Between daya and doctor: a history of the impact of modern nation-state building on health east and west of the Jordan river.

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BETWEEN DAYA AND DOCTOR; A HISTORY OF THE IMPACT OF MODERN NATION-STATE BUILDING ON HEALTH EAST AND WEST OF THE JORDAN RIVER

A Dissertation Presented

by

ELISE G. YOUNG

Submitted to the Graduate School of the University of Massachusetts Amherst in partial fulfillment of the requirements of the degree of

DOCTOR OF PHILOSOPHY

September 1997

History Department
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BETWEEN DAYA AND DOCTOR: A HISTORY OF THE IMPACT OF MODERN
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ABSTRACT

BETWEEN DAYA AND DOCTOR; A HISTORY OF THE IMPACT OF MODERN NATION-STATE BUILDING ON HEALTH EAST AND WEST OF THE JORDAN RIVER

SEPTEMBER 1997

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This dissertation is a historical analysis of politics of state building and health in Palestine and in Jordan. The study contributes to contextual studies of constructions of gender and health as a central aspect of modern nation-state building in the twentieth century.

Processes of modern state building in the region of Bilad al Sham brought about significant transformations in definitions of health, development of health care systems, and medical practices. The study examines three aspects of these changes. First is a gender analysis of ways in which science and medicine contributed to colonialist processes of state building. Second is an exploration of particular effects of war, displacement and expulsion, and changing socioeconomic political conditions, on Palestinian women's health.
Third, the study looks at the significance for Palestinian women healers, midwives, and others, of changes introduced in the health system by the British in Palestine and in Transjordan and by UNRWA in refugee camps in Jordan.

A study of women and health requires a shift in dominant historiographical approaches. This dissertation develops an analytic framework that takes as its starting point questions raised by feminist epistemology. In the period addressed, the struggle for control of health systems is also a struggle for control of knowledge making. Aspects of this struggle disadvantage and invalidate knowledge bases of women healers. A central question of the study is: how do specific Palestinian refugee women construct meaning and authorize knowledge? This dissertation examines the particular relationship of Palestinian women to historical processes of war, citizenship in the modern nation-state, refugee status, relief efforts, and development processes. In addition to archival research, findings are based on oral histories with Palestinian women refugees in Jordan in order to understand how they interpret history and construct health.

Findings show that Palestinian women represented in this study construct health as a socio-political phenomenon, rather than in purely biological terms, and that health is a metaphor for homecoming.
Health concerns are central to Palestinian women's resistance: nationalist struggle is a historical reality informing their struggle for self definition, a struggle central to defining health. Oral histories represented in this study clarify the need to address Palestinian women's health in the context of gender, race, class politics dominating the region.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>v</td>
</tr>
<tr>
<td><strong>Chapter</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1. INTRODUCTION</strong></td>
<td>1</td>
</tr>
<tr>
<td>Approach and Methodology: &quot;Knowledge&quot; in the Era of the Modern Nation-state</td>
<td>6</td>
</tr>
<tr>
<td>Feminist Epistemology and Modernization Theory: Transmission of Knowledges</td>
<td>20</td>
</tr>
<tr>
<td>Epistemology and Oral History Methodology</td>
<td>24</td>
</tr>
<tr>
<td>Feminist Theory and Middle East Studies</td>
<td>31</td>
</tr>
<tr>
<td>State of the Field: Research on Jordan</td>
<td>39</td>
</tr>
<tr>
<td>Chapter Outline</td>
<td>42</td>
</tr>
<tr>
<td><strong>2. IMPERIALISM AND HEALTH: POLITICAL IMPLICATIONS OF MALARIA ERADICATION CAMPAIGNS IN PALESTINE AND TRANSJORDAN, 1919-1939</strong></td>
<td>50</td>
</tr>
<tr>
<td>An Imperial Pursuit: Malaria Eradication and Land Reclamation</td>
<td>50</td>
</tr>
<tr>
<td>Race, Gender, Class Politics of Malaria Eradication</td>
<td>54</td>
</tr>
<tr>
<td>The Political Economy of Health and Rehabilitation</td>
<td>60</td>
</tr>
<tr>
<td>Mighty Reactions and Anti-Malaria Measures: A Testing Ground</td>
<td>70</td>
</tr>
<tr>
<td>Long Term Effects</td>
<td>78</td>
</tr>
<tr>
<td>Conclusion</td>
<td>83</td>
</tr>
</tbody>
</table>
3. BETWEEN DAYA AND DOCTOR: A FORMIDABLE ABYSS? ..... 91

- Dangerous Hags and Sanitized Hovels: Midwifery and Modernity ......................... 94
- Reorganization/Regulation/Specialization ..... 101
- A Formidable Journey: Midwives in Refugee Camps in Jordan .................................. 118
- Conclusion ........................................................................................................ 131

4. 'THE CAMP OF RETURN'- HEALTH AND PALESTINIAN WOMEN REFUGEES IN JORDAN, 1950-1995 ................. 142

- Refugee or Freedom Fighter? Identity Politics and Health in Exile .......................... 145
- The Political Economy of Refugee Health ......... 159
- Women Talk About Health: Al-Ghurbah- The Disaster ........................................ 168
- From Jabal al-Hussein Camp to the Ministry: Poverty/Reproductive Health/Resistance ................................................................................... 176
- Conclusion ........................................................................................................ 192

BIBLIOGRAPHY ........................................................................................................ 203
CHAPTER I
INTRODUCTION

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

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

Several nights later, one of my Jordanian friends arrived at my room with an herb her grandmother used for curing respiratory conditions. When I was on my feet again,
my Arabic instructor treated me to thyme she kept in her freezer. All of the women I met here used plant cures regularly, along with, if they had health insurance or the money to pay for them, allopathic medicines such as antibiotics, either from private doctors, or dispensed through clinics.

But, as I would later discover, use of plant cures in Jordan is not without complex dimensions. For example, the state discourages use of herbs in refugee camps. In the twentieth century, changes in medical practices accompanying colonialism and nation-state building had an impact on both the availability of herbal medicines and on the population's use of age old healing methods.

This study is an historical analysis of politics of state building and health in Palestine and in Jordan. Processes of modern state building in the region of Bilad al-Sham (in Arabic, land of the sun, referring to the region of Greater Syria) brought about significant transformations in definitions of health, development of health care systems, and medical practices. I examine three aspects of these changes in the course of this study. First is a gender analysis of ways in which science and medicine in the twentieth century contribute to colonialist processes of state building in the regions addressed. Second, I discuss specific consequences of state building in the region, through military occupation, war, displacement and
expulsion, changing socio-economic-political conditions, and changing mores, on women's health. I examine these variables for Palestinian women in refugee camps in Jordan, with a chapter devoted to the midwife/healer or daya (pl. dayat).

And third, given significant changes introduced in health systems between 1919 and 1990, I explore how select women of the region define health. How do women interact with and affect health care systems as an aspect of state building? For example, according to Dr. Salwa Najjab, founder of the Women's Health Project of the Union of Palestinian Medical Relief Committees, key determinants of Palestinian women's health are the Israeli military occupation, poverty, and aspects of women's subordination in indigenous social systems. Dr. Najjab and colleagues insist that these critical dimensions defining health must be addressed through structures and modes of operation of the new Palestinian state structure and its Ministry of Health. Thus, conceptions of health, theoretical and practical, have become a primary aspect of defining state building for Palestinian women on the West Bank. Using archival and current data, oral histories and observation, I explore transformations in conceptions of health and health systems in Palestine, Transjordan, and Jordan, during the mandate period, and in refugee camps in Jordan.
Why focus on a history of women and health in Palestine and Jordan? There is very little scholarship about women's experiences and perspectives in the region, and about the gendered nature of health care. Studies addressing the use of medicine as a tool of colonialism by the British and French in the nineteenth and twentieth centuries focus mainly on Egypt (with some studies of Algeria, Sudan, and Tunisia). These studies focus on three aspects: the way in which doctors, many of whom were diplomats, help to pacify populations in remote areas; how certain elites (foreign and indigenous) subsumed medical considerations under economic goals (such as control of quarantine with the goal of control of trade); and the bifurcation of European medicine and Arabic medicine. No studies have been done of these processes in Greater Syria.

Studies, then, are needed analyzing health as a gendered construct and exploring consequences of the above phenomena for women. My interest in the historical significance of transformations in definitions of health and health systems for women grew out of my interaction beginning in 1989 with the Union of Palestine Medical Relief Committees in Palestine. The U.P.M.R.C. is a grassroots health care organization whose founder, Dr. Salwa Najjab, began the first health project specifically for Palestinian women. For the past decade Dr. Najjab and Dr. Rita Giacaman of the Birzeit University Community Health Department have
been engaged in developing health related studies focusing on women. The women's health movement in Palestine is one of the most cohesive among women's movements in Palestine.

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

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

Middle East historian Beshara Doumani has shown that Zionist and Arab nationalist historiographies share the assumptions of modernization theory. Both, for example, posit a period of Ottoman decline from the seventeenth to the nineteenth centuries, until the coming of the West and Ottoman reforms from above. Both posit a sharp break between 'traditional' and 'modern.' Both mark the beginning of modern history with Napoleon's invasion of Egypt in 1798, the policies of Muhammad Ali beginning in 1831, and the period of European Jewish settlement beginning in 1882. Doumani links these assumptions with the absence of a "live portrait of the Palestinian people, especially the historically silent majority of peasants, workers, artisans, women, merchants, Bedouin." 

Further, according to modernization theory, transformations that took place in Palestine beginning in the nineteenth century were merely reactions to outside forces. Some historians judge societies of the Middle East as backward until those societies incorporate western scientific technologies, whether in regard to their armies, agricultural practices, or industry. Hence:

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

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

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

A discussion of the inadequacy of dualisms is a starting point in considering the relationship between science and medicine in Europe and in the Middle East. Nineteenth century colonialists' bifurcation of European (enlightened) and Arabic (backward) medicine furthered their economic and strategic goals. Historically the Arab world and Europe were not separate cultural areas in regard to science and technology. A highly sophisticated Islamic science grew up at the confluence of major civilizations of the Mediterranean societies, as well as in China, India, Central Asia. Important Islamic scientists, among them Avicenna, Al-Biruni, Al-Razi, are far more numerous than can be cited here. In addition, experiential knowledge and discoveries of farmers and others worked its way into the scientific canon. Relations between the Islamic world and Christian Europe involved close commercial ties: on-going exchange resulted in inventions and techniques for agriculture as well as medicine. From the eleventh century, Islamic medicine and pharmacology were known in Europe. By the sixteenth century, Europeans studied in translation
Islamic science and medicine, at that time far more advanced than in Europe.⁸

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

The Qur'an stresses that socioeconomic justice is the pillar of its teaching on monotheism (the two teachings are organically related in the Qur'an), and the literature of hadith, or reports of the words and deeds of Muhammad, strongly underline mercy toward all creatures, particularly humans, and even enjoin the Muslim community actively to exercise good will. These potent moral-spiritual factors prepared the ground for the widespread reception and astonishing evolution of medicine in Islam.⁹

Translations from Arabic to Latin and medical pursuits in Iraq, Syria, Egypt, also inspired medical activity in the West:

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

Along with surgery, ophthalmology, and pharmacology, the earliest known hospitals were in the Islamic world, with separate wards for men and women and directed by lay physicians. Further, medical practices were regulated in order to weed out charlatans:
The hisbah system, as known in Arabic, originated in the early days of Islam and developed into an active bureau concerned about public safety and to guard against fraud in trade, market commodities, weights and measures, and incompetence in professional performances.¹¹

The relevance for gender relations of regulation of healing practitioners from the early days of Islam is yet to be studied.

One consequence of the conventional view of decline in the Ottoman Empire until European reform is that we lack knowledge about medical practices and supervision under the Ottoman Empire. Practitioners of biomedicine in the Islamic world have historically coexisted with healers who practiced natural medicine and those who practiced spiritual medicine. Midwifery was a legitimate branch of medicine, and in addition to oral transmission and experiential learning, hospitals provided training for midwives. Respect for midwives has persisted in spite of their changing status through history: Jordanian governmental officials when they see Hajj Anisa Shokar, the oldest living daya in Jordan, kiss her hand.¹² She delivered most officials in the kingdom. Depending on the general political situation, rulers and state structures encouraged or discouraged scientific and medical endeavors; research is needed on how these processes affected women in particular.

The incorrect bifurcation of traditional and modern medicine has come into usage as a result of transformations in health practices in the twentieth century. Developing a
typology useful for this study, Wolfgang Bichmann contextualizes the dualist construction of traditional vs. modern medicine, distinguishing between four types of medical care. Domestic medicine refers to general knowledge and practices used within families and involving self treatment with household and modern medicines. Folk medicine is a professionalized extension of the former, involving a division of labor in societies (women and men had different specializations and women often predominated). Traditional medical systems represent structured systems of ordering, classifying, and explaining illnesses, and elaborate concepts of treatment, some of which are codified into written sciences. Cosmopolitan medicine is derived from scientific and technical developments in Europe and North America, emphasizing biological scientific approaches, from the middle of the nineteenth century. Within this area of medicine, as in others, scientifically based and pre-scientific elements coexist. The conventional use of terms 'traditional' and 'modern' to characterize medical practices reinforces Eurocentric versions of the history of science and medicine.

Thus developments in the area of science and medicine in the Middle East are often attributed solely to European influence by nineteenth and twentieth century British and French colonialists. Middle East anthropologist Soheir Morsy challenges historical accounts of Egyptian ruler Muhammad
Ali's (1805-1848) extensive health programs as reliant on European physicians and texts. Morsy revises periodization of modernization theory: she maintains that Muhammad Ali's reforms, as they affected medicine, were continuations of trends of indigenous intellectual life of the 18th century. The commercial sector of the eighteenth century, with its need for profits "within an orthodox framework," found justification for commercial practices in the hadith, the sayings of the Prophet, himself a merchant. Similarly, in the 19th century, Muhammad Ali called upon kalam (speculative theology), logic, argumentation, medicine, and the natural sciences, to provide philosophical legitimation for his reforms. Thus, concern with positivist medicine involved a local revival which came to merge with external trends in science such as those developing in Europe.

At times Middle Eastern women benefited from ways in which indigenous traditions were reworked in the face of imperialist interventions. Morsy notes that "the adaptation of cultural traditions to historically specific political economic transformations is also evident in women's relation to popular medicine, for example, peasant women's involvement with Sufi healing rituals." As Middle East historian Peter Gran points out, Sufi orders responding to dangers of western encroachment appealed to women who were adversely affected by new market relations.
One way that Palestinian women have been involved in healing is through association with Sufi cults. Anthropologist Rema Hammami, in discussing the construction of peasant religiosity in Palestine, points out that women ascetics and dervishes were as common as men ascetics, and that they were accorded the same spiritual power. Some women were shaykhas, that is, they had special abilities to heal through spiritual mediation. Hammami conjectures that the belief in inherited disposition to be touched by the spirit world gave women a "discursive opening...to evade gender boundaries encoded in Sufi ritual and organization." Affliction in this case was taken as spiritual evidence of power to heal disease.

Aspects of Sufi practice were interwoven in the daily spiritual practice of Palestinian peasantry in 19th century Palestine. Spiritual life was predominantly centered on saints and their shrines and festivals and expressed through interaction with "nature, lifecycle processes and relatively egalitarian production relations at village levels." Spiritual power resided in living persons, trees, wells, buildings, saints who were once human beings, at sacred shrines and ritualized festivals affirming communal solidarity. Peasant women's central relation to saint shrines was connected to reproduction and child rearing as well as to ensuring family health and well-being. They may
have asked a saint to cure an illness or to protect their families from the army, or ensure a good harvest.23

A number of ritual days during the spring season of saint festivals were specifically women's days. For example, the first ritual day (called Thursdays) of the season, Khamis al-Nabat, or Thursday of the Plants, "women go out into the fields in groups and gather herbs and flowers with which to wash their hair. The following day, they would don their best clothes and return to spend the day sitting in the fields in groups, chatting and enjoying the new green of spring."24 One woman's description of Khamis al-Nabat, as celebrated by beduin women in Gaza, notes that girls rolled in the grass without clothes covering themselves with dew and collected herbs and flowers chanting, "Taqsh weh naqsh shu dawa el ras ya shjarah (crack and scratch; what medicine for the head, oh plant)?"25

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

While the Ottomans followed the developing positivist tradition in Europe, the mind/body dualism of positivist scientific method and of allopathic medicine that predominates in colonial medicine was not characteristic of Palestinian peasant women's religiosity. It was not characteristic of women's relation to nature, hence to healing practices. The overproduction of allopathic medicine by European colonials, fostering an uneasy relation between allopathic medicine and other kinds of indigenous healing practices, was a part of women's class struggles against the British, Zionists, and Jordanians in the 19th and 20th centuries. The social construction of 'woman' is historically situated in this complex of struggle since women's relation to healing is one way in which they are valued in Palestinian society. But renegotiation among Palestinians of uses of biomedicine and biomedical constructs and Prophetic (the medicine delineated by the Prophet) and naturalist medicine in the period explored in this study impact upon women differently. Some Palestinian women (though it seems that their numbers are small) had been trained in allopathic medicine in schools in Egypt or Anatolia. British doctors
integrated some Palestinian women into the process of promoting allopathic medicine by providing opportunities for medical education in Beirut or in Great Britain.

