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**Bearing Life and Living Resistance:
Women's Health and Political Determinants in Occupied Palestine**

by

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**SUBMITTED TO SCRIPPS COLLEGE IN PARTIAL FULFILLMENT OF THE DEGREE OF
BACHELOR OF ARTS**

**PROFESSOR PIYA CHATTERJEE
PROFESSOR ELISE FERREE**

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HUMAN BIOLOGY**

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I dedicate this thesis to the Palestinian women there now and those who will return. And to the Lumad *kasamas* in the Philippines, the *che* in southern Chile, and the Zapatista *compañerxs* in autonomous municipality who all expressed, in one way or another, “We are friends of the Palestinian people.”

Abstract

Although Palestinian women, compared to men and even boys, are significantly less likely to directly encounter injury and death by Israeli soldiers and settlers (OCHA, 2020), women in the occupied Palestinian territories are not spared the violence of the Israeli occupation. This thesis argues that precisely because Palestinian women proliferate political resistance by bearing children and raising families, who are categorically defined as a “demographic threat” (Weiss, 2020), women are distinctly subject to the violence of Israel’s collective punishment. A historical backdrop is used to explain how the Israeli occupation, underpinned by settler colonialism, has developed a complex web of control over Palestinian life with the ultimate objective of eliminating Palestinians from the land (Woolfe, 1998). Then, three facets of Israel’s occupation are identified as key political determinants of health: resource deprivation, restricted movement, and injured and imprisoned relatives. The impact on Palestinian women’s daily lives and access to health care is examined. As I discuss the multifaceted, daily, and gendered modes of violence embedded in the Israeli occupation, I weave stories of resilient Palestinian women confronting the occupation and intracommunal patriarchy. In sum, using contemporary health data, I measure how the “homefront [has emerged] as the battlefield” (Sharoni, 1994) for Palestinian women in recent years.

Introduction

Israeli soldiers chased a group of young Palestinian rock-throwing men and finally caught up with one. As the Israeli soldiers were dragging him towards their jeep to arrest him, a young woman with a baby in her arms rushed up, screaming in anger, at the young Palestinian man. “There you are! I told you not to come here! I told you there would be trouble! Now what do you expect me to do if you are arrested? How will I eat? How will I feed our baby? I’m tired of your irresponsibility! Here, you take the baby and try to feed her!” And shoving the baby into the arms of the dumbfounded young man, she fled. The soldiers, as shocked as the young man, suddenly had a baby to deal with. In a state of bewilderment, the soldiers shoved the young man back into the street, jumped into their jeep and sped away. The man was left holding the baby. Finally, the mother reappeared from behind a nearby building where she had been hiding, went up to the grateful young man, whom she had never seen before, took her baby from his arms, and went home (Quirke, 2000 as cited in Amireh, 2012).

It is with resilience and steadfast determination that Palestinian women have long met the horror of the Israeli occupation, which seeps into and shapes every part of life in the occupied Palestinian territories (oPt). I begin with this urban legend, as recited by Quirke, because though the plot may be fictitious, the scene — unarmed Palestinian protesters met with disproportionate Israeli military force— is both commonplace in Palestine and distinctly gendered. Statistics indicate that Palestinian men and even boys, as compared to Palestinian women, are more likely to directly encounter injury and death at the hands of Israeli soldiers and settlers (OCHA, 2020). Yet, as this urban legend suggests, women are not spared from the violence of occupation. This thesis argues that the Israeli occupation, though a collective punishment (Erakat, 2019), subjects Palestinian women to distinct and disproportionate violence because women sustain life in the oPt by bearing children and proliferating political resistance through caregiving labor. Palestinian women, after all, biologically and socially¹ “birth the nation” (Kanaaneh, 2002) of a people whom Israel categorically defines as a ‘demographic threat’ (Munayyer, 2005). Informed by contemporary data on Palestinian women’s general and reproductive health, this thesis

¹ This expansive understanding of what “mothering” means comes from the work of Patricia Hill Collins (1994) on Black mothers in the U.S.

assesses the multifaceted, daily, and gendered² modes of violence situated within the relentless war on Palestine. It uses a historical backdrop to demystify key political determinants (deprivation of resources, restriction on movement, and injured/imprisoned relatives), which influence Palestinian women's health and access to health care. In the process, I hope to elevate the resilience of Palestinian women, ordinary and healthcare professionals. Though it is common for women to risk their lives and intervene in confrontations between Palestinian men and Israeli soldiers³, the opening urban legend is only a starting point from which to appreciate the expansive ways in which Palestinian women resist the Israeli occupation.

Incidentally, the specific encounter described in the legend is said to have occurred in the West Bank in 1988, at the height of the First Intifada (Table 1), which is when women's formal participation in national politics was most socially acceptable and at its height (Amireh, 2003). Following this period, just as the legend concludes with the protagonist going back home, "women were pushed out of public [political] life and were relegated to the patriarchal domestic sphere, all in the name of protecting them, men, and the Palestinian revolution" (Amireh, 2012). As such, decades of health data, collected through the meticulous and prolific research of Palestinian health professionals, has provided unique insights into the particular suffering of Palestinian women, a gendered domain which has been widely neglected within both nationalist political parties and various iterations of women's movements (Amireh, 2012). At the same time, health data, especially qualitative interviews, offer a fuller picture into the lives of ordinary women within the home and private life— sites of political resistance as the "homefront [has

² Here, I use "gendered violence" to convey an active process of demarcating categories of social difference which are not natural nor universal in every context. For the purpose of this thesis, I am referring to violence against women.

³ The 2017 case of 16 year-old Ahed Tamimi retaliating against soldiers who shot a rubber bullet into the head of her younger cousin is likely the most widely recognized incident of such intervention in recent history.

emerged] as the battlefield” (Sharoni, 1994), often quite literally. Thus, by systematically evaluating key political determinants of women’s health outcomes, this thesis tells the stories of Palestinian women’s suffering and resistance. It is an indictment of the Israeli occupation, which causes direct harm to Palestinian women and entrenches patriarchal dynamics within Palestinian communities. Finally, the thesis explores the avenues women and health workers are taking to strengthen the national liberation movement by specifying that women’s freedom from harm (and morbidities) must be included in the vision of a free Palestine— a sovereign Palestinian state free from Israeli monopoly on Palestinian life and land.

This thesis heeds lessons from feminist grassroots organizations in Palestine, such as alQaws for Sexual and Gender Diversity in Palestinian Society, in the Philippines (Chew, 2018), and in North America (Smith, 2005), all of which in their respective geographies identify the necessity of freedom from both colonialism and patriarchy as interrelated political work. Andrea Smith posits that because it is *through* gendered violence that settler colonialism was initiated and has been maintained, confronting such gendered violence— both perpetrated by colonial occupiers and structured within occupied native societies— must configure into any anti-colonial justice movement (2005). If not, Smith (2005) and Chew (2018) separately argue, are native women’s survival and wellbeing to be excised from the ‘freedom dreams’ (Kelley, 2002) of a decolonized future? In Palestine, concern around this historical trajectory of women’s exclusion is well expressed by the newly formed Tal’at, a feminist organization of Palestinian women in Palestine and in exile, which mobilized for the first time in 2019 to declare that there can be “no free homeland without free women” (Palestinian Youth Movement, 2020). Therefore, it is with this vision in mind that I analyze key political determinants of Palestinian women’s general and

reproductive health which hinder the realization of both healthy, free women and a healthy, free Palestine.

The first chapter tracks the history of settler colonialism in Palestine, as the confiscation of land underlies much of the present political conditions which shape Palestinian women's health. I begin by introducing the state of Israel's biopolitical control as it applies to Palestinian women. I argue that women's bodies and health outcomes are impacted by Israeli politics yet also function to further the aims of the state, which, characteristic to settler colonialism, is the removal of the native population (Palestinians) from the land. I explore this further using the Deir Yassin Massacre as a case study to illuminate how gendered mechanisms of war furthered expulsion from the land and still configure into Israel's collective punishment of the Palestinian population. Then, I connect how the mass uprooting and radical reconfiguration of Palestinian society consolidated women's primary roles into mothers and caregivers and confined women to the home. I conclude by looking at how women's caregiving aids both physical survival, spiritual strength, and political resistance.

