question of prosecuting these health professionals for assisting home births during the curfew. The birth attendants' accountability was primarily to the community. Maha's and Tamara's stories were interesting for the very reason that they laid bare this popular rather than formal system of accountability and uncovered a means of action for women that would affect birth assistance in the future.

The vilification of doctors likewise points to the identification of doctors with political leadership in Palestine. They are asked to be accountable and just in their practice. They are sometimes portrayed as dishonest, money grubbing and self-promoting. Such stories arise in a context where there is widespread dissatisfaction with a Palestinian leadership under fire for its mismanagement of the *intifada* and of public funds. Individual stories present in rumors and interviews about the mismanagement of birth by a doctor echoed bigger stories in the public arena about malgovernance. In her book, Adriana Petryna (2002) traces narratives of Chernobyl "sufferers" and presents life stories critical of the state and medicine. She shows how the biology of citizens is both a medium of government and part of a political process where it has become the grounds for staking citizenship claims. In my research, similar processes are found to be at work, at a time when the strategists of the state-in-the-making have made health an essential component of nation-building. Quite logically, they are opening the door to being criticized by citizens according to health-related criteria.

This brief overview of the politicized image of physicians—in the first instance, as leaders and, in the second, as villains—demonstrates the extent to which both images of the nation unveiled by discourses around medical care are contested on the ground, by future and present mothers, and by others in the profession. The first, *sumud*-rooted, unitary image is heavily questioned by a public (and by subaltern birth professionals, notably midwives) that lived through two *intifadas* and the Oslo interlude, dominated by a bungling Authority. But we have seen how the second, socially based image of the Palestinian nation is likewise doubted. It is contested by

the proponents of the first image, who continue to preach and practice the health policies of centralized "expertise," but also from within, most notably by a whole series of subaltern women who interacted with and were subjected to its practitioners. These critics are making a plea for the democratization of the entire system. They want some control over their lives and therefore medical system, and thus over affairs of state. Furthermore, the medical profession and the political system are so deeply interconnected that, at the same time that there is a need for doctors and their political involvement, they become the targets of rumor, accusation and vilification. In many ways, they have come to stand in for the failed promise of Palestinian statehood—symbolized not only by the occupation, with its checkpoints and curfews, but by Palestine's own political leaders.

Conclusion

One can only agree with Kathleen Stewart (1996) when she notes that her book, *A Space on the Side of the Road*, is "a story in which there is always something more to be said," something that she hopes to help others "begin to imagine." The key relevance to our project lies here in the notion of *beginning*, because, temporally, birth stories in Palestine, although they purport to narrate recent past events, are resolutely oriented toward the future. The models of birth elaborated, as well as the varieties of critiques expressed, concern the way in which future births can benefit from the experiences of past ones.

It has been seen how Palestinians, through their interpretations of the infrastructure of health and the experience of birth, project their disparate views of the nation (and thus of the state) they are struggling to construct, with a polarization between the Jacobin and the social model. In the former, derived from the history and functioning of Makassed Hospital in Jerusalem, Dr. Rami's discourse was first dominated by the issue of funding and how it is invariably forthcoming. The enemy remains the outside, colonialist force, and the contemporary closure is a challenge triggering behavior analogous to the past instances of *sumud*. The vision is somewhat modified by the accounts of midwives, who place the emphasis on labor at the expense of what one might call the doctor's "capital." For them, work (assisting birth mothers) is the fundamental ethical value and thus the source of economic and social value. Nonetheless, the perspective remains a vertical one, structured around the hospital hierarchy. In the social model, the institutional centralization present in the first model is contested, in the name of interactions among professionals and mothers. The alternative hierarchy proposed is: first, community; second, technology; and, finally, planning (and no longer finances, labor and centralization). The perspective is here horizontal.

The two visions share in their insistence on the unity of the land, most notably through the refusal to accept the exclusion of Jerusalem, and on the vital link between the birth process, the medical infrastructure and the ongoing resistance to occupation.

As the stories and the histories of Makassed Hospital and the UPMRC show, both the *sumud*-based, unitary vision and the one grounded in a social project engendered

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

What this article also shows is that medicine became a site of political conflict on multiple levels, the national level in fighting the occupation, the institutional level, the professional level, the ideological level and among political leaders. What my research also shows in the Palestinian case is the rise of the medical profession to political prominence during the period of occupation. Within these medical/national projects, the doctor acquires political stature, power and sovereign authority.

Writing the story of medicine and governance through the analysis of doctors, movements and political leadership presents a counterpoint to the warnings of humanitarian aid discourse and media about social disintegration, while allowing for the existence of suffering by many different subjects in Palestinian society. Furthermore, at a time when there is little consolation to be drawn from political and economic prospects, a rethinking of existing paradigms regarding medical practice (and malpractice), based on existing conditions in Palestine, is surely in order and in the interests of a people that have decided to be, in particular as regards the disposition of their bodies in the context of birth under occupation, the subject, and not simply the object, of their own history.