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

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

Healing through dietary means and through spiritual means, such as protection of the blue eye and of amulets with verses from the Qur'an, were emphasized by spiritual healers. A constellation of forces was seen as producing disease: air currents, wrong diet, age, influence of
spirits. For the most part, disease was explained in terms of social relationships, and preventive practices were incorporated into daily life, a facet of constructs of health that could have beneficial aspects for women. For example, customary admonition against physical abuse of women healers is salient in the following story. Morsy describes the case of a woman saint whose healing powers became manifest after her husband slapped her; his arm stood still, its nerves unable to move:

His arm was not cured until he begged her forgiveness and she finally massaged it for him while reading verses from the Quran. After this "sign" Amna lived a life of austerity, refraining from sexual intercourse and devoting her life to reading the Quran. Her healing power was renowned during her lifetime and still draws those seeking health from the village, and beyond, to her shrine.28

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

Imperial politics in the 19th and 20th centuries produced a particular reconfiguration in the history of
Islamic and European science and medicine. Scientists have always been involved in imperial politics within and between regions: alliances of scientists and diplomats, and scientists and capitalists, determined how scientific knowledge was disseminated. As Peter Gran, Soheir Morsy, and others point out, medicine was linked to the outcome of larger social and cultural struggles in various periods. Medical history was interlinked with class struggle and with effects of socio-economic political developments globally. For example, Morsy notes that in the late nineteenth century positivist allopathic medical practitioners in Egypt, ignoring the social production of sickness and health, (like North American biomedical specialists of the period), diagnosed women spiritual healers as "hysterical." Such medical trends, reconstructing health and disease by denigrating women's spiritual practices, might have had effects in Palestine, given on-going exchange of knowledge between Egyptian and Palestinian women. Effects of macro-political and economic processes on women healers have far reaching implications for all aspects of women's lives. Loss of land and concomitant loss of connection to sacred shrines and to constructs of and respect for women as saints and healers meant loss of protection as well as loss of participation.

The relationship between transitions and transformations in medical philosophies and practices as
well as social, economic, and political upheaval with long term consequences that have yet to be fully analyzed is also illustrated by Mohammed Thaishat at Yarmouk University in Jordan. In his study of major socio-economic changes in a small town in northern Jordan over the course of the twentieth century, he looks at transformations in existing medical beliefs, the social positions of practitioners, practitioner/patient relationships, types of medical knowledge of practitioners, and the relationship between indigenous and imported medicine in the present day system. Until the 1940s healing practices were based in religious teachings. The main healers in the town were shaykhs who were from the land owning class, the 'ashirih.' The economy of the town had depended upon agriculture and animal husbandry; but in the fifties land fragmentation and increased dependence on modern educational systems for jobs in government or in the army brought about increased differentiation in the social system. Over-use of modern biomedicine in the town led to a shift in emphasis from religious to secular interpretations of disease. Healers were no longer connected to political positions in the town. Contrary to customary practice healers began to receive patients with whom they had no relation. Impersonal health care situated health within a wage labor system, and separated doctors from patients in ways that were not familiar in the region, at least in terms of folk medicine.
and healing. Thaishat's findings, limited in that he does not explore these processes for women, nonetheless show how macro-politics in the region of Jordan influence local medical practices.  

This study shows how politics of women and health are germaine to the historical developments, including transformations in existing medical beliefs, the social position of practitioners, practitioner/patient relationships, types of medical knowledge of practitioners, and the relationship between indigenous and imported medical practices.

Feminist Epistemology and Modernization Theory: Transmission of Knowledges

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

Midwives attended women throughout the entirety of their labor, rather than only for the delivery. They provided psychological as well as physical support, and they were much less prone to invasive and interventionist techniques. Male physicians, by contrast, sometimes practiced such radical techniques as squeezing and trampling on the abdomen to force the baby's descent in a difficult birth or hanging the woman from a tree. It was male physicians who invented caesarean section, the use of forceps, and the infamous "twilight sleep," which rendered the woman semiconscious, unable to remember the experience afterward, and completely inactive and vulnerable to the doctor's decisions. And it was male physicians who introduced the lithotomy: the manner of giving birth from a supine position. Midwives, by contrast, often carried an obstetrical stool with them so that women could give birth while sitting up, thus making use of women's physiology and increasing the possibility of women's active control over the process.37

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

Midwives could turn the baby in the womb to avoid a breech presentation, they could perform abortions, and they provided a wealth of practical guidance on everything from inducing conception to curing breast infections. Midwives also had knowledge of herbal remedies that could hasten a protracted labor, reduce the pain of childbirth, and inhibit the chances of miscarriage; many of these herbal concoctions are still used today in modern pharmacology. Up until the 19th century and even into the beginning of the 20th, midwives were recognized by many doctors to be just as
successful— or more so, in their occupation as were trained physicians. Certainly among women, midwives had 'the right to be sure' in matters concerning childbirth. In the British colonial period in Palestine indigenous midwives were subject to many of the same accusations and pressure to conform to changes in birthing techniques, as Dalmiya and Alcoff describe above. When physicians in Europe took control of obstetrics thousands of women died from puerperal disease, a fever produced by bacteria on the hands of birth attendants. Since midwives only attended at births, they were not as likely to transmit bacteria as were physicians who had many other patients. Yet physicians insisted on the safety of the hospital and on the alleged ignorance and uncleanliness of the midwife. Doctors in refugee camps in Jordan, most of whom are Palestinian, often denigrate the midwife and her skills, blaming her for mistakes the doctors themselves make. However, midwives interviewed for this study express the view, based on their experiences, that doctors often endangered women in childbirth.

On what basis, Dalmiya and Alcoff query, could midwives' knowledge and practices be denigrated as superstition and untrustworthy? Just as modern scientists rely on empirical knowledge sanctioned by a community of experts, so midwives' skills are based on "direct empirical sources, practice, experience and a reliance on the body of beliefs accumulated by the acknowledged community of experts
on childbirth (that is, other midwives)." European and European trained male physicians disqualified midwives because the knowledge of midwives remained oral and experiential at a time when modern science and medicine authorized knowledge through documentation. Since historians and reporters of knowledge were men who were ignorant and disdainful of women's associative knowledge, such knowledge "eventually came to be seen as not knowledge at all but merely a set of hunches and tales circulated among gullible and prerational 'old wives.'"41

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

Epistemology and Oral History Methodology

One current approach to questions of veracity and knowledge authorization is Postmodernism. Postmodernists deconstruct knowledge and deconstruct women as subject. It is clear from time that I spent in refugee camps in Jordan that one way in which women address health is through a set of ethical assumptions, some continuous, some changing, ensuring their integrity as women. Postmodern analysis, although useful in affirming the need for contextualization, is not a theoretical stance from which it is possible to analyze the ethical features of women and health. Feminist theorist and medical ethicist Janice Raymond observes:

Postmodern theory and practice have also decentered the ethical in the sense of regarding principles such as the dignity or integrity of a woman's person as without any determinate meaning. Since there is no stabilizing center such as truth, conscience, or integrity of being, the ethical dimension vaporizes. Everything is text and more text, signs and more signs, signifiers and more signifiers, encouraging endless rounds of self-devouring equivocations.
My goal here is not to make the category of woman disappear, but rather to assert its authenticity. This does not mean that I attempt to define a homogenous woman: within a Palestinian refugee community, for example, women's experiences and views vary according to class, generation, and many other factors. My approach acknowledges women as subjects who use a range of strategies depending upon age, employment, marital status, and other elements, in order to cope with forces threatening their self determination. I attempt to understand ways in which women make meaning, given shifting social-economic-political structures affecting these women's possibilities. I am concerned with the truths of their experience as they perceive and construct those truths. I am also interested in how the women I interact with for this study constitute epistemological communities. That is to say, how do women construct meaning and authorize knowledge as a community rather than as individuals? The usefulness of approaching refugee women in camps in Jordan as epistemological communities grows out of what I learned as I conducted oral histories with those women.

The question of how knowledge is authorized (both authored and validated) as a theme in this study underpins my interest in oral histories. A recent study of the 1936 Great Revolt in Palestine by anthropologist Ted Swedenburg uses postmodern approaches to address historiographical
issues related to oral history in ways that both overlap with and diverge from my study. Swedenburg analyzes how some peasants remembered the revolt. He is influenced by the Popular Memory Group which characterizes most oral-history methodologies as presenting the past-present relation mainly as a problem of the unreliability of memory. This group asserts that this model of oral history and of memory is a passive one in which memory:

...is the sedimented form of past events, leaving traces that may be unearthed by appropriate questioning. It is a completed process, representative of the past which is itself dead and gone and therefore stable and objective...48

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

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

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

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

Swedenburg does not assume that oral histories will reveal "truths". His aim is not to fill a gap in academic knowledge nor to write a history from the point of view of the marginalized.⁵¹ Rather, he investigates the histories his subjects make in the context of struggle for control of nationalist discourse. Palestinian popular memory is a contested terrain where the Israeli state apparatus attempts to suppress and erase Palestinian history, and the PLO, official representative of the Palestinian nation, attempts to forge a national-popular past.⁵² In addition memories of the people interviewed were fused with awareness of the role of international forces in the present, particularly the United States:

Thus their memories of revolt possessed a kind of multiplevision or consciousness, as they maneuvered delicately between articulations of the popular and the national. At one level, their memories were situated in a subordinate and partially antagonistic relation to Palestinian national memory. At another they were aligned with nationalist discourse in opposition to Israel's ideological and repressive apparatuses and Israel's international supporters. Through their discussions with me, they attempted at the same time, to appeal to the international community.⁵³
Swedenburg's articulations of positionality and of historical contingency are useful for this study. Palestinian women's assertions in regard to health can be partially understood as an aspect of nationalist narratives. Indeed, British, Zionist, Palestinian, Jordanian nationalist projects all impact in critical ways women's definitions of health. And just as nationalist projects are in a constant state of flux and renegotiation, so women's relations to health systems and medical practices are in a state of flux and negotiation. That negotiation is a central theme of this study.

However, Swedenburg's focus on the rhetoric of narrative makes it difficult to ferret out important historical information in the text. His preoccupation with contingency dominates the text and creates an aura of linguistic complexity at the expense of important information contained in the oral histories.

Notions of multiple fields and contested terrain are relevant for any discussion of historical memory. But for women I interviewed these issues were not hidden agendas lending a sense of fabrication to their stories. Most women I interviewed stated clearly their hope that I would tell their stories to women in the United States. They talked to me as an emissary, in a sense, to women in the United States. And they talked openly about effects of Israeli, Palestinian, and Jordanian nationalist goals on their
health. Women interviewed clarified the impact of nationalisms on their health as historical realities informing their struggle for self definition, a struggle central to defining health. A major focus in all interviews is on poverty and other economic consequences of nationalist struggles. For example, while some trained midwives benefited from their new status in the mandate period, many lost their livelihoods and found themselves in desperate straits. The interviews in this study are not about the process of self disclosure. Rather, their aim is to acquire historical information that cannot be acquired in any other way.

Unlike Swedenburg's aim, the purpose of this study is to uncover truths; to fill gaps in our knowledge of the period, but also to raise methodological questions and show the connection of the subject matter to those questions. Information gleaned through oral histories is no more or less subject to verification than other research methodologies, since all histories are perspectival.

Ironically, Swedenburg's chapter, 'Memory Recoded', includes a section on the participation of women in the 1936 Revolt but is not based on oral histories. Although he says this is because rural women as well as men considered men primary authorities on the revolt and on local history, women in camps did not hesitate to discuss their participation in and views of history with other scholars.
Rosemary Sayigh's oral histories with Palestinian women in Lebanon give us insight into some Palestinian women's historical memory and raise the question of whether or not women's memory is different from men's. She asks the important question: what do women reveal when they remember history that men do not? How do older and younger women control each other's speech? And she conjectures that women often will disclose information that is embarrassing to men. Certainly, women's memories are distinct in the area addressed in this study, since remembrances concern their health and their craft as midwives. And, of course, women's memories are always gender distinct, as they draw from their relations as women both with other women and with men.

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

At many periods of Muslim history, including the Abbasid period, women were so debased that even their kinship with a great man would not have rendered their words worthy of note.
Such periods of historical silencing of women have prompted women historians to recover women's experiences, visions, analyses through use of oral histories. Oral histories are helpful vehicles for historicizing women's experiences and perspectives. Feminist theory and movements globally have focused on the need to validate women's speech. Theoretical developments in feminisms, especially African American feminisms, have particular relevance to my approach to women's oral history.

**Feminist Theory and Middle East Studies**

In the last decade as I have interacted with scholars from the Middle East engaged in and following feminist movements and methodologies, I have been struck by the way many scholars characterize western feminism. They reduce western feminisms to women and movements with access to the press. In addition, scholars often homogenize feminisms based on at times spurious assumptions about the positionality of particular western feminist scholars. In addition, feminist theorizing by women of what some characterize as the domestic third world, (for example, African American, Latina, and Native American women), seems to have penetrated the Middle East only as it relates to identity politics.
Parallels in historic and current oppression of African American women and of Palestinian women is a basis for considering the relevance of African American feminist theory for Palestinian women's lives. According to African American feminist Patricia Hill Collins, "race and gender oppression revolve around the same axis of disdain for the body—both portray sexuality of subordinate groups as animalistic and deviant." This is also characteristic of views of Middle Eastern women spread by colonialists abroad and academicians and the popular media in the United States. Analogies exist between the proletarianization of African American women in the market place in the United States and Palestinian refugee women in Jordan in the twentieth century. Palestinian women in refugee camps in Jordan define health given a trajectory of forces that resonate with those of African American women in inner cities in the United States. Both face environmental hazards related to poverty, poor housing, and lack of employment options, all of which negatively impact women's health.

We have only begun to explore the multiplicity of ways women in western and eastern hemispheres influence one another's politics, theories of knowledge, and movements. International feminist movements' analyses in regard to areas such as women's health, detailed in women's conferences of the past several decades, are rooted in interconnections whose histories are not well known. For example, British
nurses' often racist views of indigenous midwives and their participation in a systemic limitation of Palestinian midwives' livelihoods is a subject of this study. On the other hand, there is evidence that some women in the Zionist Working Women's Movement connected their struggles with those of Palestinians, as both received lower wages and worked in horrendous conditions. We can guess that there were a multitude of ways that these women, especially those who learned Arabic, and many did, may have communicated and influenced one another, but we have yet to recover that history. Analyses of gendered global economics and politics are crucial for historians of Middle Eastern women and of women in the United States. Comparative analysis that allows for the possibility of grand narrative, along with variation and complexity according to different contexts, is perhaps the next phase of research required.

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

Black women's centrality in families and community organizations provides African-American women with a high degree of support for invoking dialogue as a dimension of an Afrocentric feminist epistemology. However, when African-American women use dialogues in assessing knowledge claims, we might be invoking a particularly female way of knowing as well.
In addition, Collins makes the point that:

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

During February, March, and April of 1995, I conducted in-depth interviews in Arabic and English with twenty Palestinian women, half of whom were living in Jabal al-Hussein and half in Baq'a refugee camps in Jordan. I asked those who had experienced war and exile to describe health related issues. In addition, I addressed the following questions: In the context of the camps, did women view health as they had in Palestine? How did they incorporate their wartime experience into their views of health? I also asked these women, as well as women born in the camps, about how women's on-going status as refugees affected their health. Did women's healing practices change? What were their major concerns in terms of health systems and practices?

The sample interviewed included five single women in their twenties who were born in the camps, seven women who were refugees of 1948, and eight women who became refugees in 1967. Of those who came from Palestine to Jordan, all were from peasant, rural backgrounds. All women were living with their families at the time of the interviews. Half of
the sample were midwives, and many were involved in organizing to gain resources relevant to women's health. Most were politically active within the camps. None referred to religion in the course of the interviews.

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

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

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

The goal of the interviews was not to gather health related statistics, nor to verify narratives against other kinds of data. The goal was rather to document a history as perceived by the women addressed, and to discover how these women conceptualized health. And while these interviews typify views of a cross section of women in the camps I visited, they in no way represent Palestinian women in other camps in Jordan or in refugee camps throughout the Middle East, where circumstances vary widely. The interviews do,
however, provide a basis for beginning to understand how some Palestinian women have experienced war, exile, and refugee life, focusing especially on how these women, given those experiences, construct health and health practices, and focusing on the situation of women healers in Jabal al-Hussein and Baq'a refugee camps.