In comparison to the key events in Palestinian history covered in Chapter 1, the second chapter focuses on every day life for Palestinian women. I use Lauren Berlant's concept of slow death as an evocative framework for interpreting the structural violence that Palestinian women face as part of the occupation; or, as Berlant puts it, the "ordinary work of living on" (Berlant, 2007). I consider the mechanisms of biopolitical control which shape women's lives through three key political determinants of women's health: resource deprivation, restricted movement, and injured or imprisoned relatives. Though I separate the determinants for clarity, I convey their interconnection by modeling a casual network of pathways which identify women's general and reproductive health outcomes. First, I track the political significance of resource deprivation as

Palestinian society sustained the First *Intifada* (mass uprising) by developing networks of care autonomous from the Israeli state through popular committees. Second, I discuss the impact of restricted movement through Israel's simultaneous displacement and confinement. Third, I look at the caring labor women dedicate to supporting imprisoned or injured relatives, the latter of whom are comprising more and more of the Palestinian population as the Israeli military has moved from 'shoot to kill' to a 'shoot to maim' policy.

Key Sources and Framework

This thesis is informed primarily by the work of Palestinian women academic-activists, namely the research on women's health conducted by Rita Giacaman, Weeam Hammoudeh, and their colleagues at Birzeit University's Institute of Community and Public Health (ICPH); gendered violence and conflict zone research by Nadera Shalhoub-Kevorkian; Eileen Kuttab and colleagues at at Birzeit University's Institute of Women's Studies; and health research published by *The Lancet* medical journal's 'Palestinian Health Alliance.' It responds to the research needs identified by leaders in the field. Since its inception in 1978, ICPH's primary task has been "to uncover what war [in Palestine] does to the survivors" (Giacaman, 2018). To address this, in "Women's Health in the Occupied Palestinian Territories" Bates et al. stress the "need to focus more on the needs of women in a more holistic approach which includes *pre and post reproductive life*" and the "need for a greater understanding of *context* when collecting health-related data in settings such the oPt affected by political violence" (2017, emphasis mine). I also draw guidance from Black feminists studying and confronting state violence against Black mothers in the U.S. and Brazil (Smith, 2016; Edu, 2018). I apply the principles of reproductive justice, developed by Black women in the U.S. in 1994, specifically the need to "reconnect

women’s health and bodies with the rest of their lives” (Ross, 2006) to my research question: What are the health outcomes and experiences of Palestinian women who are categorized as a ‘demographic threat’ by the Israeli state?

Taking instruction from the aforementioned activists/academics/health workers, I was prompted to deviate from the prevailing research on women’s health which overrepresents reproduction and narrowly focuses on childbirth because “women’s primary significance is considered as child-bearer and child carer” (Al-Khatib et al., 2002). Reproductive justice allows us to assess birthing outcomes, which are incredibly important for the health of both mother and child, as a social process (Pell, 2014; DeJong et al., 2017) within the broader political conditions of Palestinian women’s lives. As a result, I consider a) the daily violence of living through “chronic warlike conditions” (Giacaman, 2018) endemic to the Israeli occupation, and b) Palestinian women’s health and access to healthcare more broadly. To conceptualize reproductive health within this broader context, I adapt a public health model that affirms Palestinian women’s right to live and “parent a child or children in [a] safe and healthy environment” (Ross, 2006) (Figure 1).



Figure 1. A social-ecological health model situates reproductive health outcomes within influential factors: women’s general health and health care, political conditions influencing life (selected political determinants), and the Israeli occupation.

To this end, the subject of this thesis integrates my interest in health and biology with my political commitment to a free Palestine and gender justice. It considers the medical and the political interrelated, with political determinants defined as the political “causes of the [pathological] causes” of poor health outcomes (Krech, 2012). Thus, I incorporate stories from Palestinian women’s lived experiences while I also rely on scientific rigor to avoid any facile or misleading extrapolation of individual testimonies. Ultimately, my stance has come to be that for health researchers, to examine Palestinian women’s reproductive health without considering the political context of the Israeli occupation that permeates every facet of society and daily life is as politically irresponsible as it is biologically reductive. In the spirit of critical ecologist and population geneticist Richard Levins, I work from the understanding that, “[Human ecology] is a convergence of biological and social processes in which our biology has become socialized, but for that is no less biological” (Levins and Lewontin, 2007). It is within this view that I find the optimism for better health that propels my political activism, study of human biology, and conclusion of my thesis.

Methodology

I limit the women interviewed, surveyed, and otherwise incorporated in the literature that guides this paper to those living in the occupied Palestinian territories (oPt, which includes the West Bank, East Jerusalem, and the Gaza Strip) as opposed to refugees displaced worldwide in diaspora. This is because in my political commitment to the anti-colonial cause of Palestinian autonomy, I find it important to assess the contemporary barriers on that very land. On occasion, however, I reference studies and testimonies from Palestinian women living in refugee camps in Jordan and Lebanon because, although the geopolitical conditions and health care systems are

qualitatively different, many Palestinians living within Palestine are likewise refugees. According to the United Nations Relief and Works Agency for Palestine Refugees (UNRWA), 73.7% of Palestinians currently living in Gaza were displaced to Gaza from other parts of Palestine either within their own lifetime or in recent generations (2018). Additionally, as Bosmans et al. (2008) find when interviewing Palestinian women about reproductive rights, respondents largely did not distinguish between refugees and non-refugees. Thus, refugee women's experiences of loss and violence through forced dispossession are comparable despite variation in location, context, and conditions. Moreover, due to Israel's unilateral control over who is permitted entry into Gaza, there is little contemporary ethnographic research conducted there, which in effect makes ethnographic study among Palestinian refugees outside of Palestine uniquely indispensable. Finally, though the three occupied territories are geographically disparate— from one another and even within each region— and are subjected to quite different terms of Israeli rule, such disparity in and of itself is meaningful in regards to the efficacy of a healthcare system across a fragmented society and divided governments (Fatah in West Bank, including East Jerusalem, and Hamas in Gaza).

Regarding specific methodology, the analysis includes both qualitative (i.e. ethnographic and interview-based studies) and quantitative data on Palestinian women's general and reproductive health. I found qualitative data to be particularly important as women in Palestine tend to underreport health ailments and seek health care only in cases of emergency because it is largely discouraged for women to discuss personal hardship, especially around illness (Majaj, 2013; Hammoudeh et al., 2009). Therefore, to rely solely on quantitative data would mean to exclude many among the very population of study, Palestinian women, and potentially even arrive at the false conclusion that there is little burden of non-fatal, non-emergency illness among

Palestinian women. In addition, taking into consideration women's perceptions is essential when assessing access to health care as, for instance, there is very little difference in care utilization between women who avoid traveling for health care because they know they will be stopped at a checkpoint and harassed as compared to women who avoid travel because they *think* there may be problems along the route.

As such, qualitative data, though not necessarily collected by Palestinian women, functions to convey the local experiences and lived realities that inform women's health outcomes. I hope that citing women's experiences in their own words will challenge who exactly is considered the expert within the field of health work (i.e. the doctor is the professional and therefore always knows more than the patient) and will push back against the often conservative approach within the social sciences of 'discovering' what impacted communities already know to be their reality (e.g. the people of Gaza, Palestine and Flint, Michigan alike know well that their contaminated water supply is making community members very sick). In sum, this thesis aims to contribute to the development of indigenous Palestinian knowledge production⁴, as described by Young (2012) and Shalhoub-Kevorkian (2009), while responding to the call for both "personalization of war and politicization of health" (Giacaman, 2018).