Acknowledgments I thank the interviewees for taking the time to speak with me and making this work possible. I am grateful to Michael Fischer, Harriet Ritvo and Joseph Dumit for their ongoing advice and support. I am thankful to my former colleagues at MIT and Birzeit University and my present ones at the American University of Beirut for providing me with academic support. I am indebted to friends, colleagues and teachers for engaging with this work at different times during the process of researching and writing it: Diana Allan, Omar Al-Dewachi, Sosi Andesian, Deema Arafah, Farha Ghannam, Rita Giacaman, Byron Good, Evelynn Hammonds, Yamila Hussein, Erica James, Afamia Kaddour, Natasha Khalidi, Cynthia Mynnti, Esra Ozkan, Sarah Pinto, Anne Pollock, Aslihan Sanal, Hania Sholkami, Kaushik Sunder-Rajan, my sister-in-law and brother, Dahlia Gubara and Ali Wick, and my parents, Roger Heacock and Laura Wick, as well as the reviewers and editors of CMP. The research on which this article is based was partially funded by a grant from the MEAwards Program in Population and Social Sciences, the Population Council, and the WANA regional office in Cairo.

References

Adams, Vincanne
1998 Doctors for Democracy: Health Professionals in the Nepal Revolution. New York: Cambridge University Press.

Agamben, Giorgio
1998 Homo Sacer: Sovereign Power and Bare Life. Stanford, CA: Stanford University Press.

Anderson, Benedict
1991 Imagined Communities: Reflections on the Origin and Spread of Nationalism. Revised Edition. London: Verso.

Arnold, David
1993 Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India. Berkeley: University of California Press.
Barghouti, Mustafa
2005 Palestinian Defiance. Interview by Eric Hazan. New Left Review 32(March–April): 117–131.
Barghouti, Mustafa, and Rita Giacaman
1990 The Emergence of an Infrastructure of Resistance: The Case of Health. *In* Intifada: Palestine at the Crossroads. Jamal Nassar and Roger Heacock, eds., pp. 73–90. New York: Praeger.
Blecher, Robert
2002 The Medicalization of Sovereignty: Medicine, Public Health, and Political Authority in Syria, 1861–1936. Ph.D. dissertation. Stanford University.
Choices and Challenges for Changing Childbirth Research Network
2005 Routines in Facility-Based Maternity Care: Evidence from the Arab World. British Journal of Obstetrics and Gynecology 112(September): 1270–1276.
Cousin, Andrew
2000 Ideology and Biomedicine on the Palestinian West Bank. Ph.D. dissertation. Emory University.
Farsoun, Samih, and Jean Landis
1990 The Sociology of an Uprising: The Roots of the Intifada. *In* Intifada: Palestine at the Crossroads. Jamal Nassar and Roger Heacock, eds., pp. 15–36. New York: Praeger.
Foucault, Michel
2004 Naissance de la biopolitique: Cours au Collège de France (1978–1979). Paris: Gallimard.
2003 Society Must Be Defended. David Macey, trans. London: Penguin.
Giacaman, Rita, Laura Wick, Hanan Abdul-Rahim, and Livia Wick
2005 The Politics of Childbirth in the Context of Conflict: Policies or De Facto Practices? Health Policy 72: 129–139.
Ginsburg, Fay, and Rayna Rapp
1995 Conceiving the New World Order: The Global Politics of Reproduction. Berkeley: University of California Press.
Guha, Ranajit
1988 The Prose of Counter-Insurgency. *In* Selected Subaltern Studies. Ranajit Guha and Gayatri Chakravorty Spivak, eds., pp. 45–88. New York: Oxford University Press.
Harlow, Barbara
1996 After Lives: Legacies of Revolutionary Writing. New York: Verso.
Heacock, Roger
2008 Seizing the Initiative, Regaining a Voice: The Palestinian al-Aqsa *Intifada* as a Struggle of the Marginalized. *In* Subalterns and Social Protest—History from Below in the Middle East and North Africa. Stephanie Cronin, ed. London: Routledge.
Inhorn, Marcia
1996 Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt. Philadelphia: University of Pennsylvania Press.
Kahn, Susan
2000 Reproducing Jews: A Cultural Account of Assisted Reproduction in Israel. Durham, NC: Duke University Press.
Kanaaneh, Rhoda
2002 Birthing the Nation. Strategies of Palestinian Women in Israel. Berkeley: University of California Press.
Kanafani, Ghassan
1969 Aid ila Haifa (Return to Haifa). *In* Al-Athar al-Kamila (Collected Works). Vol. 1. Beirut: Dar al-Tali'a.
Peteet, Julie
1991 Gender in Crisis: Women and the Palestinian Resistance Movement. New York: Columbia University Press.
Petryna, Adriana
2002 Life Exposed: Biological Citizens After Chernobyl. Princeton, NJ: Princeton University Press.
Renan, Ernest
[1882] 1998 Qu'est-ce qu' une Nation? Paris: Editions Mille et une Nuits.

Sayigh, Yezid
1997 Armed Struggle and the Search for State: The Palestinian National Movement, 1949–1993. Oxford: Clarendon Press.
Shehadeh, Raja
1982 The Third Way. A Journal of Life in the West Bank. London: Quartet Books.
Spivak, Gayatri Chakravorty
1988 Deconstructing Historiography. *In* Selected Subaltern Studies. Ranajit Guha and Gayatri Chakravorty Spivak, eds., pp. 3–34. New York: Oxford University Press.
Stewart, Kathleen
1996 A Space on the Side of the Road: Cultural Poetics in an "Other" America. Princeton, NJ: Princeton University Press.
Stoler, Ann Laura
2002 Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule. Berkeley: University of California Press.
1995 Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things. Durham, NC: Duke University Press.
World Bank
2003 Twenty-Seven Months—*Intifada*, Closures, and Palestinian Economic Crisis—An Assessment. Jerusalem: The World Bank West Bank and Gaza Office. May.