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

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

State of the Field: Research on Jordan

Having explored methodological considerations informing this study, I turn now to a brief discussion of contributions of this study to literature on Jordan. Research on and by Palestinian women is a phenomenon of the past several decades. For a current and very informative discussion and critique of studies of Palestinian women in the Israeli occupied territories and Palestinian 'Autonomy,' see Gender and Society, Working Papers, Women's Studies Program, Birzeit University, 1995. Research on and by Palestinian refugee women is also scarce. Orayb Najjar's, Portraits of Palestinian Women (1992) contains informative and moving interviews with Palestinian refugee women. Rosemary Sayigh's groundbreaking From Peasants to Revolutionaries, and Too Many Enemies (1994) and many of her published articles, are based on comprehensive interviews with Palestinian refugees, including women, particularly in camps in Lebanon. To date, there are no monographs on Palestinian women in refugee camps in Jordan; however, Rima
Yusuf Salah's Ph.D. dissertation, "The Changing Roles of Palestinian Women in Refugee Camps in Jordan," is an important contribution to future studies. Mona Al-Khalidi's thesis, "The Determinants of Health Status in Jordan, 1960-1988", contains a section on the refugee camps that includes some attention to women. My study, therefore, relies for the most part on oral histories that I conducted in 1995, my observations in Jordan and in Palestine, and primary documents obtained in Jordan, including archival documents of the British Colonial Office, Department of Health documents, Palestine, Transjordan, and Jordan, and reports of non-governmental organizations. My information on women in Jordan in general, including health studies, also derives from oral histories I conduct; from unpublished papers often produced for non-governmental organizations or relevant conferences, as well as published governmental documents; from statistical data; and from a few published sources, for example, Sateny Shami's study of work patterns and gender relations in Jordan.

Most versions of Jordanian history reflect nationalist historiographical approaches, privileging colonialism, Zionism, and Palestinian nationalism as constitutive of Jordanian state building. Within that category, a majority of studies focus on the important complexities of Ottoman, British, Israeli and Palestinian politics and diplomacy. The central debates raised among historians, for example, about
Hashemite connections to Zionists, continue to be critical for unraveling politicians motivations and circumstances, and for characterizing the historical development of the region, as historians make use of declassified documents. Of note among those studies, Mary C. Wilson's King Abdullah, Britain and the Making of Jordan (1987) carefully builds a history of Jordan's emergence and a revised portrait of Abdullah's role in that history based on hitherto unexplored primary sources. Laurie Brand's Jordan's Inter-Arab Relations: The Political Economy of Alliance Making (1994) situates economic security as more central than military security for Jordan's inter-Arab politics. Miriam Lowi's Water and Power: the politics of a scarce resource in the Jordan River Basin (1993), places the critical issue of control of water at the center of the politics of state building in the region. Village, Steppe and State (1995)(Eds, Tell and Rogan) revises conventional periodization informing histories of Jordan. The articles focus on a variety of ways that Jordan exists as it does because of continuity with the Ottoman past, rather than solely as a result of British imperial politics and the upheavals of modern nation-state building. Linda Layne's Home and Homeland (1995) is an ethnography of the Abbad confederation of the Jordan Valley. She looks at on-going negotiation between tribal and national identities, which she demonstrates are flexible, rather than static. Her
approach helps to overcome the often rigid and erroneous definitions and boundaries prescribed by terms such as 'tribe,' or 'bedouin.' My study of state building and health was enhanced by ethnographic studies by Jordanians, most by medical anthropologists, published at Yarmouk University. In addition, the work of Brigitte Curmi (1994) and of Jocelyn DeJong (1993) were invaluable in this endeavor.

My work contributes to contextual studies of the construction of gender and health as a central aspect of modern nation-state building in the twentieth century. I critique and analyze conventional historiography as inadequate for interpreting historical developments. My focus on Palestinians in Jordan follows conventional lines, while shifting the focus away from elites and men to bring women refugees into the forefront. My methodology brings together Women's Studies, Feminist Epistemology, and Middle Eastern history to examine effects of global politics on issues of women and health in the regions addressed.

Chapter Outline

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

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

In Chapter Two, I analyze British and American colonials' use of modern science and medicine to further their economic and political goals of controlling Palestine and Transjordan in the period 1919 to approximately 1939. Specifically I analyze the interconnected race and gender constructs of nature and their ecological ramifications, expressed in archival materials documenting malaria control programs in this period. These programs continued to be highlighted in Department of Health Reports from Palestine and Transjordan for the next several decades. The British made these programs a priority in terms of funding in order to secure the health of troops, and concomitantly to secure control of water and of land. The British also promoted Jewish ownership of land under the guise of humanitarian concerns related to malaria control, ceding land to a Zionist affiliated corporation, the Rutenberg Electric Company. Health issues noted by the British led Department of Health during the 1936-39 Great Revolt are related to ways in which the Revolt affected the work of the Department
of Health (including malaria control), not to political or
economic developments motivating the uprising. Such reports
help us analyze the consequences for the local populous of
British constructs of health.

Chapter Three has two goals. The first is to analyze
consequences for Palestinian women in Palestine and Jordan
of the professionalization of the daya (midwife/healer)
during the British Mandate period (1917-1948). The second is
to explore consequences of this history for Palestinian
women who become refugees after 1948, through discussions
with dayat in Jabal Al-Hussein and Baq`a refugee camps and
in the city of Amman. The British, and later United Nations
Relief and Works Agency, recruited midwives for training and
registration. In this process distinctly diverging views of
health and medical practices, particularly among British
officials and foreign doctors and indigenous women healers,
must be negotiated in the face of newly emerging regulations
and institutions run by European doctors, nurses, and
indigenous health practitioners trained in Great Britain. In
this process many women lose their livelihoods and become
dependent upon a foreign source of support based on foreign
ideas about who they are. The daya is a focus of health
politics because she is central to British officials' access
to women's bodies and control of reproduction. Views of
dayat themselves, who detail benefits and harm regarding
these processes, provide insight into this history.
Chapter Four tells the story of women and health in refugee camps in Jordan, beginning with the 1948 wars and ending with the Jordanian-Israeli Agreements (1994). After a detailed discussion of dispersion, refugee status, and relief efforts, I then build the chapter around oral histories conducted in Jabal al-Hussein and Baq`a refugee camps. The themes of the chapter, along with the initial description of the establishment of refugee camps in the early 1950s and after the Six-day War of 1967, are set by the interviews and include: effects of militarization, including rape, on women in the region; effects of Jordanian-Palestinian politics on women in the camps; refugee women's activism in the camps; how conditions and health related policies and practices in the camps are affecting women's health and women health practitioners; issues of health and human rights. We begin with a textual analysis of politics of British colonial medicine in the Mandate period.

Endnotes

1. Dr. Salwa Najjab-Khatib, 'Notes on Women and Health in Occupied Palestine', (1989), unpublished paper.

2. See for example, Jim Paul, 'Medicine and Imperialism in Morocco', MERIP Reports, No.60 (Sept. 1977), pp.3-13.

3. For elaboration of these last two points, see for example, Nancy E. Gallagher, Medicine and Power in Tunisia, (Cambridge:


12. I interviewed Hajj Anisa Shokar in her home in Amman, Jordan, in March, 1995, for this study. See Chapter Three.


16. Morsy, Gender and Sickness, p.18.


24. Hammami, 'Between Heaven and Earth', p.81-82.

25. Hammami, 'Between Heaven and Earth', p.82.

26. Hammami, 'Between Heaven and Earth', p.91


29. See Morsy, *Gender and Sickness*, p. 204.


33. Thaishat, 'A Case Study', p.50.

34. Thaishat, 'A Case Study', p.51-52.

35. See Linda Alcoff, Elizabeth Potter (eds) *Feminist Epistemologies* (New York; Routledge, 1993), for one such study with a comprehensive bibliography.

36. Vrinda Dalmiya and Linda Alcoff, 'Are "Old Wives' Tales" justified?' in Linda Alcoff and Elizabeth Potter (eds.), *Feminist


46. Feminist philosopher Lynn Hankinson Nelson points out that agents of epistemology are not isolated, and develops a typology asserting that communities are the primary generator and repositories of knowledge. See Lynn Hankinson Nelson, "Epistemological Communities' in Alcoff and Potter, 1993.


49. Swedenburg, Memories of Revolt, p.xxviii.

50. Swedenburg, Memories of Revolt, p.xxviii.

51. Swedenburg, Memories of Revolt, p.xxvi.

52. Swedenburg, Memories of Revolt, p.6.

53. Swedenburg, Memories of Revolt, p.xxx.


60. Collins, Black Feminist Thought, p. 209.


CHAPTER 2

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

An Imperial Pursuit: Malaria Eradication and Land Reclamation

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

The goal of this chapter is to analyze the politics of British and American led malaria eradication in Palestine, focusing on the post World War One period. Beneficial effects of European and American imported medical practices that reduced the devastating effects of epidemic diseases are well known. However, by decoding the language and motivations of colonial medical practitioners working with philanthropists and politicians we have a basis for understanding the paradoxical role of health care in both aiding the indigenous male and female population, and in
abetting loss of control for both men and women, of their environment.

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

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

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

The scientific goal of the malaria eradication program was to eliminate the *Anopheles gambiae* mosquito that carried the disease. This was done by cataloging wells and cisterns and spreading Paris Green dust or oiling with pyrethreun paraffin, pesticides containing arsenic which killed the mosquito larvae. DDT (dichloro-diphenyl-trichloroethane) was also used in later stages, and eventually became the primary vehicle for eradication. While there is no doubt that in the short term British public health policies reduced suffering from malaria, associated consequences, examined in this chapter, are less sanguine. The malaria eradication program cannot be separated from colonial politics in the twentieth century.
During the imperial age, views of disease and of a primitive colonized world were linked in an antithetical relationship to a sanitary, civilized Europe:

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

Malaria control and control of other epidemic diseases could become a convincing example of the superior progress of a more civilized imperial order. The structures and practices of malaria eradication reflected the role of biological science in supporting imperialist politics. Americans and European Zionists supported the British led program by contributing funds. As noted later in this chapter, British documentation at times reflected a prioritizing of Zionist settlement policies based on monetary assistance for malaria control. Thus, the political economy of malaria eradication supported the eventual transfer of control of Palestine to the Zionist enterprise. British and American conceptions of Palestine and of its inhabitants shaped the politics of malaria eradication. This chapter analyzes British and American constructions of the land and of its inhabitants, transmitted through the scientific endeavor of malaria eradication.
In 1921, British governmental officials, furthering the goal of malaria control begun in 1919, drew up a program for major anti-malaria works, "embodying drainage and reclamation schemes of some magnitude." By 1926 the assigned 'Section' (designated workers for a particular geographic area) had completed surveys and schemes in connection with the drainage of marshes in Beisan, Huleh, Kishon, Naamein, Birket Ramadan, and Wadi Rubin regions, involving an area of about 52,000 acres, as well as projects for the remodeling of drainage and irrigation of Jericho.

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

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

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

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

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

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

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

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

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

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

Lowdermilk connected Palestine and Palestinians with disease. He equated scientist with beneficent conqueror. Such notions characterized western thinking in the nineteenth and early twentieth centuries. While recruiting indigenous laborers to spray pesticides, European, American, and Zionist officials in account after account, dismissed the labor of Palestinians and denounced the ways in which 'the Arabs' had neglected the land. American colonists used similar arguments as they wrested control of the Americas from its indigenous inhabitants.¹² American engineers studied, learned from, and competed with British engineers who made possible British occupation of India, of Egypt, and of Palestine:

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

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

Water being essential to prosperity and of limited amount, its control must be in the State which, in providing for its use, shall equally guard all the various interests involved. The
waters of all natural streams, springs, and other collections of water are hereby declared to be the property of the State.\textsuperscript{14} The European construction and treatment of Native American and Muslim as savage, primitive, irrational, and needing to be tamed also had gendered implications.\textsuperscript{15} In North America, as in mandated Palestine, deserts were the domain of men: engineers were the heroes who made the desert bloom.\textsuperscript{16} European Zionist ideology took root in and contributed to this intellectual milieu which constructed women as nature, and nature as an uncontrollable force needing to be tamed. For example, Zionists promoted the myth that Palestine was barren; the Jewish male, himself effeminized by anti-Semitic ideologies of the period, proved his virility by planting his seed.\textsuperscript{17} Zionists, (like Europeans generally) involved in reclamation of land, phrased as redemption of land, at once idealized and denigrated nature as sacred virgin to be protected, and wanton whore to be tamed.\textsuperscript{18}

The mythos of land and labor as vehicles for Jewish redemption hid the goal of capitalization of land and labor sought by some Zionists and by some British and Americans as well.\textsuperscript{19} Palestinians (and later Jews from Arab countries, including women) were to provide the cheap and supposedly docile labor required. As noted in the Department of Overseas Trade Report on Economic Conditions in Palestine, July, 1931:
The earnings of women (female labor is usually employed in the textile and clothing industries and the manufacture of cigarettes, artificial teeth and cardboard boxes) are lower than those of men employed in the same trades. European labourers receive on the average about 100 mils per day more than Oriental laborers.20

European Zionist officials, like many British officials, assigned a qualitatively different nature to Arab and to European. Their typical Arab was dishonest, lazy, uneducated, greedy and unpatriotic.21 British scientific methods would rehabilitate the Arab, opening a window of health never before available, particularly given the debased state of the Ottoman Empire, known before its demise after World War One as the "sick man of Europe."

The Political Economy of Health and Rehabilitation

Some aspects of this rehabilitation were efficient and cheap; others, for example re-organization and repair of irrigation systems, were costly and time consuming. In either case, the British Department of Public Works and the Rockefeller officials, depended upon funds from the Colonial Office and cooperation from the local population. According to the Department of Health Report, 1921, the Ottoman Medical Service could have served the primary needs of the country, but its plans were not carried out.22 It seems that, following the characterization of Ottoman decline in the period, the great tradition of building hospitals and
medical schools under the Ottomans, as well as centuries old practices of sanitation associated with Prophetic medicine, had come to an end.23

The word sanitary appeared often in reports. The new department had to shoulder responsibility for sanitary services throughout the land, as well as establishing hospitals and dispensaries with voluntary and charitable efforts already existing.24 However, The Supreme Muslim Council (created by the British Mandate in 1921 to manage Islamic institutions), contributed funds for malaria control, and local laborers were persuaded to take up the cause. The 1922 Department of Health Annual Report gave an encouraging picture of native cooperation:

It is a remarkable fact that a people unused for centuries to sanitary reform has grasped with such readiness the essential fact that good sanitation means good health and health spells prosperity. Such has been our experience amongst the Arab population, who by careful and tactful dealing on the part of the P.M.S. and their medical staff have responded readily to sanitary enterprise and health projects and have co-operated with the Department of health in its campaign against dirt and disease.25

The 1929 Annual Report of the Department of Health noted that 2,286 laborers worked for 17,698 days without cost to the Government, constructing a total length of 280,756 metres of canals and drainage ditches.26 Other Department of Health reports talked about the need for propaganda to persuade workers to participate, without specifying what that propaganda should consist of. An antimalarial ordinance
enforced work in rural districts: the Department of Health Annual Report, 1930, noted that application of the Ordinance was required for the most part in cases involving provision of mosquito-proof covers to cisterns and wells.27

Malaria eradication was a site for renegotiation of class conflict, inseparable from nationalist conflict, given opportunities for alliances typical of colonial situations. Large landowners benefited from cooperating, just as some Palestinian doctors benefited from charging higher fees through their association with the new Department of Health.28 In 1928, The Malaria Research Unit with the financial assistance of the Palestine Jewish Colonization Association and a number of Jewish and Arab land owners, canalized malarious wadis and marshes.29 A Jewish concern paid for a major portion of a scheme to improve drainage of the Kishom River near Haifa, including substitution of cement drains for stone lined canals, after the concern bought into ownership of the land.30 The goal of industrial and agricultural development were motivations for thorough malaria surveys, as well as concern for Jewish settlers, and concern for the welfare of British and British led troops such as the Transjordanian Frontier Force.