⁴ This idea of knowledge production does not seek to cast Palestinian ideas and understandings as a monolith, rather it arises from the practical need to develop theory/analysis specific to the reality of living in Palestine. In the domain of health literature, Rita Giacaman describes her and her colleagues' experiences: "In the Palestinian context, where we had long been silenced and our narrative was disqualified (a practice that continues to prevail), knowledge production became part of the resistance to our settler-colonial predicament... derived from our collective attempt to understand, give meaning to, and document what was happening to our own lives in warlike conditions" (2018).

Chapter 1: A Gendered History of Palestinian Uprooting

The state of Israel regulates nearly every aspect of life in Palestine; on the most basic level, who is allowed to live, where, and the conditions of everyday life. Israel not only regularly confiscates Palestinian land and uproots Palestinians from their homes. The Israeli state also controls the laws under which the remaining Palestinians live through what national observers consider the “*de facto* annexation of the whole occupied Palestinian territory” and deprivation of Palestinians’ civil rights (United Nations Forum on the Question of Palestine, 2019). As succinctly summarized by human rights attorney Noura Erakat, Israel governs the oPt “without *either* preserving the sovereign rights of its [Palestinian] inhabitants *or* absorbing them under [Israel’s] civil jurisdiction”-- meaning, the Palestinian territories are disallowed an autonomous system of governance and instead have been governed under Israeli military law since 1967 (2019). In effect, Israel differentially manages life across ethnic lines, wherein Palestinians live under military law, whereas Israelis enjoy civil rights. A recent report from Human Rights Watch explains that for Palestinian society living under military law, “[Israel] suspending these [civil] rights for a week or month interrupts public life, but suspension for decades *fundamentally distorts it*” (2019; emphasis mine). Five decades of military law have buttressed a complex system of oppression under which, the U.S. Campaign for Palestinian Rights writes, “Palestinian lives and bodies are simultaneously devalued, dehumanized, and obsessively controlled” (n.d.).

It is the obsessive control over Palestinian women’s lives and bodies that this paper analyzes overall. I interrogate the methods of control through key political determinants of health and the consequences through women’s health outcomes-- general and reproductive. To develop this analysis, I rely on the theory of *biopolitics*, popularized by philosopher Michel Foucault and

expanded upon in the context of Palestine by queer theorist Jasbir Puar. Puar gives us the definition of “all population measures,” or methods of obsessive control employed by a state, that “enable some forms of living and inhibit others” as measured by “birthrates, fertility, longevity, disease, impairment, toxicity, productivity” (Puar, 2017). In the case of Palestine, it is clear that this differential, as solidified through the application of civil law to Israelis and military law to Palestinians, seeks to enable Israeli life and inhibit the lives of Palestinians. For our purposes, biopolitics is on the one hand, how Israeli political decisions (land confiscation, denial of sovereignty, restrictions on mobility, deprivation of resources, military bombardment) affect women’s health outcomes. On the other hand, it looks at how poor health outcomes for Palestinian women, suffering that debilitates women’s lives and ability to resist, buttresses Israel’s political control over Palestine. This analysis is meant less as a depressing or hopeless “recapitulation of [Israeli] state power” (Salaita, 2016), but rather an honest assessment of the harms that Palestinian women are living through and the dire need for global solidarity as Palestinian women have expressed.

Before delving into the political determinants informing contemporary women’s health outcomes, however, it is important to assess the broader political situation in Palestine and how such forms of biopolitical control developed historically. I start by explaining why Palestine is a case of settler colonialism, as this is essential to understand why Palestinian reproduction has been politicized, the significance of demographics, and why women’s quotidian life—or existence more broadly—is part of a much larger picture of political resistance. This allows us to situate women’s lives and health outcomes in present-day Palestine. The history begins at *al-Nakba*, or “the catastrophe” in Arabic” and includes a case study of the Deir Yassin Massacre

which exemplifies how violence against women has functioned as a fundamental component of the Israeli project of settler colonialism.

Colonized and Occupied

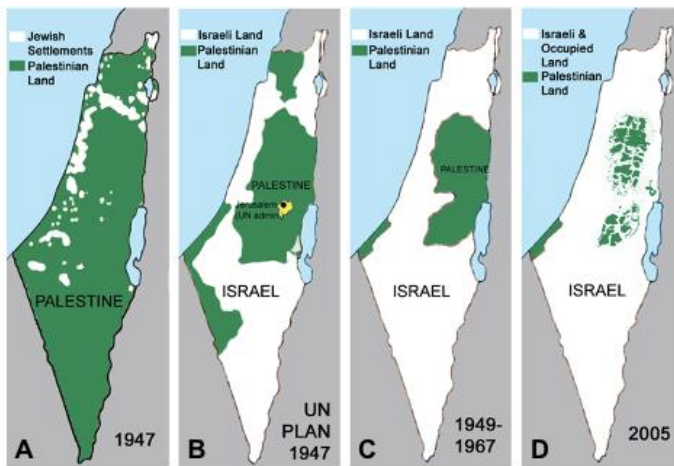
The history of Israeli colonization and occupation provides essential context for how Israel came to exercise and entrench biopolitical regulation over the population as a whole. But exactly does it mean for Palestinians to be an occupied people, and how did this originate from the establishment of Israel, the occupying power? When taken for granted, these terms of occupation can obscure the lived realities and painful histories of occupation. In her scholarship on contemporary violence against Palestinian women, Shalhoub-Kevorkian argues that “[i]n order to develop a critical analysis that takes into account the suffering of the Palestinian”-- both as embedded in Israel’s origins and the “recurrent trauma” that persists in Palestinian society-- it is essential for academics “use the *Nakba* as a central event and epistemological point of departure” (2014). Indeed, many scholars assert, and yet more Palestinians experience, that the mass expulsion characteristic of the Nakba continues to this day as the settler colonial state of Israel is maintained and expanded (Pappe, 2006). Therefore, we will use this early period to delineate key events, which followed as a way to demystify Israel’s contemporary and gendered management of Palestinian life.

On the whole, the nation state of Israel, analogous to the United States, is a settler colonial society. It was founded through the process of forced displacement of a native people, confiscation of native lands, and influx of non-natives to settle atop the remains. This was precisely the political project of Zionism, which originated from European Jews who sought to establish an exclusively Jewish state on Historic Palestine (Figure 1A)— land already inhabited by the Palestinian population of indigenous, and primarily not Jewish, Arab people (Naber et al.,

2016). With the backing of the British colonial empire and the United Nations, the Zionist movement accelerated the colonization of Palestine in 1947. Under the UN's Partition Plan, 55% of Historic Palestine was unilaterally allocated for the development of a Jewish state, while the remaining 45% of Palestine was left for the Palestinians— a proposal which Palestinian political leadership rejected from the beginning (Pappe, 2006) (Figure 1B). This Plan launched the most concentrated ethnic cleansing of Palestinians to date, what remains stained in collective memory as *al-Nakba*, the “catastrophe,” which the indigenous inhabitants endured from 1947-1949. The message was, “Leave [the] land or be killed” (*Palestine Remix*). With the help of neighboring Arab states, Palestinian resistance forces attempted to keep hold of their land, but eventually were outnumbered and outgunned. No less than 750,000 Palestinians, or 75% of the population at the time, were uprooted from their lands (Erakat, 2019). Some stayed in what became the new state Israel only to endure treatment as second-class citizens, many were expelled from their homes and took shelter in refugee camps in Palestinian territory, and more fled to surrounding countries as refugees. Amidst the Nakba, the state of Israel was officially established in 1948 on what Israelis celebrate as Israeli Independence Day, while Palestinians mourn the loss of Palestine and their collective dignity.

Because settler colonialism can be understood as a structure of indigenous subordination, as opposed to a singular historical event (Wolfe, 1998), the confiscation of Palestinian land continued after 1948. By 1949, urban cities were almost entirely cleansed of Palestinians, half of all Palestinian villages had been demolished, and Israel occupied 78% of Historic Palestine (Figure 1C). The 22% land remaining for Palestine (the West Bank and Gaza Strip) was demarcated by the 1949 Armistice Lines, which were intended to be temporary boundaries of Palestinian territories— as opposed to a contiguous country— until a two-state solution could be

secured. Tensions lead to the Six Day War in 1967, which came to an end when Israel invaded the remaining Palestinian land and extended military law over the territories, furthering the project of settler colonial rule by encouraging Israeli settlement in flagrant violation of Geneva Conventions. By the 1990s, the internationally mediated Oslo Accords, the supposed ‘peace process,’ did little to secure autonomous Palestinian political control. While the Accords outlined a gradual transition of Israeli military rule to an interim administrative body (the Palestinian National Authority) by the end of the century, to date three decades later, Palestinian autonomy yet to be realized (for a comprehensive summary of key events in the ongoing colonization of Palestine, see Table 1).