The attempt to persuade local workers to cooperate in health projects by arguing that health meant prosperity was somewhat ironic given the negative economic consequences for many Arab laborers and farmers as a result of World War I
and the British mandate. The British continued Ottoman policy of heavy taxation of the peasantry. As a result of the British invasion of 1917, draft (work) animals were appropriated for the war effort, crops were lost, and fields burned. Under mandate, cheap imports meant loss of livelihood for many, although some peasants benefited from new markets. Ongoing privatization of land as a result of British regulations and Zionist settlement combined with reduction in infant morality and increase in population, meant that land holdings were often too small for subsistence. 31

Palestinian women were among those particularly disadvantaged by British economic policies. Many peasant women lost independence in a capitalist wage labor system which increased the ability of male heads of households to manage women's labor. 32 Rema Hammami has argued that the agricultural labor of Palestinian women gave them societal power since it was both compensated and recognized as a critical contribution to the productive unit of the family. When family labor was subsumed under a capitalist wage labor system targeting men as the primary source of income, women's labor became the "unrecognized property of the family." 33

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

In 1921 the British High Commissioner of Palestine, Sir Herbert Samuel, granted a concession to Zionist entrepreneur, Pinhas Rutenberg, for the generation and distribution of electricity throughout Palestine. The Rutenberg Hydro-Electric Corporation remodeled large areas of land and controlled the use of water for irrigation as well as the flow of water. The corporation drained springs and seepage areas, and when breeding places could not be eliminated, they were treated regularly with the pesticide, Paris Green, and, on occasion, with pyrethrum paraffin preparation. In addition, the Rockefeller Foundation, which was experienced in malaria eradication, assisted, working with the Jewish Joint Distribution Committee of America. With the rationale of humanitarian concerns, British and Americans made field surveys of the mosquito breeding areas in 1928. The collaborative effort involved drawing maps, supervising construction of drainage projects, assisting local health officials in routine malaria control, and conducting experiments to determine the source of mosquitos infestation. The work of the Department of Health was augmented (and overlapped with Zionist interests) since they
found that areas where malaria incidence increased corresponded closely with the areas of Jewish agricultural settlement.36

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

In view of the recently awakened interest in this small strip of country on the Mediterranean, it has seemed advisable to set forth somewhat comprehensively a survey of conditions as they are, and to point out the line in which commercial development is possible and which may offer opportunities to American trade.37

A report of the American Consul at Jerusalem, Addison Southard, submitted to Herbert Hoover (then a successful mining engineer) in 1922, noted that investigators found hydroelectric power to be "by far the most important project which exists for the economic rehabilitation of Palestine."38 The report also noted that the large amount of capital required would be a serious obstacle to its full realization. Through cooperation and coordination among the British, Americans, and European Zionist leaders, this problem was solved. According to American officials, the majority of the Arab population would make its contribution too:

The main factor in the commercial rebirth of Palestine is the sentimental and material attention it is receiving from one of the most active and virile commercial races in the world which appears determined to spare no effort in making the best of
every economic possibility which the country possesses. Plans included the purchase and preparation of land for immigrants, the founding of Jewish institutions involving building activity, the development of irrigation and hydroelectric power, credit banks (which are of greatest importance in a land without capital), agricultural research and reforesting, public health, social welfare, and other undertakings. This is to be the contribution of the Jewish element. The majority population of the country, which is of Arabic origin, is not in a position to provide financial capital to any great extent, but it will supply a valuable capital of certain physical and mental virility which should react mightily to the various economic factors that will probably be set in motion.  

Here the roles of European Jew and indigenous Arab were delineated in gendered terms: Jewish institutions (virile, active) would be involved in financing public health, while Arabs (passive and perhaps effeminized) would fill the role of a cheap labor force. But the Arab population did, as we know, "react mightily" to Jewish involvement, particularly to the "various economic factors set in motion." Many protested the official Zionist policy of separation of Jewish and Arab labor. This policy not only contradicted the promise of benefits to Palestinians from Zionist capital investment, but also threatened the indigenous economic base. Consular and League of Nations reports noted the opposition of the indigenous population to British and Zionist policies aimed at controlling land and labor only in so far as these reports dismissed political problems as out of place in a commercial report.
Hence, Americans, British, and Zionists continued to reclaim land through malaria eradication programs involving mapping, rerouting, and control of water sources, and granting of concessions for development of hydroelectric power. Referring to the Huleh Basin Scheme, which aimed to reclaim the Huleh swamps, a League of Nations Report noted that:

It appears to us that it is in large schemes of reclamation of this kind that the Mandatory Power can best fulfill its obligation of encouraging "in cooperation with the Jewish Agency...close settlement by Jews on the land." The sum proposed would be, we consider, a justifiable charge on public revenues for a scheme which eliminated malaria from an extensive tract, irrigated 60,000 dunums outside the concession, and inside it, after reserving 15,000 dunums to Arabs, provided 36,000 dunums for Jewish colonists. (emphasis mine)

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

...it is difficult to know how much of the decline in prevalence of malaria in Palestine during the last few years has been due to the control measures in force, and how much is simply
the result of a natural decline from war-time epidemic conditions.\textsuperscript{11} 

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

The damming of the River Jordan has caused flooding for about three kilometers of the river which necessitated a large amount of cleaning and control of breeding by chemical means. The Yarmuk basin in which water will eventually be impounded will constitute a lake many acres in extent, a large part of which will consist of shallows. The growth of aquatic vegetation which will naturally occur very rapidly over this shallow area is likely to prove ideal for anopheles breeding which will constitute a serious danger to the Transjordan Frontier Force Camp near the basin, to the staff of the Electric Corporation, an elaborate set of plans are being evolved to carry out all measures of control necessitated by the new conditions which have been created by the works.\textsuperscript{12}

Reports to the Rockefeller Foundation acknowledged that drainage was not the main problem. Rather, at issue were conservation and control of available water supplies. Still, the Haifa Bay Development Company and Land Corporation undertook extensive drainage projects to afford adequate areas of land for industrial development in the neighborhood of Haifa.\textsuperscript{13}

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

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

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

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

Mighty Reactions and Anti-Malaria Measures: A Testing Ground 

The British introduced health initiatives through increased hospital and clinical services, public health measures, use of drugs, medical surveillance, and ordinances proscribing medical practices. Their programs and policies contributed to measurable improvements according to newly defined parameters defining the health status of the populations. While British officers, between 1936 and 1939, raided homes and shot women and men, the mandate Government instituted relief measures for persons whose livelihoods were affected by the disturbances. Politics may have been a hindrance to the British led Department of Health, but a hindrance that could be easily overcome through the
dedication of a loyal staff. The loyal staff included Arab doctors who benefited from working for the British-run Department of Health. At the same time, from the Palestinian perspective, health practices were also considered within the domain of the nationalist cause. It is significant that some among the Palestinian nationalist leadership considered Palestinian doctors accountable to their people and to a Palestinian agenda. According to one British physician who served in Hebron during the 1936 rebellion, two Arab doctors from the Health Department were hauled before a rebel court and reproved for taking too much money from poor patients.49

Moreover, in this period a history of interrelationship between Jews, Muslims, and Christians in the area of health, medicine, and medical practices was disrupted. Palestinians competed with Jews for scarce services since the British health Department was short of funds. Owing to disturbances beginning in 1929, Jews had begun seeking admission to Jewish hospitals. A separation of Jewish and Arab health facilities, along with separation of Jewish and Arab labor, redefined health customs and practices. Historically, Jews and Muslims, including female midwives and doctors, were accustomed to interaction in the area of medical philosophy and practice. One Palestinian woman interviewed for this study put it this way:

My mother had Jewish friends. Hatt al-Nassar is named Sarina after her Jewish neighbor, and there is another sister Sarah also after her neighbor...they were Arab Jewish...They had their
own feasts, each sect and religion, but they used to have cooperation with vegetables and so on and also they used to exchange different sweets during the feasts. My father brought for my mother a Jewish doctor and there were also two Arab doctors...there was no segregation.\textsuperscript{30}

During the 1936-39 revolt, one woman doctor, a Jew who attended to Arab villagers in the al-Tayyiba area, concealed a rebel chief and treated his wounds, returning his favor of having rescued her from thieves.\textsuperscript{31}

Gradually during the mandate years, Arab and Jewish women began seeking health support in separate spheres. Arab and Jewish women began receiving ante-natal care and treatment from British women doctors in separate clinics rather than from one another. Hospitals began to service separate populations. Jewish women attended hospitals sponsored by Jewish organizations. And [Jewish, Christian, Muslim] Palestinian midwives "who had been secretly and illegally carrying on so-called gynecological practice of a most unsatisfactory kind," were increasingly phased out.\textsuperscript{32}

During the period of increasing unrest characterizing the mandate, many European Jews increasingly had access both to health care through private sources and to means of economic survival not available to the majority of the Palestinian population. And while Palestinians benefited from British humanitarianism in the sphere of health care, many suffered from deleterious economic policies. Palestinian women and men of peasant background shared with
anthropologist Rema Hammami their remembrances of hardship during the mandate period:

The British used to play with the prices. In the good harvest year the British would put a ceiling on the prices we'd sell a rutl (approximately 3 kilos) of wheat for two piasters. When it was a bad year they would make a rutl of wheat for 20 piasters. They didn't want us to raise our heads. It was part of their colonial plan. Abu al-Abed from Faluja similarly remembered: It was a colonial policy, and when the muhassil (tax collector) would do the accounts the government would lower the prices, a kilo that was five qurush they would make it for two qurush- so we'd lose so we made the strike in 1919 and then in 1936 the strike for six months.53

In 1937, the Annual Report of the Department of Health noted much poverty among the Arabs in towns and in villages: "The villagers have been accustomed to produce and exist on their own grain, vegetables, and farm produce, but adverse economic conditions and rapid increase of population have diminished their means of livelihood."54

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

1936 again proved to be a testing ground for the Department of Health. Anti-malarial measures in Palestine were held up by the general strike. Increased military activities were carried out throughout the malarial season, April to November. There were military patrols on roads and railways by day and night, guards stationed throughout the country, and "frequent operations involving the movement of considerable bodies of men for several days on end over large parts of the country." Although considered susceptible to malaria, the young British soldiers benefited from routine anti-larval measures of the Department of Health, so that out of a force of 15,000, there were 117 primary cases of malaria, and 22 relapses. The disturbances impeded work because of the difficulty of
obtaining labor. But during the acute stages of the rebellion, the District Superintendent of Police supplied guards for anti-malarial labor gangs in the Northern part of Jaffa sub-district: "A breakdown of the measures for the prevention of malaria in this area was thereby narrowly averted."^58

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

The Department was satisfied that there were no epidemics and that the general health of the Arab and Jewish populations was satisfactory given disturbances and
privations. Unrest in Palestine from May to October 1936 presented difficulties in carrying out services in rural districts where personnel were in danger of attack. But it was to their credit that they (Arab, Jewish, British) carried on their duties in urban and rural areas with "the greatest loyalty and devotion...First aid in casualties amongst troops, police and civilians were readily available, and in certain instances gallantly administered, by the department's medical officers and by voluntary and charitable medical organizations and units." Because of the increase in the British police force, and British government officers' and army officers' wives and children, more hospital beds, however, were needed. The 1936 infant mortality rate at 121/100 (general population average) was the lowest recorded in Palestine; and the death rate at 16.11 was the lowest yet recorded. From the point of view of British medical officers' statistics, the health project was a success.

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

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

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

**Long Term Effects**

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

Increasingly in the twentieth century, the dominant scientific and medical model was a mechanistic model, isolating part from whole. Chemicals (such as DDT) developed
for use in warfare were later used as pesticides for agricultural use and as drugs to treat disease symptoms, or to eradicate malaria, without attention to their effect on the population or environment. While customary land use practices in Palestine placed high value on preserving fertility, cash crop farming places 'use value' (profitability) on the land regardless of long term effects."

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

Militarism-- including manufacture of products of war, as well as mobilization of armed forces overseas-- encouraged successful collaboration between science and industry in promoting pesticide use by agribusiness and for malaria control. The Rockefeller Foundation engaged in experimental (use of chemicals that had not formerly been used for medical purposes) attempts to eliminate health hazards affecting the military stationed in Europe and in the Middle East. This alliance of medicine and military led to medical use of modern insecticides when the Allied
Military Government eliminated typhus in Italy by dusting with DDT. DDT destroys the ability of cells to use oxygen, which process that causes mutation of normal cells and can result in cancer and infertility. British officials, assisted by the Rockefeller Foundation, applied more than 1,000 pounds of DDT during the course of a malaria eradication campaign in Egypt. Yet, British investment in dams and consequent rerouting of water in order to change from basin to perennial irrigation for cash crop production of cotton, increased the incidence of malaria. And as late as 1950, the Jordanian Department of Health Annual Report noted that:

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

Although not aware of the harmful effects of DDT in 1919, by 1950 the British and the Egyptian Ministry of Health were at least partially aware of the health dangers posed by use of DDT. For example, in April of 1946, the Rockefeller Foundation working for the Egyptian government issued detailed instructions, including explicit warnings of dangers involved, for the use of DDT-oil application by hand sprayers. The instructions describe the dress and equipment required of the sprayer and how to spray mosquito breeding places with DDT-oil:
When DDT-oil is sprayed on water surfaces in the small quantities here specified, it is a poison only to aquatic insects. It has no effect upon plants, animals, or man, even if the latter drink the water. However, DDT, especially when it is in oil, is a poison to man if it gets on his skin in large quantities. The oil in which the DDT is dissolved is also irritating to the skin of some people. DDT can be absorbed through the intact skin, and the presence of oil favors such absorption.74

The United States Army believed that the situation in the Nile Valley offered an excellent opportunity to test under controlled conditions the residual effect of DDT insecticide on boats and proposed that 1,000 pounds of DDT be allotted to The Rockefeller Foundation for use there.75 Experimentation extended to use of a special spreading agent developed by Shell Company in London.76 As Assistant Secretary of State G. Howland wrote to Dr. Wilbur A. Sawyer, Director of the International health Division, Rockefeller Foundation, malaria eradication was of great importance to medical progress, to the war effort and to "political enlightenment."77 In other words, malaria eradication would be useful for developing medical techniques, for safeguarding foreign troops, and to convince the local population of the dictum of Europe's civilizing mission justifying the politics of European expansionism.

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

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

Conclusion

Evidence documented in this chapter demonstrates the political uses of modern medicine, hence of health, by British and Americans during the mandate period in Palestine and in Transjordan. While colonial administrators' efforts in the area of health care saved Palestinian lives, their efforts were motivated first of all by concern for the health status of Europeans. Secondly, British colonials were concerned about the health status of the indigenous population in so far as they provided a cheap labor force. By 1939, the British led Department of Health, with support of the Rockefeller Foundation, and Zionist agencies, had instituted a malaria control program making the environment
safer for British troops, American industrialists, European Zionist settlers, and, of course, for the indigenous Palestinian population. In the course of draining swamps, reorganizing patterns of land ownership, tracking and revamping water rights, policies of the British mandate carried out through their Department of Health had, for Palestinians, the paradoxical result of contributing to loss of control over their landbase.

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

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

Endnotes


12. For example: 'Native use was non-use, native lands were empty and 'void,' and could be defined as valueless, free, 'nature,' to be 'justly' appropriated. New colonies are now being created, carved out by reductionist thought, capital and profit, controlled by patriarchal might.' (Mies, 1993:32)


15. Joanna De Groot, analyzing the construction of language and image in the 19th century shows how science created: '...new structures within which 'knowledge' and 'understanding' of these groups (women and non-European) were established by European males...the founding of learned societies, journals, academic institutions for medicine, anthropology, geography, linguistic studies...brought the study of human characteristics, differences, or cultures firmly into the sphere of science, rationality, and professional expertise.' (De Groot, 1989:95)

16. In her study of the photographic portrayal of women of the Middle East, 1860-1950, Sarah Graham-Brown notes that 'both literature and paintings portrayed the deserts as the domain of men.' (Graham-Brown, 1988:8)


18. As De Groot notes, imperial power, a masculinized construction based on the distinction between public authority and reason, and domesticity and service "gave western men power over gender, class, and ethnic 'inferiors.'" (De Groot, 1990:122)


23. The Department of Health, Annual Report, Palestine, 1926 notes that The Dentists Ordinance 1926 "supersedes the previously existing but inadequate Ottoman laws and the clauses in Public Health Ordinance No. 1 of May 1918, with regard to the practice of dentistry in Palestine." The Ordinance was concerned with regulating the practice of dentistry and limited grants of licences to persons who had studied for a period of at least three academic years in a recognized dental or medical school and allowed grant of permits at the discretion of the Department of
Health. (Department of Health, Annual Report, Palestine, 1926, p.44.) The Ordinance, mimicking the age old practice of hisbah noted in Chapter One of this study, (by means of which charlatans were eliminated from medical practice) was clearly a vehicle for British control of medical practices. It’s possible that, as with other Ottoman laws, the British utilized an already existing practice to their benefit.


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


30. Resume of Activities in Palestine in 1925, Rockefeller Archives, Group 5, Series 8251, p.3.


32. Hammami, 'Between Heaven and Earth', p.245.


40. League of Nations Report, (Chpt. IX, 258)
44. Department of Health Annual Report, Palestine, 1930, p.34.
64. Department of Health, Annual Report, Palestine, 1936, p.11.

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

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


74. Anopheles Eradication Service, Ministry of Public Health, Egypt, Instructions to the Larva DDT-ER (Provision Edition of
April, 1946) p. 4.


76. J. Austin Kerr MD to Dr. George K. Strobe, Rockefeller Foundation, June 19, 1945.

77. Shaw to Sawyer, Department of State, Washington, April 17, 1944.


CHAPTER 3
BETWEEN DAYA AND DOCTOR: A FORMIDABLE ABYSS?

Palestinian women's interactions with health systems and practices in Palestine and Jordan are discussed in this chapter, exemplified by women who supported themselves as midwives during the mandate years and through the post-1948 period. In relation both to British reorganization of the health system and as refugees, indigenous women healers experienced changes affecting their ability to work, their relations with women they served, and their customary healing practices.

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

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

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

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

The midwives brought their plight to the attention of the Senior Medical Officer because supervision of midwives had begun under British occupation with Public Health Ordinance No. I of the Occupied Enemy Territory Administration. Midwifery was a central concern of the British Department of Health which wasted no time in reactivating a system for registration of women who were healers and midwives (dayat). Early in 1918, the British gave midwives temporary registration forms inherited from the Turkish Health Department, eventually replacing them with forms (later altered again to suit record keeping purposes) issued by the new Department of Health. Midwives experienced a number of consequences as a result of the new health system. For example, as noted in the petition quoted above, some indigenous midwives were no longer able to be self supporting. The numbers of women attending hospitals for delivery increased in the mandate period, and hospital nurses were trained in midwifery. In 1929 the Department of Health issued the Midwives Ordinance, officially making midwifery a part of medical practice under control of the British. Using British records, related literature regarding midwifery, and testimonies of Palestinian midwives, this chapter examines the incorporation of midwifery into the British health system.
In Chapter two we examined the relationship between British and American constructs of health and disease and their constructs of colonized peoples. For example, beduin is conflated with disease, ignorance, and misuse of land. Similar constructs pervade documentation during the mandate period regarding women and reproduction: midwives and mothers are represented as unclean and ignorant. The British introduced definitions of motherhood, along with standards and indicators of women's health, based on scientific medical models developed in Europe and in the United States.

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

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

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

Dangerous Hags and Sanitized Hovels: Midwifery and Modernity

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

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

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

She depicted the daya as jealously guarding her power and exerting a malicious control over the village home: in Woodsmall's estimation the daya was the archetypal conniving woman. Woodsmall misrepresented both the midwife and Arab women's customary practices (the hammam, or public bath) and worlds:

The encroachments of modern science in her special province the midwife bitterly resents and often aggressively opposes. For example, a vigorous midwife in Mosul carried on an active and successful propaganda a few years ago against the hospital there, choosing wisely the one place where harem women gather, the bath, which since privacy
Woodsmall characterized the midwife with her 'primitive implements' as a repository of ignorance, superstition, and fatalism, defining characteristics, according to some Europeans, of the East. Doctors and nurses lamented that the midwife's malpractice causes...

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

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

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

New terms set by the British led Department of Health were introduced through a network of infant welfare and maternity programs, and through laws and regulations pertaining to medical practices, including birth. Infant welfare and maternity programs were introduced in Palestine beginning in 1921 by the British, Hadassah Medical organization (primarily for Jews), the Supreme Moslem Council, the American Colony Aid Center in Jerusalem, and private centers and local societies. 11 Nurses in hospitals were given midwifery training, and in 1922 a course opened in a government hospital for retraining local midwives. The number of women trained as midwives increased from 3 in 1922 to 21 in 1928. 12 There were at the end of 1928, 655 doctors, 180 pharmacists, 202 dentists, and 292 midwives licensed to practice their professions in Palestine. 13
In Palestine and in Transjordan foreign health practitioners complained about mothers and midwives. Nurses complained that native dayat "knew nothing of aseptic techniques," and that

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

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

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

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

A glance over the years shows that others did not give in to the nurse, even after several generations had been instructed in 'modern' methods. The Oriental population, with its extended families and its own brand of health care, withstood many of the western ideas. To them, western medicine was on the same level as medical practice by the wise man or the wise woman. If the advice of the one did not work, one went to the other for help.\textsuperscript{16}
Still, attempts to westernize resulted in "rapid strides in the work of Infant Welfare Centers," according to a 1927 Department of Health, Annual Report, Palestine. The report quotes at length Mrs. E. Cotching M.D. in charge of the Haifa Infant Welfare Association's Center. Dr. Cotching applauded rapid strides made in the work of Infant Welfare Centers. She noted the overall purpose of preventive medicine and education of mothers who "are mere children," as

The object of the center is to teach these mothers not only how to prevent their children dying, but how to keep them healthy and well, free from such diseases as diarrhoea; how to preserve their eyesight and how to save them unnecessary suffering. When once the mothers of Haifa can be convinced that this is possible and that most diseases and deaths of babies are due to their lack of knowledge, there will be a tremendous fall in the Infant Mortality and also healthier citizens in the future.17

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

There are still many cruel practices carried out by some of the old women in this country as treatment for certain diseases such as burning the skin of the baby here and there and leaving open sores all over the body, putting lemon juice in the babies eyes, giving a male child's urine as a medicine to those suffering from measles. The practice of wearing charms "to keep away the evil eye" still persists and poor mothers pay as much as a pound for such a charm. Charms are also sold by certain people, which when worn by a woman who is unable to feed her baby in nature's way are supposed to possess the power to enable her to so...18
Trained nurses, Cotching observed, worked relentlessly, delivering leaflets on infant management, encouraging mothers to attend Infant Welfare Centers, although as yet the benefits had not reached the Arab population in rural areas. But in spite of Cotching’s faith in the ability of the clinics to reduce infant mortality, between 1924 and 1928 infant mortality rates (per one thousand of the general(settled)population) fluctuated, rising from 184.8 in 1924 to 188.6 in 1925, falling to 163.0 in 1926, and rising again in 1927:

So far infant welfare work has been limited to the towns and Jewish rural settlements; the large Arab village population of nearly half a million persons remains untouched but efforts were being made to establish, and nurses were being specially trained to conduct, village Centers for infant welfare and health work...

The rise in infantile mortality from 163.03 to 200.46 serves to emphasize the great need that exists in Palestine for organized effort to protect infant life and health.¹⁹

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

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

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

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

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

Reorganization/Regulation/Specialization

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

The British had issued public health and health education regulations in 1918: in 1923 they issued an ordinance regulating the practice of midwifery.\textsuperscript{22} The ordinance, revised in 1929, stipulated that no person, unless she is authorized under the ordinance, could either practice midwifery or prepare to practice midwifery. Persons wishing to practice had to be licensed (a fee of 250 mils was charged on grant of a license), or have their names entered in a registry of unqualified persons practicing midwifery. The latter were allowed to call themselves 'Registered Dayahs'. Their certificates of registration were valid for one year, after which time renewal had to be sought in person by the holder of the certificate. The daya's name could be removed from the registry for such offenses as negligence, lack of reasonable skill, or failure to comply with rules and regulations.\textsuperscript{23}
A qualified midwife under the ordinance was allowed to call herself a 'Licensed Midwife.' Licensed midwives received diplomas from courses enabling them to practice midwifery. They were inspected and supervised in their homes and workplaces at least twice yearly. They could attend talks and demonstrations at refresher courses given for both dayat and midwives. They could charge higher fees, but could not officially practice outside of assigned locations.

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

By 1929 the Palestine Department of Health had appointed district medical officers to supervise and oversee appointments and responsibilities of midwives, as well as other health matters. By 1933 there were 10 government and 27 non-governmental hospitals, along with 19 government, and 42 non-governmental dispensaries and clinics. Regulation of health and health practices was well under way. Government regulations of licensed midwives and registered dayat in Palestine and Transjordan stipulated their duties to mother and child, medications they were permitted to dispense, limitations of functions, situations calling for doctor
intervention, and notifications required for the medical officer in her district. The Medical Practitioners Ordinance came into force in February of that year, forbidding the practice of medicine by any except licensed doctors. It prohibited advertising and "covering" (a practice whereby a doctor would take responsibility for a case he did not treat) of unqualified persons by doctors. Contraventions of the ordinance were brought to court. For example, an unqualified man practicing medicine for some years among villagers was fined with the option of six months imprisonment. One midwife was fined for conducting a private hospital. A doctor was fined for advertising his practice, and another fined and his license suspended for a month for employing an unqualified assistant. Another doctor was fined for dispensing drugs without authority.

The 1927 Department of Health Annual Report also noted the need for Arab medical women who "understand the manners and customs of the Arab population" and "that there are now Palestinian women studying medicine in Beirut." Women doctors trained in the current European practices and licensed midwives on a lower rung in the new hierarchy would facilitate the transition to the new medical and health system. The British picture of the new woman medical practitioner was of a woman with the means to obtain medical education-- young, sanitized and morally responsible to colonialists' expectations.
Sixteen midwives were trained in 1930 in Palestine and were certified under the Midwives Ordinance of 1929. Their course of instruction was coordinated with the work of the Ante-natal Clinic and Infant Welfare Center operating from the Old City. In 1930, midwives carried an average of 27.2 cases each. There were 417 infants cared for by the Infant Welfare Center in Jerusalem. There were 6649 visits to clinics and 3414 visits made to infants' houses.\textsuperscript{29}

At the end of 1933, 368 women licensed midwives and 1,193 untrained dayat practiced in villages in Palestine.\textsuperscript{30} The list of medical practitioners and midwives collected by the Palestine Department of Health, 1938, documents 336 licensed midwives whose addresses were known, and 171 whose addresses were unknown.\textsuperscript{31} Trained midwives included women who emigrated from Europe and the U.S., predominantly Jews, as well as Palestinian Jews, Muslims, and Christians.

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

All the midwives in the country are unqualified and practically every woman acts as a midwife. The Department started the registration of a limited number of midwives, considering their comparative capabilities, with the object of issuing to them Certificates of Registration for control purposes. The Department is taking up with the Government the matter of employing four municipal qualified midwives for Amman, Irbid, Kerak, and Ma'an Towns, to be paid by those Municipalities until such time as private qualified
midwives practice that profession in Transjordan.\textsuperscript{12}
(underline mine)

A special sum was put in the 1928-29 public health budget for training of five midwives, stressing concerns for maternity and child health centers, and for school health services, that would be repeated yearly.\textsuperscript{33} Ignorant mothers and untrained midwives, along with impure water and poverty, especially among the beduin, were cited by British nurses as major causes of high infant mortality. Midwives would become specialists: delivery should be in the hands of trained experts. Although there were on-going complaints about the inadequate share of the budget allotted to health, hospital beds provided by charitable societies increased from 66 to 99 in 1927. The population only gradually began to use government hospitals and clinics.

Licensing of midwives began in Transjordan 1931. In 1933 there were two midwives with Department licenses practicing in Amman, one in Salt, and one in Karak. (In addition to medical staff of the Department of Health listed, there were three medical officers and one senior medical officer attached to the Trans-Jordanian Frontier Force, one medical officer of the Royal Air Force, Amman, two medical officers of the Iraq Petroleum Company.\textsuperscript{13}) By 1935 four midwives were licensed, in 1936 seven, and in 1937 eleven. In 1936 the Amman Infant Welfare Center was the only center in the country. Cases were registered from 1935, as
were the number of attendances, although there was a slight increase in the number of visits to houses of children made by the nurse from 2356 to 2590. Arrangements were made to train a few women in midwifery at the Palestine Health Department Center for training of midwives at the expense of the municipality where they would be later appointed as municipal midwives.

Transjordan licensed fourteen midwives in 1943. In 1948, Jordan licensed eleven midwives in Amman, two in Salt, one in Kerak, one in Ajloun, two in Madaba, and five in Zerka. Those numbers increased in 1950 when 246 unqualified (they had not taken courses) midwives were licensed, with the largest number appointed in Amman, Irbid, Ajloun, and Madaba. In 1950 the wife of the British minister at Amman continued to sponsor the Infant Welfare Center, where lectures were given to mothers on hygiene and care of children. In addition 175 unqualified practical midwives were licensed by the District Medical Officers all over the country.

Throughout the mandate period in Palestine, the system put in place to control and regulate midwifery continued to be negotiated. Midwives and others brought concerns regarding appointment or dismissal to the attention of the Senior Medical Officer: often the age of a particular midwife affected that appointment or dismissal. In addition, local village heads raised concerns about who would pay
midwives' or dayat's fees and about the level of the fee. For example, in 1946 there was confusion about whether or not three dayat had been assigned to the Hebron subdistrict. Mukhtar (village head) Mussa Imsalim stated that his part of the village paid the major share of the funds from which the dayats' salaries were taken and that only two dayat were needed. In addition, the third daya, Handah Ali Mohd Abu Zalata, was of the same family as Fatmi Mohd, already appointed:

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

In October of 1946, the assistant district commissioner at Hebron, Palestine, wrote to the senior medical officer asking for a schedule of village midwives appointed by him and suggesting that the midwives be linked to village clinics and inspected during the monthly visit of the doctor. The commissioner suggested a ratio of one midwife for every 1000 villagers. Midwives' salaries would be paid from the village account to the Department of Health. Finally the commissioner suggested that a Mrs. Rogers give courses annually and that midwives be given bonuses to encourage their attendance. The senior medical officer confirmed the "spirit of the letter" and pointed out that efforts should be made by mukhtars of different villages to select more intelligent and younger women "than the present stock."
In addition to being assigned a vigorous workload, midwives generally had to pay for their own equipment and for their licenses. Sometimes, however, the department paid for a woman's license or equipment because they found her more suitable than the midwife servicing a particular district. Still, mukhtars continued to exert control, assigning midwives to their villages and deciding how many were needed, at times to the dismay of the superintendent of midwifery and child welfare, for example when the mukhtaars of Kudna village retained a daya who the superintendent considered unsuitable:

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

Midwives thus had to navigate a new and complicated chain of command. One midwife appealed to the law courts petitions writer for help. Khadijah, divorced wife of Ahmad Hamdi Es-Sabed, had applied for and received a license to act as a professional midwife ("I am a well qualified Midwife and Nurse"). However, her license was only applicable in a village (Tour, British spelling) near Jerusalem. Khadijah had rejected the license based on the distance of the village from her home in the Old City in Jerusalem, and on the scarcity of clients in the village. Materially and professionally, she was "unable to remain unlicensed and workless":
...as I am a lady in loneliness, protectless and hostless, I became sorry for rejecting the Midwife License I applied for, I have to maintain myself and depend on my profession's work wages...For obtaining a Midwife's License, I shall wait, maximum, one week from today, otherwise, I shall be obliged to practice my profession as a Midwife even without a license, whether you license me or not, agree or not. My livelihood obliges me to practice working as a Midwife.45

In a brief reply from the director of medical services to the mukhtar of Bab El Silsilah quarter, Old City, Jerusalem requesting a permit for Khadijah to practice, Khadijah's wish to work there was denied. She was thus forced to practice illegally, or to move, not an easy task given a woman's dependence on her local support network.46

Reports cite increasing poverty in this period among midwives. As noted earlier, midwives complained about decreasing work. Some hospitals had no midwife on staff. When pregnant women who sought ante-natal care from midwives went to hospitals for their deliveries, the midwife received no payment. For example, one certified midwife, Labibeh I. Nassir, protested to the superintendent of medicine. Finding herself unable to earn her living in Bethlehem, she had moved to Romema in Jerusalem, where she would have found many clients had it not been for the government hospital accepting pregnancy patients. She found that women sought her for a free examination and then proceeded to the hospital. Nassir noted that she was willing to attend to the women at equal pay or less.47 The superintendent of midwifery acknowledged that a normal delivery case could be
attended to at home. Ten midwives from various quarters in Jerusalem suggested solutions to this problem:

This state of affairs (very few of us are able to gain their [sic] livelihood with great difficulty and suffering) we humbly submit, can only be attributed to and caused by the facilities accorded by the German and French Hospitals, the Bethlehem Hospital, the Hospital of Doctor Rifka and in particular the Government and Italian Hospitals...It is perhaps also worthwhile to mention the Jewish Hospitals and to submit that there are in them no physicians who work in deliveries, but such duties are entrusted solely to the midwives who carry out their duties properly and efficiently. As an example, we beg to refer to the practice adopted and followed in the German Hospital of Haifa, where in cases of delivery, a midwife is brought from outside for the purpose and the Doctor in charge of the hospital does not participate or intervene in delivery except when abnormal cases arise requiring the presence and assistance of a Doctor...We wish to refer and lay stress to the fact that the sisters working in most hospitals are not licensed midwives and therefore it is unfair to allow them to carry on this profession and deprive licensed midwives of their means of living.18

The midwives added that they incurred large expenses, spent a great deal of energy, and lost much time completing their professional studies and obtaining licenses. They protested that when they called for assistance from a private practitioner, he usually ordered the patient transferred to his hospital whether or not this was necessary, thus depriving the midwife of fees expected from delivery.19 In such cases, according to midwives' testimonies, often the midwife herself paid the fare to transport the patient to the hospital. Further, given that midwives are called less frequently for deliveries, midwives
often were not in a position to pay the necessary expenses for their tool bags. Since the government maternity hospital charged low fees they were deprived of their profession and livelihoods. The midwives requested that the authorities take measures to safeguard their interests and "protect our rights against such injustice and prejudice":

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

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

She is also forbidding the Midwives and Dayahs[sic] of Hebron to attend the Refresher course given by Staff/Nurse Amelia Bandak at the Infant Welfare Center, I gather she frightens them. She is definitely a bad influence apart from breaking Rules and Regulations, she is asking for a Prison Sentence... Bahsur Abdul Hadi, License No.344 is also conducting a general and gynecological Clinic. Both she and Farideh Ahmad Gheith do internal examinations, in the homes of women. I take a very serious view of this, it means that Hebron is falling back instead of progressing, it is also such a bad example for the Dayahs, it is some years now that an annual course of Talks and demonstrations has been held at the Infant Welfare Center, these two women, who should know better, appear to think they can do as they like and flaunt disrespect and dishonor to the Department of Health, action must be taken.51

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

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

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

At the age of twenty Hajjah Anisa retrained as a midwife in Nablus in 1925. Although the Supreme Muslim
Council allowed Muslim girls to go to government hospitals in Jerusalem, most Muslims did not want to go to hospitals where they would be treated by predominantly Christian doctors and midwives. The minister of health, when he discovered Hajjah Anisa's talents as a midwife, insisted that she accompany other midwives as they went from house to house, so that Muslim families would be receptive to allowing their daughters to visit midwives in hospitals. He encouraged her to supervise the dayat as well.