Source: Palestine Solidarity Campaign.

Figure 2. The progressive confiscation and colonization of Palestinian land from before the beginning of the Nakba in 1947 to 2019 (present). Green denotes Palestinian land, and white is under Israeli rule. The Gaza Strip is the leftmost region in (C) and the West Bank, including East Jerusalem, is on the right. (B) The UN Partition Plan of 1947. (C) Independent Palestinian land until Israel invaded in the 1967 War (D) Though maps are useful for understanding how little land is under Palestinian control, even the areas in green are diminishing nearly every day as Israeli settlements proliferate under Israel’s de facto annexation of the entire region.

Table 1. Key events in the Israeli occupation of Palestine.

1948	Deir Yassin Massacre and state of Israel established through al-Nakba (75% Palestinian land expropriated)
1967	Six Day War (100% Palestinian land occupied)
1987–1993	First Intifada (“shaking off”): Five years of mass-based, grassroots protesting against Israeli occupation and expropriation of land
1993–1995	Oslo Accord: Self-rule of Palestinian territories granted nominally; Israeli settlement expansion continues
2007	Hamas is democratically elected in Gaza; international boycott of the administration and Israeli siege on Gaza begins
2008–2009	Operation Cast Lead (war on Gaza)
2014	Operation Protective Edge (war on Gaza)
2017	Trump recognizes all of Jerusalem as capital of Israel
2019	U.S. no longer considers settlements illegal, though they remain such under international law

As anthropologist Maya Mikdashi describes, “Historic Palestine... is an Israeli settler colony at varying stages of success [for the Israeli state]” (2014). In this sense, the Gaza Strip is at a simultaneously advanced and dire stage. Gaza is a coastal enclave that touches the Mediterranean Ocean, but whose residents are hardly ever permitted to. Gazans are walled-in, and since 2007, Israel’s blockade has unilaterally regulated exactly who and what is permitted to enter or leave Gaza by land, airspace, and sea. As nearly 2 million Palestinians inhabit Gaza, it is one of the most densely populated places on earth and is known as the world’s largest ‘open-air prison’ (Erakat, 2019). More than 1.4 million of the Palestinians living in Gaza are refugees; some of whom can even see their family’s homes through the fence surrounding Gaza or what’s left of the demolished structures, others still have the key to their front door, yet all are denied the right to return. Further inland, the West Bank consists of Palestinian towns and cities

fragmented by Israel's militarized checkpoints and sniper watchtowers, Jewish-only settlements, and a 440-mile concrete separation barrier more aptly described as Israel's 'apartheid wall.' Like with many contemporary nation states established by colonizing land, Israel's boundaries remain controversial to this day. While Israel continues to violate the very borders it imposed on Palestinian political leadership in 1967 by *de facto* annexing more land, Palestinian refugees living within and outside of Palestine continue to demand the right of return to their homeland as is granted under international law (Erakat, 2019).

In summary, the biopolitical control that Israel exercises over the Palestinian population today is the product of Zionist settler colonialism. The remaining land left for Palestinians, which diminishes near daily as Israel's settlements encroach around the West Bank, is occupied under Israeli military control by means of permanent military presence and military law for Palestinians. The oPt are disparate territories which have no genuine sovereignty: the Gaza Strip remains captive under Israeli siege, and the West Bank (Area A, B, C, from most to least Palestinian autonomy) is dissected by Israeli civilian settlements and military bases. In the oPt, Puar explains, "It is almost impossible to describe the complexity of Israeli territorial control that inhibits Palestinian movement, the scale of loss that families and villages have endured over decades of colonial rule, or the exhaustion and fear that dominate everyday existence" (2016). The calculated management of Palestinian life through military occupation functions as population control because, in the eyes of the Israeli state, Palestinians are quantified as a demographic threat to the land they lay claim. Shimon Peres, a former Israeli prime minister, once said in an interview that for Israel, "Defensible borders is not only a matter of size [of land] but a matter of demography..." (Stadlen, 2007). Therefore, in part due to the biological

capability to bear children that some women have, Palestinian women are particularly targeted by the state of Israel.

Gendered Mechanisms of War: Deir Yassin as a Case Study

The trauma of the Nakba is collective, but not unidimensional. Though the Deir Yassin Massacre is widely recognized as a turning point in accelerating the Nakba and expelling Palestinians from their homeland, the gendered mechanisms of war are seldom discussed. In 1948, an estimated one hundred and twenty Palestinians villagers were massacred in their homes in the village of Deir Yassin by Zionist militias (Hogan, 2001). It is well documented that following the massacre, hundreds of Palestinian villages near and far from Deir Yassin were deserted as words of the massacre spread quickly by the survivors who fled and the Zionist militias who widely broadcasted the high death toll. According to feminist scholars, however, what substantially hastened the mass fleeing of Palestinians from other villages was the threat of sexual assault against Palestinian women and girls (Hasso, 2000; Zinngrebe, 2016).

In Palestine, sheltering women from harm and forbidding sexual transgression is tied to the dignity and *honor* of her family. Like other places in the world where women's sexual purity is also culturally mandated, in Palestine transgressing sexual purity is considered both an affront to a woman's privacy and safety and that of her family (Hasso, 2000). Based on this patriarchal organization of family relationships, feminist historian Frances Hasso (2000) argues, Israeli militias weaponized rape to both cause unbelievable harm to their victims and weaponize the notion of honor to instill immense fear in villages across Palestine. In effect, militias used sexual violence as a way to coerce the exodus of entire villages and colonize the land (Hasso, 2000). Only three weeks following this rampage of sexualized terror and psychological warfare in Deir

Yassin (Sayigh, 1979; Warnock, 1990 as cited in Hasso, 2000; Zinngrebe, 2016; Peteet, 1991), the state of Israel was officially founded.

During the first decades following the establishment of the nation state, Israeli-only settlements proliferated on once-Palestinian land as Palestinians fled mass evictions, home demolitions, and the ubiquitous vulnerability of threats to honor. Indeed, Elise Young documents histories of sexual violence through her years spent compiling oral histories from Palestinian women living in refugee camps in Jordan. Young characterizes sexual violence against Palestinian women as a major public health crisis and an aspect of Israeli colonization that functioned to “break down [Palestinian] resistance” (2012). In “A Feminist Politics of Health Care: The Case of Palestinian Women Under Israeli Occupation, 1979-1982,” Young also notes the sexualized humiliation of imprisoned women wherein Israeli military agents were known for handcuffing pregnant women during labor (1994). This is why many Palestinian women recognize, “Israel was built on the ruins of the Palestinian homeland, on its land, pain, and displacement. It was built on the destruction of our [Palestinian women’s] communal social ties, the violation and invasion of our homes and bodies” (Ihmoud et al., 2014).

The Survival of the Family Unit and Surviving the Family Unit

The uprooting of the Palestinian people in the Nakba tore apart the structuring of Palestinian society. Whether through sexual violence or other forms of war, many families were ripped apart during the Nakba and often remained isolated indefinitely due to Israel’s severe restrictions on movement (Physicians for Human Rights - Israel, 2019). In the case of colonized Algeria, anti-colonial philosopher Frantz Fanon describes a pattern of colonizers working to undermine indigenous social structures by “separating the people from each other, of

fragmenting them, with the sole objective of making any cohesion impossible” to the extent that “[n]o previous rhythm is to be found unaltered. Caught in the meshes of the barbed wires, the members of regrouped Algerian families neither eat nor sleep as they did before” (Fanon as referenced in Smith, 2016). The same effect took place in Palestine and left the family unit, though ‘regrouped,’ as one of the only surviving social institutions (Peteet, 1991; Jad, 1998). As nearly the entire population was dispossessed of their homes and lands and displaced to overcrowded refugee camps in Palestine or to ghettoized neighborhoods in Israeli cities, ways of life within and external to the family were radically altered. Prior to the Nakba, Palestine consisted largely of peasantry living in villages scattered across countryside, cooperatively tending to the land amongst extended family, and contributing to the predominantly agricultural economy (Assaf in Mayer, 1994). The transition from an agricultural to industrial economy left women largely confined to the home and tending to the needs of family members. Additionally, domestic labor, such as housework and childrearing, which had once been a cooperative endeavor among extended family became largely the work of individual mothers and wives (Peteet, 1991).

The kinship networks that survived functioned thereafter as the primary source of economic security and cultural continuity for many Palestinians (Jad, 1998). Indeed, to this day in Palestine the family itself fills the needs of the populace that the impotent quasi-governments in the West Bank and Gaza fail to provide, such as child care and providing for people in old age in the absence of any social security system. This bolstered importance of the family unit in Palestinian society, however, has had devastating consequences for women. As the Israeli government annexes more Palestinian land and denies the majority of construction permits for new homes on areas purportedly under Palestinian control (Shezaf, 2020), increasingly crowded

living conditions amongst extended family increases tensions and the amount of domestic labor that women have to do (Al-Khatib et al., 2007). Additionally, living in such close proximity denies women privacy and subjects them to constant pressure and scrutiny from various family members. Women also have few opportunities to escape the watch of relatives due to both high unemployment for women— 50% on average and 75% in Gaza (International Labour Organization of the UN, 2018)— and fears around women traveling through checkpoints. The latter is influenced by the high likelihood of violence and humiliation by Israeli soldiers or settlers and is compounded by the patriarchal notion of honor.

For Palestinian women, family functions as both a site of oppression, exacerbated by the crowded living conditions and ongoing trauma of Israeli settlements and military affronts (Dana and Walker 2015), and a structure for their survival and that of Palestine. Indeed, many qualitative studies of women’s perceptions of gendered violence suggest very few, if any, women advocate for dissolution of the family unit as the solution. In fact, Veronese et al. (2019) find that women in Gaza identified family ties and motherhood as protective factors for psychological health amidst prolonged armed conflict and political oppression. Women described family as a powerful source of solidarity, support, and courage (Veronese et al., 2019).

Caring Labor of Women and Mothers

In 2012, the United Nations released a report whose title asked a formidable question, “Gaza in 2020: A Liveable Place?” The report outlined assessments which projected that “without fundamental change and collective effort,” Gaza would become “unlivable” within the decade (UN Country Team, 2012). Yet, to date, two million Palestinians live in the Gaza Strip and 5 million live in the Israeli-occupied Palestinian territories. As I finish this thesis in 2020 and

ask what it means to live an “unlivable” life, to drink 96% undrinkable water (OCHA, 2018), I have found that these questions have gendered answers as Palestinian women are the primary caretakers within the Palestinian population (Peteet, 1991). As prescribed by patriarchal gender roles, women are tasked with the responsibility of caring labor-- which fundamentally means keeping children and family members alive in the face of living conditions antagonistic to any measure of wellbeing. Jarringly, it is estimated that more than 25% of total illness in Gaza is caused by contaminated drinking water, with children most burdened, and 12% of infant deaths (Efron, 2019). The prescribed duty is particularly strenuous in all of oPt as 45% of the population living in the West Bank and 50% in Gaza are younger than 15 years-old (Palestinian Central Bureau of Statistics, 2016), most of whom are likely raised under the care of mothers and female relatives who must go extra lengths to prevent premature death of young ones. Overall, the “home economy sustains families, but [puts] women under [a] heavy burden” (Giacaman and Johnson, 2002).

The caring labor of Palestinian women, however, does not solely function as a safety net between life and mortality for the families and communities they raise. Surely in their expected domestic duties, women prepare food for their own nourishment and that of new generations, but this labor is also a practice of political resistance intelligible through the project of national liberation. This political dimension looks like tending to a house which Israel has retroactively deemed illegal; bearing a child who is considered a ‘demographic threat’ by the state of Israel even while still in the womb; purchasing produce from a Palestinian farmer whose crop has been repeatedly uprooted by Israeli settlers (Fields, 2017). In effect, as the goal of a settler colonial society like Israel is the elimination of the native (Woolfe, 1998), indigeneity is a political category, Steven Salaita posits (2016), and this is expressly clear for Palestinian women whose

quotidian labor strengthens the resolve of community living on ancestral land. This “everyday life... saturated with endless acts of resistance, including refuting, navigating, and contesting the [Israeli] occupation” (Puar and Medien, 2018) is captured in essence by the indigenous justice slogan, ‘existence is resistance’ (Figure 3).



Figure 3. Image of art that reads “To Exist is to Resist” on the Israeli ‘separation barrier’ which cuts through the West Bank.

Conversely, resistance is a fundamental purpose of Palestinian existence as political resistance is considered integral to a life of integrity (Shalhoub-Kevorkian, 2008), redefining *living* as something ontologically distinct from survival or solely avoiding mortality. Jasbir Puar tracks the threat that this sort of living presents to the Israeli state in her discussion of disability and the intentional maiming of Palestinians by Israeli forces, as opposed to former ‘shoot to kill’ policies (2017). The Israeli state’s maiming of Palestinian people, Puar argues, “seeks to render impotent any future resistance” and “future capacity to sustain Palestinian life on its own terms” (2017). This Israeli tactic of targeting resistance and wearing down integrity is demonstrated in a summation of four decades of health research at the Institute of Community and Public Health:

“Palestinians are ruled [by Israel] not only with brute force, but also with ambiguity, uncertainty, insecurity, loss of dignity, and deliberate humiliation, all important consequences of chronic war that need acknowledgment and *not merely as a matter of physical survival...*” (Giacaman, 2018; emphasis mine).

Christen Smith’s work, though in a different part of the world, provides an explanation as to why Palestinian mothers are pointedly afflicted by the Israeli occupation. From her work on Black mothers in the U.S. and Brazil, Smith finds that Black mothers pose a substantial threat to colonial state power through the political resistance embedded in their roles as caregivers (2016). By analyzing anti-Black state violence and police brutality, Smith concludes, “[The state] intends to kill and quell the possibility for rebellion and new life. Thus, in the case of anti-Black state violence...” are “mechanisms that terrorize Black mothers and inhibit their ability to further care for Black life, *not just kill*” (2016; emphasis mine). Therefore, on the whole, in Palestine, it is both the very lives and resistance-living, so to speak, of Palestinian mothers that the Israeli state seeks to regulate and diminish.

Chapter 2: Women's and Mother's Occupied Health

Palestinian women live amidst a traumatic past and existentially uncertain future, endemic to living on land that Israel seeks to confiscate. In the 1980s, when Middle East historian Elise Young interviewed Palestinian women expelled to refugee camps in Jordan, Young found that nearly all of the women identified the right of return to Palestine as the “single most important factor affecting their health” (2012). This conceptualization of health ties wellbeing to land, autonomy, and dignity— a thread shared globally among different indigenous cosmovisions. In more recent years, its significance among Palestinians has not faltered. Fatmeh Breijeh, a Palestinian mother, in explaining why she teaches her children to resist displacement from the land says, “Our roots are fixed here. We, this land, this land, we are from this land. Look at the earth, at the soil; you will find it's our color. Every blade of grass, we know... the blessings of our land” (Naijar, 2014 as cited in Elia, 2017). Likewise, Rita Giacaman affirms “the social and political meaning that we Palestinians attribute to our collective experience” of trauma (2018).