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

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

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

Everyone I spoke with in Jordan about women and health knew of Hajjah Anisa Shokar. She had attended the births of most of Jordan's officials. Every important family had a story to tell about her participation at a birth. Some told me that when important government officials meet her in the street, they kiss her hand. Not long after I left Jordan, a friend of mine wrote to tell me that a public ceremony had been arranged to honor her. It was striking that the reputation and position of this distinguished woman had in no way been diminished by the forces she herself described as over the years having slowly eroded the meaning and practice of the daya in communal life. For Palestinian midwives residing in refugee camps in Jordan, the situation was even more complex.
Changes in socio-economic-political structures in Palestine and Transjordan during the mandate period, with attendant transformations in the health care system, had contradictory effects for women practicing midwifery and healing. Some became impoverished. Some acquired status as they became incorporated into the British system; this meant reduction in status for others. Between 1917 and 1948, all were vulnerable to increased militarization of the region, to social, economic and political unrest, and to warfare.

Palestinian women who worked as midwives under British administration were among the many thousands who suffered the consequences of the 1948-49 war: some were injured, some killed, and many became refugees. (A May 1949 report of the League of Red Cross Societies in Lebanon, Syria, and Jordan, estimated that women and children were three quarters of the refugees cared for.) Some refugees were among the 150,000 internally displaced in the new state of Israel. According to Palestinian estimates, 849,186 Palestinians became refugees in 1948. War forced 284,324 Palestinians to flee to surrounding countries. Between 1948 and 1967 Palestinian women became refugees through a number of policies of the Israeli government, including refusal to renew family reunification documents (after a Palestinian woman had been out of the country during hostilities, or
when she left to visit relatives or friends) and deportation. As a result of the 1967 war, more than a million Palestinians became refugees; 531,198 were going through the experience for the second time.57 In 1967 107,000 Palestinians became refugees in Jordan.58 In Chapter four I offer a detailed discussion of the experience of war and dispersion of Palestinian refugees.

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

In 1995, as noted in Chapter 1, I interviewed midwives in refugee camps in Jordan in order to see how their war experience and life in the camps had influenced their views of health, health practices, and health systems. In addition, I wanted to understand the effects of on-going transformations in the mandate period on their ability to work and on their healing practices in Jordan.
Midwives and registered dayat were incorporated into the health system under UNRWA through training courses, as they had been under the British mandate. Hence their work continued to be supervised by doctors, many of whom, however, were Palestinian themselves. Still, midwives' often critical assessments of UNRWA reflect tensions given the imposed hierarchy and other kinds of pressures detailed below. On the other hand, midwives also expressed a willingness to work with doctors and a pride in their updated equipment."

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

Registered dayat and licensed midwives cannot practice in refugee camps without a certificate from UNRWA, so that one daya interviewed, even with her degree from the hospital course in Nablus, was not able to practice until properly certified. According to this daya, who was a refugee in Baq`a camp (established in Jordan in 1968), government certification has devalued rather than elevated the daya among women in the camp. If dayat are in need of training, perhaps they were not proficient in the first place. As she put it, "now women are more questioning."61

This sixty-one year old daya had been twice a refugee, first from Jaffa to Nablus in 1948, and from Nablus to Amman in 1960. She had been in Amman for thirty-five years. Before the 1947-48 war in Palestine she lived on a mountain overlooking the sea in an area where bananas and oranges were grown. She was fourteen when she left and had been married for two years. When she and her husband resettled in a village near Nablus where villagers grew olive trees, she decided to learn from the villagers how to make ceramic pots. There she met midwives she had known in Jaffa, including one woman from Egypt. In Nablus she studied with these dayat, learning how to administer to women in all stages of pregnancy and with various problems associated with birth. It was in Nablus that she was approached by a
doctor who, because of her skills, said he wanted to teach her to become a midwife. She stood by the doctor's side in the hospital and eventually obtained a degree making her practice official. I wondered what the doctor had learned from her during those months of training.

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

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

Once I referred a woman in her seventh month to a doctor. She was having dizzy spells. The doctor told her who do you see, and she told him that she is seeing a midwife. The doctor told her, what are you crazy to have a midwife take care of you. She told him that the midwife is the one who sent me to you, and if you don't accept that I will not come to you.

When the daya sees a patient, she's involved even with her social situation, and if there are problems in the family she sits with her and listens to her problems and interferes if the woman is not happy with her mother-in-law. She talks to the family. She gives advice and recipes of how to be fertile and to have a boy or girl. Sometimes she gives sexual counseling if the woman doesn't know what to do. Some dayat do magic, but I don't believe in it, my degree is enough to cover what I do.

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

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

It appears that there are many contexts where midwives are necessary and useful auxiliaries for doctors. According to women interviewed, many women feel more comfortable with and trust the dayat. They view them as medical practitioners, but also as friends. A daya's advice is rooted in a historical reality shared with the women she serves.
According to dayat interviewed, some doctors derive power from maligning midwives and from creating an atmosphere conducive to putting blame on a daya for the doctor's malpractice. This daya was well aware of harm that doctors can do.

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

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

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

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

Some women trust their own diagnoses over that of a doctor. Herbal cures may be the preferred treatment based on a woman's past experience. Another aspect of the question of
preferred practitioners and practices in the refugee camps concerns conditions which produce new diseases and ill health. Refugees, for example, suffer from stress related diseases, malnutrition, and environmental pollution. Traditional healers may not have access to the tools of their trade, such as particular herbs, making women more dependent upon doctors.

Another daya trained in both the old fashion and the new described a bias among camp officials and doctors against use of the old medicines. Umm Isa left the village where she was born around Haifa in 1948 and lived in towns around Jericho for twenty years. In 1967 she came to Baqqa Camp in Jordan. She studied in Salt through the Ministry of Health to become a midwife. At thirty-five she had five daughters and three sons. The mother-in-law of her sister was a daya, and she learned from her also and enjoyed delivering babies.

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

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

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

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

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

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

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

Using 'sickness' as a metaphor for their frustration and sense of homelessness, many midwives protested that women get sicker in the camps. In addition, they expressed frustration with their lack of control over reproduction and perhaps disappointment in new technologies, asserting that doctors do not necessarily make childbirth an easier or safer experience. Concentrating less on improvements in women's reproductive health, the sample of *dayat* interviewed for this study emphasized tensions and shortcomings in the UNRWA health system related to loss of control over their work. At the same time they expressed satisfaction at what they had learned in training courses and were not averse to cooperating with doctors, although they were reluctant to let doctors interfere in their relationships with the women who seek their help. They also expressed a tacit approval of UNRWA health services by expressing criticism when the system did not function as it was set up to function. All were politically astute, aware of current developments, clear about their support for the Intifada, disappointed with Abu Ammar (Arafat) and limited self rule, and all were of the opinion that the people who had worked from the inside for freedom were being shortchanged.
The *daya* has always had a central role in consolidating communal mores. *Dayat* can preserve historical traditions in ways that are beneficial to women's health, or in ways that proscribe women's limitations and possibilities. They might, for example, serve as keepers of customs which limit women's abilities to define themselves beyond the spheres of motherhood and reproduction. Or they might support women in limiting the customary number of children they have by advising them on contraception without the participation of the husband. As trained midwives in their new settings (clinics, hospitals, refugee camps) they have had to compete with other women and men for control of health practices.

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

**Conclusion**

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

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

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

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

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

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

Control of women and reproduction was a critical aspect of imperial rule in Palestine and Jordan. The economic benefits for the medical establishment accrued to colonialist and, to a lesser extent, to indigenous male and sometimes female doctors. Some of the Palestinians suffering from and protesting those benefits to the medical establishment were impoverished midwives. As in the sphere of agriculture, new medical technologies and practices replaced customary practices associated with women, practices that supported women's survival, and that validated women's importance within her family and community. If the midwife was in the way of the development of modern institutional medicine, doctor dependent hospital births were one way to displace her.69

Another way of displacing the midwife was through socialization of mothers according to a new set of standards based on the disparagement of both women and Arabs. Western nurses and health practitioners contributed to the racist literature of the times. Through erroneous accounts and interpretations of Palestinian women's lives and customs noted earlier in this chapter many of these health practitioners underscored the association of Arab women and of Arab in general with ignorance and disease. Some European and North American nurses elevated themselves as carriers of
a sanitized and moral approach to health. Women from Europe and North America who were installed as health practitioners under the colonialist mandate, participated in inscribing new health norms and took work away from indigenous women. Hence, the colonial health system exacerbated geographic divisions between women.

Yet, Palestinian women did attend and benefit from clinics. In Arab villages where clinics were scarce, foreign nurses complained about the impossibility of treating the volume of women seeking help. Palestinian mothers used services to improve their situations. Many valued new forms of knowledge disseminated by western doctors and complained about uneven distribution of public health services. From the perspective of one British woman who took an active role in implementing health policies during the interwar period in Jordan, in some instances Palestinian women forged important friendships with nurses and doctors.

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

Endnotes

1. Petition to the Senior Medical Officer, Department of Health Office, (Jerusalem, 12 July, 1937), Israel State Archives.

2. The inspection and supervision of Midwives, Department of Health Office, (Jerusalem, 1930), pp. 1-2, Israel State Archives.


4. Giacaman, Life and Health, pp. 74-75.

5. Ruth Frances Woodsmall, Moslem Women Enter a New World (New York; Round Table Press, 193), p. 287.


9. Bramall and Towler, Midwives in History, p. 44.


42. Office of the Assistant District Commissioner, Hebron, 31 October 1946, No. VW/39/1. (Israel State Archives, Jerusalem).

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


45. c/o Mr. Mahmoud Qumei', Petitions Writer, Law Courts' Compound, Jerusalem, March 1947 (Israel State Archives, Jerusalem).

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

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


Jerusalem. 8.X1.1945. Letter to the Senior Medical Officer, 
Department of Health Office, Jerusalem from the Superintendent of 

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

53. Conversation with Hajjah Anisa in her home in Amman, Jordan, 

54. Nafez Nazzal, The Palestinian Exodus from Galilee (Beirut; 

55. Zureik, Palestinian Refugees, p.17.

56. Zureik, Palestinian Refugees, p.17.

57. Elia Zureik, Palestinian Refugees and the Peace Process 


59. It is important for the reader to know that when interviewed, 
the Director of UNRWA Health Services in Baq'a camp spoke in 
glowing terms of the training program for midwives, but adamantly 
refused to allow me to interview dayat. He also discouraged me 
from pursuing my interest in informal health practices initiated 
by lay women in the camp, denying that any such practices 
 existed. The Palestinian who was my guide in Baq'a camp 
 unofficially told me afterwards that he would arrange interviews, 
but two weeks later when I called as arranged, said that he could 
 not. Hence, it was through the Jordanian Women's Union that I was 
able to contact and interview dayat in Baq'a and Jabal al-Hussein 
camps. This incident may or may not have larger meaning.

60. Palestinians in Jordan and UNRWA: Summary Plan of 

61. Conversation with daya, Baq'a refugee camp, April, 1995.


63. Conversation with refugee, Jabal al-Hussein refugee camp, 

64. Conversation with Umm Isa, Jabal al-Hussein refugee camp, 

65. Conversation with Umm Isa, Jabal al-Hussein refugee camp, 
66. In the conclusion I am using the term daya to refer both to licensed midwives and registered dayat.

67. Giacaman, Life and Health, pp.146-149.

68. Morsy, Gender and Sickness, pg.5.

69. See Ehrenreich and English, For Her Own Good, p.94.
Tuesday afternoon, returning from my first visit to Jabal al-Hussein refugee camp, I stood for a moment in the doorway, feeling the February chill. The sky was a dusky blue. Yesterday's snow fall covering tiny purple flowers with a heavy wet mass had already melted. Plaintive calls to prayer were reverberating over the hills.

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

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

Chapter 4 focuses on Palestinian refugees living in refugee camps in Jordan. In the first two sections I address the following questions: What is the significance of the particular health effects of war and exile for women? Who was considered a refugee, and how did camp officials define and address the health needs of refugees? What is the particular significance of those definitions and health practices for women? In the final section, centered on oral histories, I ask how Palestinian women in camps in Jordan construct and address health. What influence does gender have on the politics of Palestinian refugee status and on the possibility for resolution of the refugee tragedy?

Of the world's more than 20 million refugees, approximately 80 per cent are women and their dependent children. Among those 20 million refugees the largest number, estimated at 80 per cent, are Muslim, including Palestinians. And approximately 75 per cent of these refugees are Muslim women and children.

There are more than two hundred thousand Palestinians registered with UNRWA as refugees living in ten official camps in Jordan established since 1948. Since 1967, three unofficial camps have been created. This is the largest number of Palestinian refugees living in camps outside of the Gaza Strip. (By June 30, 1994, over 3 million
Palestinians were registered refugees in UNRWA's five fields of operation. The total number of Palestinian refugees in Jordan is more than one million.

Jordan is the only country to grant refugees citizenship rights under the 1954 Jordanian Nationality Law. After 1988 when Jordan renounced legal claim to the West Bank, West Bank refugees received a Jordanian passport valid for five years. Palestinians who came to Jordan from Gaza after the 1967 war are also not considered citizens (Gaza had been under Egyptian administration); and Gazans who returned to Jordan, expelled from Kuwait after the Gulf War, were not entitled to citizenship, property, or the right to work.⁶

Although conferred citizenship, women refugees were subject to the same disabilities as all other Jordanian women in the realm of citizenship. The language of the law speaks to the citizen as male.⁷ For example, Jordanian women cannot apply for passports on their own. A mother cannot give her nationality to her child. Only a male head of household can get insurance for his sons and daughters.

In addition, if a woman harms or kills a man who has been harming her and threatening her life, the law does not take her motivation into consideration.⁸ The government maintains that honor crimes when, for example, a brother or husband murders a woman who has been raped, are a tribal matter, so that if a man finds his sister or wife sleeping
with someone and kills her, he is not convicted. Women are expected to tolerate domestic violence rather than shame their families by disclosing their situations. Nor does the government stop mechanisms supporting trafficking in women. Hence, the meaning of citizenship for women is not the same as for men. Later in this chapter, refugee women describe ways they cope with some of these disparities in their struggle for self determination.

Refugee or Freedom Fighter? Identity Politics and Health in Exile

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

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

In December of 1948 the United Nations Security Council passed Resolution 194 granting Palestinian refugees the
right to return to their homeland. Section 11 states that
the refugees wishing to return to their homes and live at
peace with their neighbors should be permitted to do so at
the earliest practicable date, and that compensation should
be paid for the property of those choosing not to return and
for loss of or damage to property which, under principles of
international law or in equity, should be made good by the
governments or authorities responsible. Israel became a
member of the United Nations although refusing to adhere to
Resolution 194. Reinforced in new resolutions after the 1967
war, Palestinian refugees' rights continued to be
systematically denied.9

The survival of Palestinians in exile depended upon how
they were defined. In 1948, the international community had
not yet decided whether Palestinians fit the definition of,
and thereby were entitled to the rations of, refugees.10 The
League of Nations had appointed the first high commissioner
for Refugees in 1921, and over the next ten years instituted
several organizations to take on provision of food, shelter,
clothing, medical and other services, for victims of war.11
Refugee was defined in December 1946 by the International
Refugee Organization created to deal with the refugee
problem in Europe, with a focus on issues of compensation,
resettlement, and protection if refugees choose to return to
countries of persecution.12 After the 1948 Arab-Israeli
War, the United Nations created the United Nations Relief
for Palestine Refugees (UNRPR) to support voluntary relief organizations providing emergency care for the Palestinian refugees.

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

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

At first UNRWA defined a Palestinian refugee as a person normally resident in Palestine who has lost his home and his livelihood as a result of the hostilities and who is in need. By 1952, "UNRWA considered a refugee to be a person whose normal residence had been Palestine for a minimum of two years preceding the 1948 conflict and who, as a result, had lost both his home and his means of livelihood." Because of the wide range of situations among Palestinians, UNRWA's definition of refugee was confusing and inadequate. Some Palestinians lost homes, but not livelihoods, or were beduin who lost markets and grazing areas, but since they were nomadic, had technically not lost their homes. The definition of refugee did not take into account the many ways in which newly imposed borders
destroyed a way of life that depended upon geographic continuity:

Were bedouin, about 100,000 persons who used to move perpetually between Sinai, Palestine and Jordan-refugees and entitled to relief if they were cut off from their grazing lands in South Palestine? Were the fellahin refugees if they were no longer able to get a livelihood from migration to Palestine? Were villagers, still living in their own homes but separated from their land by mines, barbed wire, or artificial demarcation lines, refugees? And finally, were indigenous inhabitants of an area now destitute because of the economic consequences of war entitled to relief?21

Approximately 160,000 Palestinians did not qualify for UNRWA assistance but were separated from their productive land by armistice lines. Disruption of commerce and transport by new and hostile frontiers left many unemployed and without assets.22

Elia Zureik points out that UNRWA's definition excluded many displaced persons who fell outside UNRWA's responsibility and definition. These included Palestinians who ended up in areas outside UNRWA's area of operations; internally displaced whose needs were supposed to be addressed by Israel; residents from Gaza, West Bank, East Jerusalem displaced for the first time in 1967; individuals deported after 1967; those who left the occupied territories and were prevented from returning; those outside British Mandatory Palestine when the 1948 or 1967 wars took place; well off Palestinians who did not register with UNRWA.23

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

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

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

Women refugees shared the experience of disruptions of households, and loosing sisters, mothers, husbands, children, brothers, male and female friends, and other relatives. And undoubtably women shared among themselves war experiences that they were reluctant to recount at the time.
For example, one of the most egregious, yet least acknowledged war experiences of Palestinian women was rape. Most academic and popular literature has not addressed rape as a major health issue for women in relation to the Palestinian refugee crisis.