Accordingly, the assessment of Palestinian women's health that follows considers the political context from which women's morbidities arise. It builds on the history tracked in the last chapter and the gendered mechanisms of violence underpinning the Israeli settler colonial project. This chapter focuses less on heightened periods of conflict and more on the aftermath and the times, as unpredictable as they are, in between. From the salient themes which have emerged throughout the literature, I will consider resource deprivation, restricted movement, and injured and imprisoned relatives as key political determinants impacting Palestinian women's

health and access to quality health care. The interconnected causal pathways (Figure 4) include women’s reproductive health outcomes, but not in abstraction from the rest of their lives.

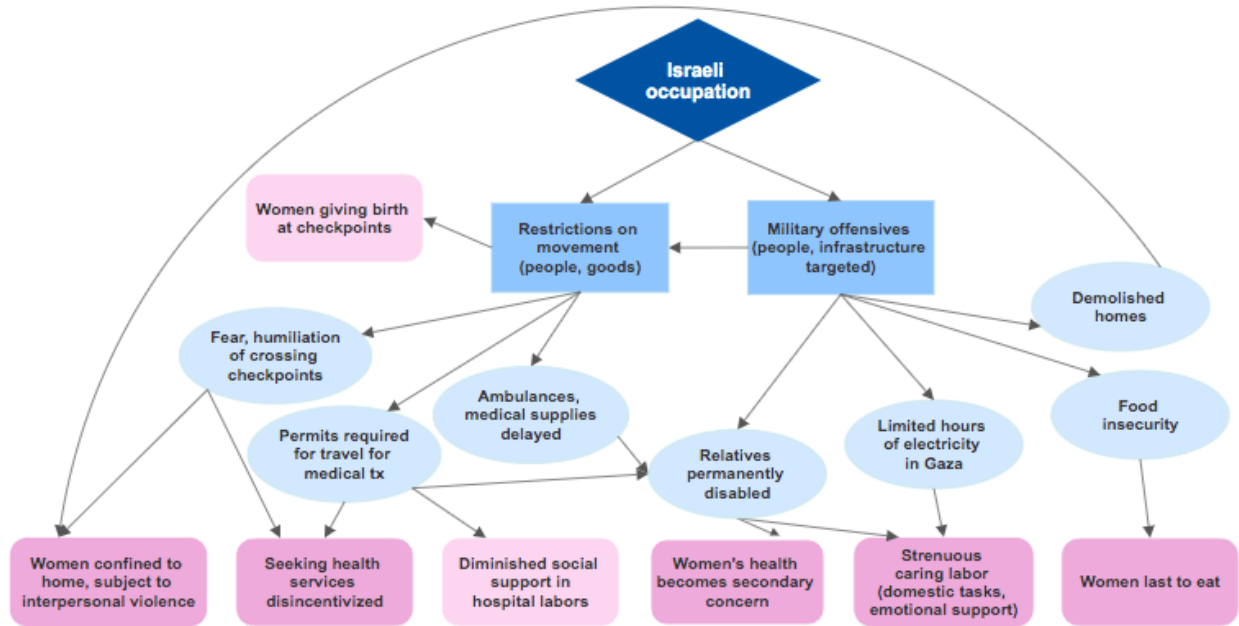


Figure 4. Interconnected casual pathways of two political determinants (restriction on movement and military offenses) as related to women’s general (purple) and reproductive health outcomes (pink). The effects on women include both direct violence and intracommunal patriarchal violence (e.g. interpersonal violence) compounded by the occupation.

The genocidal endeavor of the ongoing Nakba functions as both a form of population control and a method of corroding Palestinian resistance. Lauren Berlant’s concept of *slow death* (2007) offers us a framework to interpret the structural violence that Palestinian women face as part of the occupation. Here, Berlant, departing from understanding suffering through only singular events of trauma or disaster (Puar, 2017) such as events of heightened conflict summarized in Table 1. Instead, she defines slow death as: “[The] physical wearing out of a population and the deterioration of people in that population that is very nearly a defining condition of their experience and historical existence” and, as a result, the exhausting yet

“ordinary work of living on” (Berlant, 2007). In a similar vein, Achille Mbembe looks to Gaza and describes the structural and daily violence experienced by the besieged population:

“The state of siege is itself a military institution... entire populations are the target.... The besieged villages and towns are sealed off and cut off from the world. Daily life is militarized. Freedom is given to local military commanders to use their discretion as to when and whom to shoot. Movement between the territorial cells requires formal permits. Local civil institutions are systematically destroyed. The besieged population is deprived of their means of income. *Invisible killing* is added to outright executions” (2003, emphasis mine).

The “invisible killing” (Mbembe, 2003) of Palestinian women is necessary to examine in a context where international media coverage tells us that harm to women (and children) is an aberration in Palestine or collateral (Elia, 2017). Decades ago, Murray et al. (2002) noted this invisible killing and more importantly, the dearth of attention it has received in public health assessments of harm from war. In their report “Armed Conflict as a Public Health Problem” presented to the World Health Organization, Murray et al. emphasized the deadliness of armed warfare beyond mortality in direct confrontation:

Conflict obviously causes deaths and injuries on the battlefield, but also health consequences from the displacement of populations, the breakdown of health and social services, and the heightened risk of disease transmission. Despite the size of the health consequences, military conflict has not received the same attention from public health research and policy as many other causes of illness and death (2002).

Palestinian men are terribly well accounted for in conventional biomedical assessment of suffering (i.e. death and injury counts). The following discussion considers the suffering of Palestinian women, the “invisible frontliners” (Shalhoub-Kevorkian, 2008), to examine how Israel’s tightening control over Palestine is killing women, slowly and structurally.

Resource Deprivation

Sustaining autonomous life on ancestral land has long been a component of the Palestinian path towards liberation and a politic which Israel has sought to crush. Dating back to 1983, the grassroots Palestinian Popular Committees were coordinated as a very means of supporting the Palestinian people and propelling a lasting resistance movement against the Israeli occupation. The committees encompassed diverse sectors of the population, including those unified under the Union of Palestinian Women's Committees and the Union of Palestinian Medical Relief Committees. The committees functioned to serve the needs of the population whose means of survival were significantly disrupted by Israeli-imposed road closures and sieges throughout the territory since 1967. This vital politic of autonomy made possible the First Intifada (see Table 1):

The women's committees were the backbone of the civil disobedience acts that sparked and sustained the first intifada, from sit-ins and street demonstrations to rock throwing, arranging alternative schooling, garbage collection, food distribution, and other networks of support (Amireh, 2012).

As such, the Palestinian people's access to and organization of resources posed a serious threat to Israel's ability to maintain domination over land and people. Thus, the Israeli monopoly on resources expanded from expropriating the land to regulating most natural resources in Palestine and imposing heavy restrictions on imports (Bates et al., 2017). The devastating effects of resource deprivation will be examined through both existing health care infrastructure in Palestine and women's health in every-day life.

Israel's web of control over resources in Palestine has circumscribed the possibility of functioning health care infrastructure as the system is "fragmented, over-burdened and under-resourced" (Bates et al., 2017) in both the Gaza and the West Bank (Hassan et al., 2012). In besieged Gaza, the Israeli state calculates the exact amount of electricity and quantity of water health facilities are permitted per day. As a result, hospitals and health clinics rely on imported

medical supplies, like drugs and basic medical devices as they are deprived of the capacity to produce their own (Keelan, 2015); however, not nearly enough supplies are allowed in to adequately serve the population's medical needs (Hassan et al., 2012). Even the existing physical infrastructure, such as hospitals in clinics in Gaza, are significantly limited in capacity due to Israel's frequent bombardment of the area because the materials necessary for reconstruction are barred from entry. Within structurally sound health facilities, many lack the personnel necessary to function at full capacity. During the 2008 invasion of Gaza, for example, many midwives found themselves psychologically unprepared and materially ill-equipped to facilitate births outside of the hospital. At the time, the entirety of the few supplied hospitals were using all personnel possible to treat Palestinians severely maimed by the bombardment (Wick & Hassan, 2012). Health providers struggle both to train and retain specialized staff as few Gazans are allowed to leave for higher education and those who are able to leave have little incentive to return to such restricted and impoverished life (Hamayel et al., 2017). As summarized by Leone et al. (2019), "[H]ealthcare in Gaza Strip has been on the brink of collapse mainly due to the siege conditions imposed by Israel and Egypt."

What does exist of a healthcare system is funded largely by foreign governments, the UN, and the aid industry, as taxation in the context of such high rates of employment provides little to support social services (Leone et al., 2019). This means the agendas of international donors and priorities of NGOs determine which health services are allocated more funding (Bosmans et al., 2008), as opposed to more democratic means of decision-making that would reflect the health care needs of an entire population. Funding constraints also limit efficient collaboration between NGOs, resulting in an atomized system (Tucktuck et al., 2017). Moreover, much of the humanitarian health aid, from Israel and abroad, comes with stipulated political conditions,

making it so if the Palestinian political elite were to oppose the occupation-- as, I hope this thesis demonstrates, is ultimately necessary for the betterment of Palestinian health-- all life-saving health aid would immediately cease (Roy, 2012). The flaws in this foundation of privatized and externalized health care is explained by Al-Shabaka, a human rights think tank, in their article “In Israeli-Occupied Palestine, Health Care is not a Right” (2019):

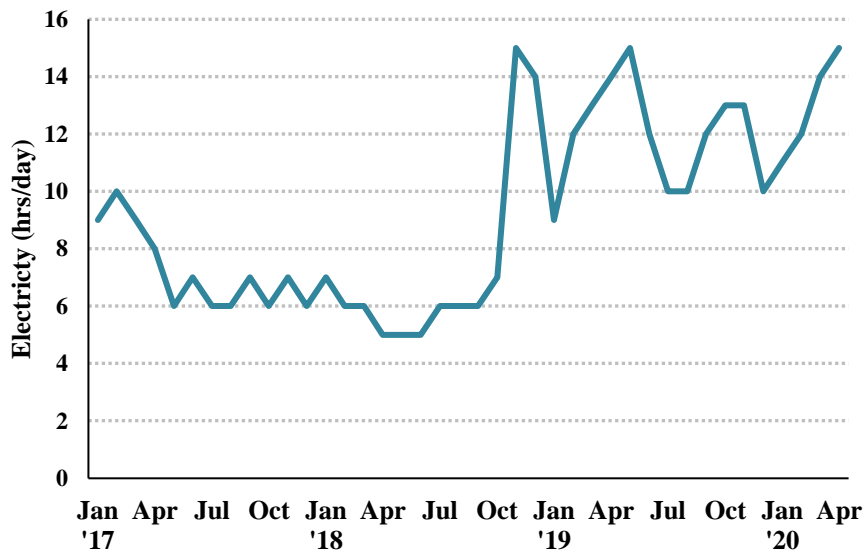
A health care system should not be at the mercy of a military occupier or dependent on external aid and the mercurial motivations and priorities of donors.... This is an unsustainable and unjust model for a health system. Only through addressing the fundamental inequities and everyday violence of Israel’s occupation can Palestinian health and access to health care truly improve.

Political geographer Ron Smith arrives at similar conclusions through his research interviewing health professionals, UNRWA employees (UN Relief Works Agency Health Department), and officials of the Ministry of Health in Gaza over the span of six years (2009-2014)— a period which, of note, accounts for the effects of Operation Protective Edge in 2014, Israel’s most fatal and destructive war on Gaza to date (2015; refer back to Table 1). Smith finds that sovereignty is crucial to the promotion of health care and formation of a cohesive health care system. Overall, in calling for political solutions to the medical crisis in Gaza, Smith argues, “Assistance for Gazan health systems must support local control over resources” (2015). Though his analysis focuses on the Gaza Strip, Smith’s conclusions apply similarly to the West Bank because even though the area is less affected by blockades (Bates et al., 2017), Israel exerts primary control over quantities of resources, from water to pharmaceuticals (*Haaretz*, 2015), allowed for health care. Thus, the regulation and ultimately deprivation of resources guarantees Israel control over Gaza and the West Bank by stunting autonomous life, or sovereignty of the Palestinian people, as observed through the ineffectual healthcare system.

Scarce resources are a result of a politically manufactured humanitarian crisis (Smith, 2015) which configures into Israel's biopolitical regulation of the Palestinian population to quell life and resistance. For Israel, it has come down to a science, an exact calculation for the "bare minimum requisite for [Palestinian] life" which, most importantly, "can be withheld at any moment" (Puar, 2017). This unilateral power over Palestinian life is most glaring in Israel's regulation of the precise quantity of food allowed to enter Gaza per truckload. That is, the state has calculated the minimum number of calories per Gazan needed to avoid starvation: 2,279 calories per day (Hass, 2012). This policy, as described by the Israeli Prime Minister's advisor at the beginning of the siege on Gaza, functions "like an appointment with a dietician. The Palestinians will get a lot thinner, but won't die" (Levy, 2006). Also due to these strict regulations on flow of goods, 70% of inhabitants in Gaza rely on aid organizations for basic supplies (Physicians for Human Rights - Israel, 2019) and food insecurity in Gaza is a frequent reality.

With the food that is available, any perishable items risk spoilage which is quite common due to the electricity crisis in Gaza. Like food, Israel's unilateral regulation of electricity in Gaza functions as a "weapon of war" made only more destructive when Israel bombed Gaza's only power plant in 2006 ("Gaza Left in the Dark"). Though the electricity crisis in Gaza has improved substantially since 2017, lack of consistent access persists (Figure 5). For women, this means that household tasks require more time and labor in the absence of simple appliances such as refrigerators, washing machines, and electric water heaters ("Gaza's Electricity Crisis," 2017). Under the stress of food and electricity deprivation, a study by the UN Populations Fund (UNFPA) found that 61% of women in Gaza believe the Israeli blockade and electricity cuts have contributed to higher rates of interpersonal violence against women (2014). Thus, in line

with Dana and Walker’s findings in the West Bank (2014), the Israeli control over Palestine compounds patriarchal norms within Palestinian families and communities, burdening women with more strenuous household labor (Giacaman and Johnson, 2002) and putting women at risk of abuse.



Source: United Nations Office for the Coordination of Humanitarian Affairs (OCHA oPt), 2020.

Figure 5. Average daily supply of electricity per household in the Gaza Strip (January 2017-March 2020). (Mean= 9.25 hrs, min= 4 hrs, max= 15 hrs). Unpredictable fluctuations and insufficient access make the task of caregiving labor more strenuous for women.

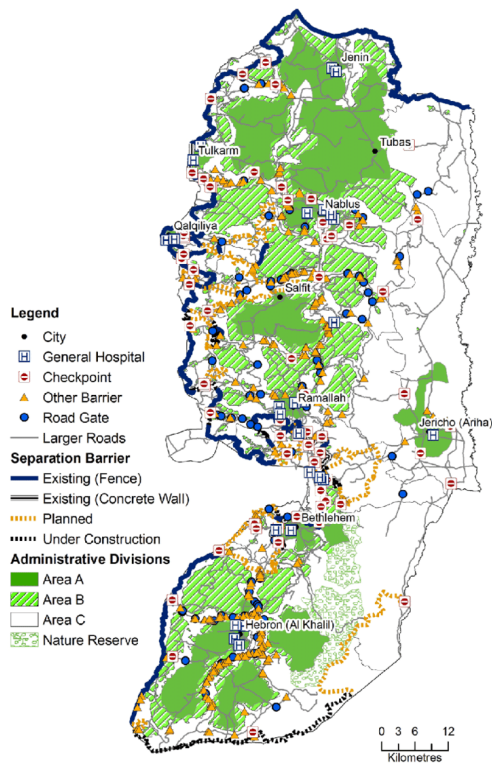
There are not many studies that quantitatively articulate what resource deprivation *directly* entails for Palestinian women’s health beyond women’s reproductive and maternal health (Hammoudeh et al., 2017; Bates et al., 2017). Bates et al. (2017), in responding to this gap in understanding, survey 14,819 women aged 15-54 and living in either the West Bank or Gaza Strip to assess health needs and perceptions. Consistent with the research of Majaj et al. (2013) in their study “‘It’s Not Easy to Acknowledge that I’m Ill’: A Qualitative Investigation into the Health-Seeking Behavior of Rural Palestinian Women” and the findings of a cultural expectation

of women's modesty and stigma around discussing personal health issues, Bates et al. demonstrate that Palestinian women largely underrated their health needs (2017). Surprisingly, Gazan women as compared to women living in the West Bank reported better health (through objective and subjective measures) despite such outcomes being "at odds with their relatively poorer health infrastructure, living conditions, nutrition and socioeconomic status due to the severity of occupation violence in Gaza" (Bates et al., 2017). The authors speculate that Palestinian women in general "consider their health as relatively less significant compared to that of their family and their wider community enduring dire conditions" (Bates et al., 2017). Therefore, in resource deprived conditions, the adverse effects on women's health are evident and yet this neglected topic of study further demonstrates the slow death that Palestinian women bear structurally and often silently.