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

52 men tied with a rope and dropped into a well and shot. 10 were killed. Women pleaded for mercy. 3 cases of rape...a girl aged 14 was raped. Another 4 were killed.27

In interviews by historian Nefaz Nazzal and anthropologist Rosemary Sayigh, women's accounts of devastation, of watching relatives and friends bleed to death, also include rape.28 Women and children were injured by gunshot, shrapnel, or mines- and by rape.

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

As we lined up, a few Jewish soldiers ordered four girls to accompany them to carry water for the soldiers. Instead, they took them to our empty houses and raped them.29

Although accounts of rape have surfaced when Palestinian women have been asked to describe their experiences of war, as well as when asked to describe subsequent developments as refugees, no soldier or state has ever been prosecuted. Yet, commanders and politicians knew
of rape and reported it to Ben-Gurion, Israel's first prime minister.  

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

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

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

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

If the girls stayed in their houses they used to get raped by the army. Because the resistance had a base here this was a very vital place for the army to take down. So the deaths that occurred at that time were very big. Twenty thousand people died. The army wanted to break down the resistance. Women were raped, and after they raped them, they killed them. They found their corpses there. This went on for one month. Then the resistance went underground.35

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

If resistance remained now, we wouldn't be here. The woman played a vital role. The boys were the cubs and the girls blossoms, and they were all part of these groups. They use to gather money and ammunition for the people, arms training, all of them women and men, only after 1970's this stopped. It's the war with the Jordanian government. If men went out they wouldn't come back. Others would be disappearing in Jordanian jails and nobody knew anything about them. With all camps surrounded by the Jordanian army, people were trying to stay in shelters. With all their family in one place, women would sneak out and go to get food and to get water and go to their houses to get stuff for different families. Women were killed. Yes, the Jordanian army use to be scared of the women because women were very strong and they use to have arguments with them, use to spit in
their face and say— I'm Arab like you, what are you doing? And my mother once shoved one of them.36

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

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

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

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

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

Furthermore, according to international declarations and conventions...

...women who are attacked by military personnel may find difficulty in showing that they are victims of rape rather than random violence. Even victims of rape by military forces face difficulties in obtaining refugee status when the
adjudicators of their refugee claim view such attacks as a normal part of warfare.¹¹

The 1950 United Nations Relief and Works Agency definition of a supposedly gender-neutral refugee had a particular salience for women: with no legally defined identity, hence no access to assistance to meet their particular needs, women had fewer options (less job opportunities, more physical vulnerability) than men. The international community responded to the needs of refugee women as mothers: this concern came in the form of a plea for funds for food and shelter, and in the form of nutritional programs for pregnant women and for children. (And even then, food and other supplies were distributed to heads of households, typically men.) It was not until the 1980's when advocacy on the part of women's organizations globally raised awareness about the needs and rights of women, who comprise the largest number of poor and of single headed households, that UNRWA began emphasizing programs for women. The range of consequences during the early period for all Palestinian women, whether they were mothers at the time of their exile or not, has yet to be documented. For example, UNRWA officials found that refugees in Lebanon in 1951 "felt "forsaken and abandoned" by political organizations, international institutions, and the big powers...The disintegration of their society was shown by the fact that prostitution was becoming noticeable among a village population that had not known it before."¹² Women
had few options for economic survival. In the early years, UNRWA programs to retrain men for possible employment were far more common than training programs for women. These were limited to women's traditional work, such as sewing.43

The Political Economy of Refugee Health

United Nation's mediator, Count Bernadotte, assessed the situation of approximately 95,000 refugees during October of 1948, many of whom were without blankets and clothing: "every week's delay will mean a progressive death-roll from exposure." He appealed to the United Nations International Children's Emergency Fund (UNICEF) for aid in the name of children, pregnant women, and nursing mothers.44 Fifty three states, many international organizations and some oil companies responded.45 The League of Red Cross Societies took responsibility for medical inspections in Lebanon, Syria, Transjordan, Egypt, and Iraq. The International Committee of Red Cross aided the Israeli and Jordanian occupied area of the former British mandate of Palestine; and the American Friends Service Committee held responsibility for Egyptian-occupied Gaza and the town of Acre in Israel. Transjordan contributed $933,481 until April 1950 to UNRPR's (United Nations Relief for Palestine Refugees) relief fund.46
Palestinians were living in tents in makeshift camps with communal latrines and washing facilities, with little or no privacy. As one Palestinian interviewee put it in our discussion about the history of Jabal al-Hussein camp, "the toilets were shared by all of the people of the camps because we were living in tents, and also the water resources were shared by all the people of the camp." Many women felt exposed because they had fled without headscarfs.

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

By the time UNRWA set up its medical clinics, official definitions of what was necessary to maintain health (defined primarily in terms of nutrition and immunization) were those of international voluntary and governmental
organizations and were driven by questions of cost and the international politics of relief. A United Nations Resolution approved $29,500,000 for direct relief for a monthly average of 500,000 refugees for nine months—December 1, 1948 through August 1949, as well as $2.5 million for administrative and local operational expenses. The United Nations Disaster Relief Project coordinated relief, beginning in September, 1948. The staff included a chief medical officer of the World Health Organization. A senior medical officer of WHO in Beirut directed the medical program. As noted, the United Nations Relief for Palestine Refugees (UNRPR) took over the Disaster Relief Project until the founding of UNRWA. The immediate tasks of UNRPR were to provide food and water for a million people, to prevent epidemic diseases by inoculation, and to provide hospital services on an emergency basis. The Disaster Relief Project inoculated refugees in cases of threats or actual outbreaks of epidemic disease. UNICEF's distribution of milk and cod liver oil for mothers and children accounted for approximately one fourth of commodities delivered under United Nation's auspices. Jordan agreed to allow in all refugee supplies duty free, without inspection, giving UNRWA full control as well as privileges and immunities while fulfilling its tasks.

International politics determined the amount and delivery of relief supplies. Once supplied, refugees
depended on distribution agencies and on agreements between states. In April 1949, for example, the League of Red Cross Societies was not able to deliver supplies because Lebanon refused to pay the private company loading and unloading supplies until Syria and Jordan contributed their share of the costs.34

Early on, UNRPR reduced the caloric value of rations delivered. This was their solution to the fact that more Palestinians were registered as refugees than the number of rations received by agencies. Since more than half of refugee children were under 15 and most adult males were not regularly working, UNRPR considered reduced rations adequate nourishment. Given differential value that UNRPR placed on men and women, and the fact that girls typically had a higher rate of malnutrition than boys,55 women were more vulnerable to rationing. Girls might go hungry in order that their brothers and fathers were fed. And since the predominant medical model utilized by WHO and other international organizations was a male model, specific health effects for women of a range of health issues, including their physical safety as noted above, were overlooked. For example, asbestos shelters (also jeopardizing mens' health)) may be a factor in incidences of breast cancer in the camps, which women note is on the rise.

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

In his study of UNRWA, 1950-1991, Benjamin Schiff characterizes four phases of UNRWA's development. Between 1950 and 1957, UNRWA was a vehicle for regional development plans, much along the lines of those described in chapter two of this text. With its new "superpower status and technological prowess," the United States visualized a Middle East Tennessee Valley Authority "sowing seeds of cooperation among nations, absorbing refugee creativity and labor in a transformed Jordan Valley region." Schiff contends that one reason why the United States supported
UNRWA was because refugees who were healthier and happier were less likely to become Communists or terrorists.60

During its second phase, 1957-June 1967, when it became apparent that "grandiose plans for regional development" had to be abandoned, UNRWA focused its resources on health (effectively reducing infectious diseases, implementing mass immunization, reducing mortality rates and reducing malnutrition) and education, expanding its bureaucracy, and becoming in the eyes of many, a model in the Middle East in both areas. After the 1967 War and through the Intifada period (phases three and four), with increased support internationally for Palestinian self determination, and at the same time, faced with mounting resistance against the Palestinian struggle, UNRWA once again had to supply emergency relief services, in Jordan during the period of Black September, and in the occupied territories in 1987. UNRWA finally became what many Palestinians had advocated for, "an agency involved in the protection as well as relief of the refugees."61

During this latter phase, UNRWA began emphasizing programs for women. The agency established women's centers and skills programs enabling more women to find employment. Refugee women played a major role in this phase, deciding what kinds of training they wanted and following up on projects.62
UNRWA became from its inception the vehicle for a range of political objectives of its donors and of those it was servicing. It represented the stalemate produced by political developments in relation to the Zionist state since UNRWA was the product of Israel's refusal to comply with international law. Refugees found employment through UNRWA (more than 20,000 Palestinian administrators, managers, teachers, nurses and doctors67), but they were drawn into a paternalistic bureaucracy which often left them without decision making power. Some viewed UNRWA as a welfare agency contributing to refugee's dependency, hence dampening their politicization. Israel, on the other hand, accused UNRWA of politicizing Palestinians. Host governments depended on UNRWA to provide resources for refugees, and they used incoming funds to make improvements in their own countries. Refugees obtained homes through UNRWA but wanted primarily to return to their former homes. Refugees were able to continue a tradition of high levels of education, and UNRWA provided literacy training, which was particularly beneficial for women. At the same time, there were many complicating factors in regard to both education and health, for example, control of the curriculum, overcrowded health clinics, and other issues related to health services and practices, discussed below.

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

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

If health was tied to a complex web of international and local politics, it was also tied to European and Americans' derogatory views of Arabs and tendency to blame refugees for whatever went wrong. For example, refugees got no credit for the fact that, as tents in makeshift camps gave way to asbestos shelters, then to mud huts and eventually to one or two room houses of concrete block, in spite of unsanitary and overcrowded conditions, there were
no serious outbreaks of disease. International organizations, proud of their relief efforts, felt the recipients spoiled the effects of their efforts. Reports often asserted that poor standards of health of refugees was endemic to poor classes in the Middle East, rather than a consequence of war.\textsuperscript{65} A mythology developed flattening the health of Palestinian peasants, farmers, villagers into a one-dimensional picture of ignorant, underfed, impoverished women, men, and children. Did Palestinian women know how to cook? Were shops and bazaars dens of filth? Investigations were carried out, reports written.

These reports reached contradictory conclusions. One such report found Palestinians on the whole to be in reasonable nutritional shape, "considering their previous circumstances and those of the population among whom they are at present living. In Trans-Jordan and the Gaza Strip, they appear to be in better nutritional state than the local population."\textsuperscript{66} While UNRPR, WHO, and UNRWA reports praised health and nutritional standards, a YMCA report of Jan. 1950 cited fair standards of food, clothing, shelter, medical care, but low morale from poverty and inactivity.\textsuperscript{67}

Refugees protested the quality of medical care, and were "further unsettled by sometimes groundless or exaggerated Press reports about them."\textsuperscript{68} In the eyes of some Palestinians medical care was a means to control the refugees; others saw medical neglect as a way of "solving
the refugee problem." Refugees protested that low caloric value and stale food caused malnutrition and disease, that foods were mismanaged and had to be destroyed, that food was differentially distributed between unemployed and employed." When camp residents found that a miller in Amman sold inferior quality flour to UNRWA in order to make larger profits, it was cause for a mass reassertion of their right to return to farms, orchards, and local customs." In the eyes of many refugees, as Rosemary Sayigh concludes after discussions with refugees in camps in Lebanon, medical services available to refugees were not much in advance over those in Palestine." Given the complexity of the politics of relief, it is no wonder that many refugees assert that people were healthier in Palestine.

**Women Talk About Health: Al-Ghurbah—The Disaster**

As noted earlier, Palestinian women experienced wartime hardships of 1948 in specific ways given their particular situations (access to resources, urban or rural origins, age), and they experienced particular hardships because they were women (such as rape). Pregnant women faced multiple dangers, as one interviewee tells of her pregnant mother. This Palestinian-Jordanian woman told me that her mother had both a Jewish doctor and an Arab doctor during her pregnancy. During the mandate period, her mother had taken
...soldiers...

daughter described to me, under the British mandate, her under dangerous conditions. She was from Jaffa where, as her hardship was not unfamiliar to this woman who delivered...

was crossing...? didn't want to see what's going to happen when she was crossing her eyes all the time because she the baby... and you could see the soldiers so she got the chickens and knitted them into the draper of a block of wood under their feet. They were soaked with water and all throughout the day they were put a bucket of water and then they reached the bridge and then got her the day after she delivered her. They wanted bombarded. At 2 a.m. when she started pleading they started concentrating from being scared from the day she entered the hospital and the kitchen and then she got there. She was registered in a hospital staying with you... she was staying in... pulled her husband said, if I'm staying... I'm leaving. Her husband said, if I'm staying, she refused to leave. She sent the child... they refused to leave. From the window we could see all the deep there were bombs, people were being killed like in 1948 my mother was pregnant... in the market...

mother turned to the day to save her child...

when her mother's panic precipitated an early delivery, her... before the war... things were starting to get tense... but Hadassah hospital, owned by the Jews... this was 1945...
Umm Abdullah, a Palestinian refugee originally from Haifa, and now a nurse who organizes women in Jabal al-Hussein refugee camp, experienced similar hardships and became politicized as a result of her experiences during trying times of war and exile. She has since devoted herself to improving the situation of refugee women. In a matter of fact manner, she described her instinct for relieving suffering and for attention to the collective rather than the personal. Stepping outside of proscribed norms regarding motherhood, Umm Abdullah had displayed a loyalty to her people that transcended her particular situation. She was in Karamah refugee camp in Jordan for the historic battle that happened there in 1968, and described her contributions to the victory that Palestinians remember with great pride:

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

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

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

At that time a person used to work and put in all her energy because the hope was so much that there was something on the horizon that can be done and can be changed, so that was the priority. And the cause was not a personal cause; it was a public cause; people need me, so it's not a private matter; public needs were more important than personal needs at that point. The circumstances and the suffering that they saw made us-- no people suffered as much. This is the minimal that I can do now that part of my life is just for that cause and that's a minimum thing. I wish that all the women would raise their children in a manner that they would have these feelings toward their country.75

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

Umm Abdullah was resolute when she described her sister-in-law's experience in Gaza, that of her friend Umm Ramzi, and her own, beginning in 1948. Umm Ramzi's husband had passed away a year ago from heart failure and she had lost her son in a car accident. Her remaining sons go to
school, one to become a mechanic, the other a hairdresser. Her daughter studies child education at the National College in Amman. Umm Abdullah described a history of resistance informed not only by external events such as war, but also informed by the necessity to survive when her father-in-law and husband left her on her own.

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

As did many children, Umm Ramzi witnessed the slaughter of men of her village, enduring the on-going state of war as the Zionist state, threatened by the growing strength of Arab nationalists, joined forces with Britain and France to regain control of the Gulf of Aqaba and of the Suez Canal, nationalized by Nasser in the summer of 1956.

When the occupation came we left from Haifa and went to Jenin. When Deir Yassin happened, Umm Ramsey was two years old. The people got really scared and ran away. So Jenin was the closest town. In 1956, Umm Ramzi was ten years old, and when they came to the town they called from the speakers, and they asked all the young men from 16 to 40 to go to a certain school. Everyone was sleeping, and she said in this house next to them there were seven men and their families. They lived here, they searched in the house, they took them out, they asked them to line up. She remembers this, and she was looking. They killed all of them. And she said what they used to do they used to take
them in lines, and they said, we'll kill this line...in 1956 they killed more people than in 1948.79

In 1967, Umm Abdullah was deserted by her husband. She had married as soon as she was capable of conceiving, but her father-in-law, more concerned for his only son than for her welfare, took his son away with him. He then refused to let Umm Abdullah return to Jenin after she had her first child. At the intersection of sexual politics and war, Umm Abdullah cast her fate with her mother-in-law as they left for Jordan with only the clothes on their backs:

We both remember the war of '67. I left, while my family stayed in Jenin. In my family, I'm the one who left. When the Israelis came the first town they entered was Jenin, and I was working and my father-in-law was very scared for my husband because he was his only son. So he took his son and they went away, and left me. I could work in UNRWA (United Nations Relief and Works Agency) in Jenin, but I left Jenin and went to Kabatya. Then I had my first child. I was only 14, and I tried to return to Jenin, but my husband and father-in-law refused to let me return.

During the war of 1967, women didn't leave when the war started until they saw people killed in front of them. Every time when any soldier sees anybody they can kill them on sight. My mother-in-law when she saw this killing of people on sight, said, let's run away to Jordan. She had only two sons. They only came here with their clothes on their backs.80

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

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

Trained by UNRWA in a Jenin refugee camp, Umm Abdullah became a nurse and worked in women's health centers. After 1967 she worked in emergency camps set up in Jordan, among them, Karameh Camp. She was then transferred to another camp where she worked for thirteen years, until moved to the central clinic for refugees in Amman. Eventually she was rewarded by UNRWA with a medal for being the youngest employee to work for them for thirty-one years.

Women from the neighborhood on the periphery of Jabal al-Hussein camp started the Women's Collaborative and Rehabilitation Society in 1973 to address issues of women's poverty. A leader in forming the society, Umm Abdullah told me how the society functions:

Women from this society started the society in 1973, and they've been in touch with families in the camp (Jabal al-Hussein) ever since. The Union (Jordanian Women's Union) at that time was not working, was not active, because of the politics of the country. So we worked with women from this neighborhood and outside the camp. This is the first women's society in the whole area. Fifty five
women are involved from the ages of eighteen to forty five. We run a productive kitchen, handiworks, health lectures in cooperation with UNICEF. There is another institution that markets our products. The government and NGOs do not give us funds, so we have to rely on donations. We have 980 women who graduated with skills from courses that we teach. Forty five graduated from the different workshops we have.81

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

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

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

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

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

When I asked Umm Abdullah, Rema, a woman in her early twenties living with her mother, father, and brothers in Jabal al-Hussein camp, and Kitam, a mother of eight from Baq' a camp, to describe women's major health issues in the camps, all responded- "poverty." Kitam talked about problems created by unemployment. Poverty made it difficult for some to take advantage of opportunities in the area of education described earlier:
All are living in debt, waiting for donations. Families who own houses are better off...those who are financially O.K. are the merchants who have shops. Some of them brought some money so they bought. Other people, employees in any other type of institution, can't afford houses.

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

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

While some refugees live on the outskirts of the camps where housing is more substantial and less crowded, most live with large families in one or two rooms. Low rents in refugee camps draw Jordanians, Egyptians, Syrians, Sri Lankans and others whose incomes are meager, in addition to Palestinians. UNICEF reports note that population density in camps is highest in Jordan. Nonetheless, the camps do not have legal status as villages or towns. They are
administered by the Palestinian Affairs Department of the Jordanian Ministry of Foreign Affairs.\textsuperscript{84}

I was in Jordan on the heels of the October 1994 Israeli-Jordanian treaty.\textsuperscript{85} While some I spoke to viewed the agreements as positive for the economy, women interviewed in the camps consistently maintained that the agreements had been negotiated at their expense because their status has not been resolved. As one woman put it, "Nothing has changed. The conditions are the same...A person who is poor is always lost in these situations."\textsuperscript{86}

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

In 1948, the youth in the camp wanted it to be called the Camp of Return, but the government wouldn't allow it because the camp is situated in the area of Jebel al-Hussein, Mount Hussein. To name their new living situation Camp of Return was an attempt to name themselves. At the center of their self definition was the praxis of resistance, that for some of the camp population at least,
would inform camp life until (and beyond) Black September, 1970. But King Hussein asserted his ownership of the Palestinian issue by insisting that the camp located in his capital city be named after its location—Jabal al-Hussein.

Rema, describing the early period of the camp, noted that Palestinians came to the camps organized to resist resettlement. Their national representative, the Palestine Liberation Organization, would not allow people to build more than one level, called building Type A. By building the minimum living space, Palestinians demonstrated that their stay was not permanent. People who could afford to left the camp and tried to exist on the outside.87

Rema connected women's lack of economic status in the camps with lack of services for women and connected both with gender relations:

The atmosphere for women in the camps is very negative. It limits women from developing in all aspects. This is related to the services that are offered to women in the camp. The services are limited, so women's development is limited, and it's related to the low economic status and also to the relationship between women and men in the camp. And the relationship between the man and the woman is always affected by the economic background which is always related to the man's economical power, and also educational background, and therefore controls the woman from progressing.88

Rema told me that the economic situation for men in the camp was not much better. With a high level of unemployment of men, women suffer, since most are dependent upon husband's, father's and son's incomes:
The elderly are mostly labor workers and owners of shops. The youth are either helpers for their fathers, or they are students, or are unemployed. Apprentices are very limited. You can find someone who is a carpenter, or a mechanic, but it's a limited percentage. UNRWA made a center to teach men certain apprentices, but it's not situated in the camp. It's in a place called Wadi Seer, and they learn there how to become electricians, mechanics, carpenters, iron-smiths, blacksmiths- but not everyone can get into that center. There are certain requirements for a person to apply to the Center. He has to be from the territories of '48, and he has to have a ninth grade degree, and also none of the people in his immediate family can be working for any of the agencies of UNRWA. His financial situation must be bad. If these conditions are fulfilled, then they are allowed to apply.99

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

We depend on religious holidays for donations...During that time many people come and ask. But local agencies didn't give any money this year. The National Treasury for poor families helps women find jobs- the ones who graduate from the programs work in factories...in needlework factories.99

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

...small apprenticeships, like embroidery, wool, sewing machines. Charges to learn these skills are very minimal. The government didn't do anything like that. Younger women are more likely to take advantage of such programs. Most employed women are teachers.91
But Kitam has not had the benefit of vocational training and struggles with poverty and consequent health problems:

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

We live on the services of UNRWA and if they stop we can't live. People have kidney problems, high blood pressure, half the camp population has diabetes. One of my sons has a problem with his leg, as his bone came out...and his eyesight. UNRWA will give you two pills to cover everything.

My daughter was hit by a car, and didn't get help during the Gulf War. She has a rod in her thigh. The doctor charged one thousand two hundred JD. The hospital is owned by the PLO and they don't give free services. She had to have her intestines repaired after the accident, so they paid 900 JD. I asked the doctor to do it for free. He said he can't afford it...although he has a very big house. When the school heard she had an operation, they wouldn't accept her.

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

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

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

UNRWA gives basic general health care, but let's say if someone has a need to go to the hospital they pay only 50 percent for emergency cases. If the refugee doesn't have a card given to refugees in 1948, and has to go to hospital, UNRWA will not pay. Refugees from 1967 don't have them. They use to have two cards, one for food, but they don't do this anymore. Now they're giving food cards only in severe cases when no-one is working, below the poverty line.¹⁴

In addition, Umm Abdullah pointed out that the number of doctors available through UNRWA is not sufficient to meet the needs of the camp population. Doctors are overworked, therefore the people are shortchanged. And only one percent are women. Another problem for women is that she may not be able to afford hospitalization.

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

If a woman has time when she is going to deliver she can go to the UNRWA medical centers and they will pay for her transfer to a hospital, but she has to pay 12 JD...and then it takes a long time...and if she doesn't she will have the child at home with a midwife.⁹⁵

Rema concurred, explaining that only women refugees from 1948 qualified for pre-natal and ante-natal care. In addition, midwives who worked for UNRWA varied in their delivery of services:
It depends on humanitarian sense...she would sometimes pass by two times a week, see how the child is doing...all of these midwives belong to UNRWA. After two weeks, the first two weeks, the mother takes the child to the health center, and they will weigh him and open a file for him. But sometimes the midwife doesn't do anything besides delivering the baby...it depends on her personality.\textsuperscript{96}

UNRWA doctors saw more than 100 persons in clinics in a day. UNICEF reports that in 1985 there were 22 physicians in the camps per 100,000 population, and 12 nurses/100,000 population. 68\% of the camp population go first to an UNRWA clinic when ill; 25\% go to private doctors; 7\% go to a Jordanian government hospital and clinic where they have to pay a fee. Services for the disabled, initiated in the late 1980s, were still minimal.\textsuperscript{97}

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

In modern scientific terms, women's health is measured by her ability to deliver a healthy child. A standard indicator of success of western medical practices in colonized countries is reduction of infant mortality rates.\textsuperscript{98} The rate of infant mortality for Palestinians in refugee camps was 151 per 1,000 live births in 1961,
80/1,000 in 1976, 55/1,000 in 1986, and 35/1,000 live births in 1989. In 1995, the infant mortality rate in the camps was 35/1,000. The under five mortality rate in Palestinian camps in 1989 was 45/1,000 live births. Girls suffer higher mortality rates than boys, and major causes of infant mortality are prematurity, diarrhoeal disease and gastroenteritis and respiratory infections. Maternal mortality among Palestinian women in general was estimated in 1989 by UNICEF and the Ministry of health at 40 per 100,000 births, while ESCWA indicators show a rate of 200 per 100,000 births in 1988 for Jordanian women as a whole.

Estimated demographic indicators for Jordan and selected groups of developing and developed countries (1991) show that developing countries have much higher rates of infant mortality, and maternal mortality, and that Jordan's figures are closer to the level of developed countries than Arab countries as a whole. However, these figures are deceptive. There are significant large disparities among developed countries; for example, nineteen industrialized countries have lower infant mortality rates than the United States. Infant mortality in the United States, Greece, and Spain was 11/1,000 in 1989. (Other figures for the same year include 5/1,000 in Japan, 7/1,000 in Canada, Denmark, The Netherlands, West Germany, 20/1,000 in Hungary and Poland, 25/1,000 in Romania and the Soviet Union, 32/1,000 in North Korea.)
Furthermore, low birth weight, the main cause of infant mortality, occurs predominantly among adolescents, poor women and women of color, so that in the United States, African Americans are twice as likely to die before reaching their first birthday. Just as minorities within the United States suffer higher infant mortality rates and maternal mortality rates, so refugees suffer higher rates than the general population in Jordan. The role of medicalization in furthering the transition to capitalist economies has uneven implications for women depending upon their histories and subsequent access to centers of power. Thus infant mortality rates for Palestinians in low income squatter areas, 40/1,000 according to a 1992 UNICEF Report, exceeds even that of refugee camps, and is much higher than the rate for Jordanian women in higher income areas. Under five mortality in low income squatter areas is 46/1,000 for males and 78/1,000 for females. Increasing numbers of children are working in the streets. Palestinian babies in Jordan have the highest low birth weight of all Palestinian communities, a fact which is not reflected in figures comparing Jordan's health picture with that of other Arab and developed countries.

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

As a result, women suffer from anemia. Their teeth fall out, they have genital problems, women's diseases, osteopetrosis, bone disease. They have problems during pregnancy. There are many miscarriages. She has one pregnancy after another—there is no planning, all her body weight is destroyed. She cannot travel the distance to Mother and Child Health Centers, so she must rely on UNRWA. UNRWA gives out free contraception, but many women do not think it's good for them.166

Another area of concern for refugee women has been the impact of the camp environment on women's health (as noted by Kitam above). Older women suffered from rheumatism and arthritis. Living spaces were damp, roofs leak, and many had no source of heat. Public sewage was exposed and open: there were garbage dumps which generated foul smells, insects and disease. If UNRWA had a holiday for three days, the camp became very dirty:

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

The situation here now is really bad, the humidity, the garbage...all of this can lead to cancer...Three years ago the sewage was open...we had to gather money and give it to the people from City Hall to bribe them to give us a sewage system. Before that we had to go down to where the water was flowing and throw it there.
The Ministry of Social Development divided the camp into two areas, higher and lower. At the lower end of the camp there is a stream of water, and they have problems from trash in the stream, flies, mosquitos. In the winter when it rains, it floods into the houses, polluted water, wrecking houses and destroying furniture. The government didn't do anything, UNRWA didn't do anything- only gave us blankets and sandbags. Only last year the government made pavements and this doesn't flood.  

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

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

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

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

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

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

And employers who work within UNRWA in charge of employees called a sit-in. Committees within UNRWA who are in charge of the employers- they called for a sit-in. They did this before when they
said they were not going to get any raise, because usually they do. They are joining forces with the employees of UNRWA because UNRWA offers services and within the camp at the same time that they cut the budget it affects the workers and the people who benefit from the services. 109

Rema's and Umm Abdullah's discussions of the involvement of women in resistance work portrayed women as political actors in the course of historical events leading up to Black September and after within and outside of prescribed gender roles. Women have defined political objectives in their own formal organizations, and as 'arms' of official male bureaucracies. Although never recognized in Jordan, The General Union of Palestinian Women (of the PLO) founded in 1965 in Jerusalem, created chapters and offered services in refugee camps, including literacy classes and military training. 110

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

This generation is all educated, that's one thing. The drop out rate within Amman is very low, but outside the city it is higher. This generation has much awareness about their right to education— that they have the right to be educated. Outside the city the families prefer to educate their sons.
From grades one to six, which is considered the basic that they have to learn, 80 percent are educated. As the camp population gets older it goes to fifty percent. Only 25% have a basic high school education. Umm Ramzi is 47, she finished grade 6 when she first came here. 5% of older women go back to school.

There are literacy campaigns, and they are done by the government during the summer, in the afternoon. It is very important for them because...one woman 60 years old went back to school in order to read the Koran. And they want to learn to read street signs. To know the names of the streets. The class is the one that is given, 40 students- every summer, every summer they change.**[^11]**

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

> In this area there are problems of domestic violence, father, brother. People are in close contact with each other- and I've been working in this area for thirty years, so people have this grassroots connection with each other, so if there is a family problem everybody helps."[^12]

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

> Sometimes when there is a family problem, Umm Mohammed herself comes, she knows the family and she intervenes, she talks to the man of the house and she discusses it without going to the law, especially if there are children- so people maintain social bonds, if they can solve the problem..."[^13]

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

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

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

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

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

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

Conclusion

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

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

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

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

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

All women interviewed for this study constructed the present through remembering the past. Remembering became an affirmation of group cohesion and of resisting and overcoming obstacles in the present. Health was a metaphor for homecoming, a confirmation of the intersection of personal and political realities.
Palestinian women interviewed defined health as shaped by economic, political, social factors. Their model of health moved beyond the biological to emphasize interconnections between disease factors and history. They addressed health issues within the larger context of Palestinian women's social subordination, both exacerbated and in some ways overcome in their new setting. As they defined health, they defined a set of ethics about ruler and ruled, about sharing resources, about the right of shelter, nutrition, work—about Palestinian women's right to self determination. Their knowledge base was constitutive of community as it was constructed by community in the struggle for survival. And some connected their struggle for survival with the necessity for cooperation among women worldwide:

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


13. R. Hammami notes that headed by Gordon Clapp of the Tennessee Valley Authority, the Clapp Commission became known among Palestinians as Lajnet Kilaab, Committee of the Dogs. It was suppose to redress the economic situation of the refugees when repatriation seemed unlikely.(Hammami, 1994, p.257)

14. Laurie Brand, Palestinians in the Arab world: Institution building and the search for state (New York; Columbia University


42. Schiff, Refugees Unto the Third Generation, p.21.

43. In Palestine women were highly respected for their expertise in sewing, but in refugee camps women lost control over their labor power. This may change as more programs are established in Jordan by NGOs granting loans to women to produce traditional embroidery.

44. Gabbay, A Political Study, p.115.

45. These included the Near East Foundation, American Medical Relief, Save the Children, UNESCO, American Friends Service Committee, Church World Services, American-Arabian Oil Company, and Iraq Petroleum Company.

46. Gabbay, A Political Study, p.122.


50. Sayigh, Too Many Enemies.


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


60. Schiff, Refugees Unto the Third Generation, p.8.

61. Schiff, Refugees Unto the Third Generation, p.9.

62. Schiff, Refugees Unto the Third Generation, pp.57-59.

63. Zureik, Palestinian Refugees, p.126.

64. Plascov, The Palestinian Refugees, p. 25.


68. Plascov, The Palestinian Refugees, p.149.


77. A harbor city on the eastern Mediterranean coast of Palestine with a heterogenous population.

78. The village of Deir Yassin was located near Jerusalem. On April 9, 1948 a massacre of its Palestinians civilians was carried out there by Irgun and LEHI (both Jewish underground militia organizations) soldiers.


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


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


92. Conversation with Palestinian woman refugee, Kitam, 44 years old, refugee of 1967, living in Ba'q'a refugee camp, in Ba'q'a refugee camp, on the outskirts of Amman, Jordan, April 1995.


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


110. Brand, 1988:186


117. Khalidi, 'Observations on the Right of Return'.

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

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Director of Health Service, UNRWA, Ba'qa refugee Camp, on the outskirts of Amman, Jordan
Rana Hammad, Director of Hospice, Amman, Jordan
Manal Hamzeh, Audiologist, in her office in Amman, Jordan
Mona Hamzeh, Department of Health and Education, Amman, Jordan
Dr. Zeid Hamzeh, Physician, former Monister of health, in his office in Amman, Jordan
Safia Hijazi, Director, Save the Children, in her office in Amman, Jordan
Ida in the offices of the Jordanian Women's Unioin, Amman, Jordan
Maha Khatib, in her office at UNIFEM, Amman, Jordan
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Shadia Nusseir, Chief Coordinator, Coordinating Office for the Beijing Conference, in her office in Amman, Jordan
Amal Sabbagh, CADRE, Regional Centre on Agrrian Reform, in her office in Amman, Jordan
Firial Saleh, Hai Nazal Development Center, Amman, Jordan
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Leah Frances Sawaiha, Public health specialist, Amman, Jordan
Maha Shaheed, in her office at UNICEF
Baraster Zahra Sharbeh, in her office in Amman, Jordan
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