Restricted Movement

Israel's regulation on Palestinian movement simultaneously uproots and confines with force. Israel has manufactured a complex network of militarized control through laws and physical barriers that prohibit the Palestinian population's ability to move freely and travel within the region (Shalhoub-Kevorkian, 2015). Military checkpoints, arbitrary and indefinite road closures, curfews, and a complex ID system all function to monitor, delay, and ultimately obstruct the movement of Palestinians (physical barriers shown in Figure 6). As described by Mbembe (2003), "The occupied territories are... divided into a web of intricate internal borders and various isolated cells" impermeable without Israeli permission. What's more, under Israeli laws that privilege Israelis and subjugate Palestinians, Palestinians are required to use roads separate from Israelis. The 'Arab route' typically entails longer wait times to cross through

checkpoints and greater distance to reach the same destination— that is, if Israeli soldiers manning the checkpoints allow Palestinians to cross as the decision is left to their discretion (“Restrictions on Movement,” 2017). This road system of ethnic segregation also applies to ambulances, and travel is commonly delayed by Israeli military searches and patient transfer from a Palestinian to Israeli ambulance if a Palestinian patient is en route to a hospital in Israel. In fact, the main ambulance supplier in the West Bank reported that in 2014, 93% of its ambulance transfers with acutely ill passengers were subject to “time consuming delays” of 10 minutes or longer at checkpoints due to Israeli security protocols (WHO as cited in Keelan, 2015).



Source: Eklund & Martensson, 2012.

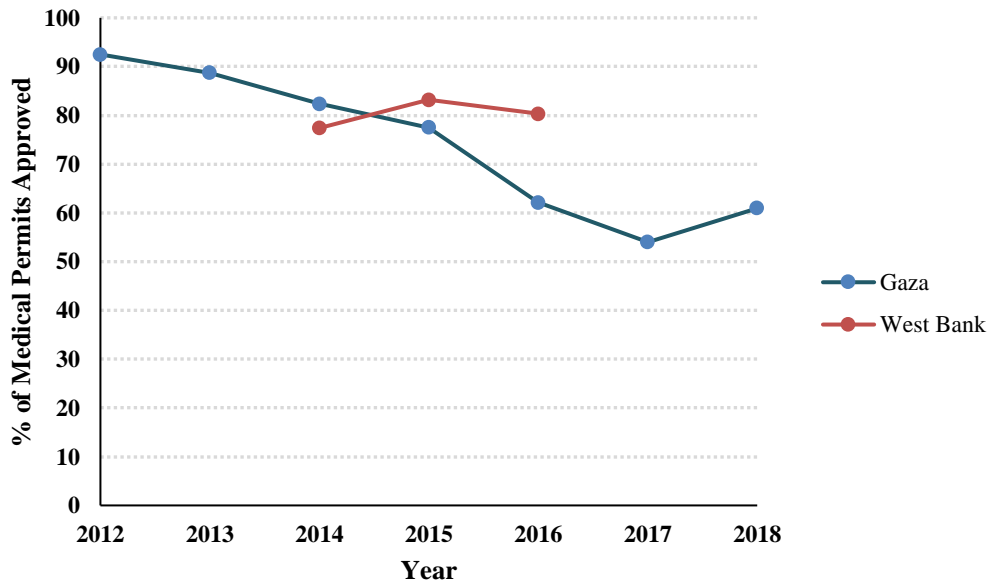
Figure 6. Map depicting the restrictions on movement imposed around main roads and major cities in the West Bank. Physical obstructions are classified into categories: checkpoints, road gates, the Israeli ‘separation barrier,’ and other barriers (e.g. flying/temporary checkpoints and concrete blocks) and totaled 705 in 2019 (OCHA oPt).

Palestinian health facilities with the greatest capacity, in both number of patients and specialization of care, are most concentrated in East Jerusalem; however, Palestinians who reside outside of the city are prohibited entry except with specific permits. This means that the majority of the population does not have access to the most comprehensive care available in Palestine. For those whose permits are approved, there is no guarantee that family members will be able to accompany them to appointments or be at their side during emergencies. Such was the case with Kareem and his pregnant wife (Hamayel et al., 2017):

She was seven months pregnant at the time. She had complications and needed to deliver right away. She called frantically and said she needed to go into an operation. It was 10:00 pm, and my permit had expired at 7:00 pm. I couldn't get in ... the most I could do was pick up her sister and drop her off at the checkpoint ... I sat in the car and began to cry. It was one of the very few times I've cried in my life. It was the worst moment. I kept saying: Why me? Why now? It was a horrible feeling. My sister-in-law's husband was able to be there and I, her husband, could not be there.

Though his wife was able to receive quality care, which saved her and her newborn twins, it came at a great emotional cost to both parents. What's more, the twins had to be incubated after birth due to the complications during delivery and yet Kareem's wife had to drive to the hospital in Jerusalem while she still had stitches in as Kareem's visitation permit did not allow him to drive. In a study on postpartum women's quality of life, from the 1020 Palestinian women interviewed, 44.1% of women agreed that emotional support is the most needed as compared to financial and medical support (Hammoudeh et al., 2009). Hammoudeh et al. also found that women with supportive familial and social networks expressed higher life satisfaction even in cases of economic and infrastructural deprivation. Thus, women are presented with a challenging dilemma of whether to prioritize medical care, if financially possible, or social support.

In Gaza, permit applications for medical travel are regularly denied even though health care infrastructure is severely impaired, as mentioned in the previous section. Physicians for Human Rights - Israel has tracked the major decline in approved health permits for Gazans and found that in 2012, 92.5% permits were approved, whereas by 2017 only 54% were approved (“Women’s Right to Health in Gaza Strip,” 2019; Figure 7). This same report also revealed a new trend, identified in 2018, of Israel specifically blocking the travel of female cancer patients for lifesaving medical treatment (2019). Further, although no statistical data is yet available to cross-check this qualitative finding, evidence suggests that restrictions on movement have affected the oPt population’s access to health care irrespective of socioeconomic status (Leone et al., 2019).



Source: United Nations Office for the Coordination of Humanitarian Affairs, Physicians for Human Rights - Israel, and the World Health Organization.

Figure 7. Percent of medical referrals submitted by Palestinian patients and approved for travel by Israeli authorities (2012-2018). For patients needing to leave Gaza for medical care, the approval rate has mostly decreased over time. Lack of data from the West Bank reflects the fragmented health system and divided governments, which leads to inconsistencies in type of data collected across the oPt.

In addition to disruptive delays and medical negligence, checkpoints pose the threat of violence and harassment, especially to Palestinian women. “They [Palestinian women] are delayed for long hours, often without food or water, endure verbal or physical abuse, such as stripping semi-naked or being slapped, punched or kicked, shot, and in some cases killed (“Gendered Aspect of Israeli Checkpoints,” 2015). The fear of Israeli soldiers is heightened in times of intense conflict, as surprisingly, women in the West Bank are less likely to seek antenatal care than women in Gaza even though the intensity of armed conflict is consistently higher in Gaza (Leone et al., 2019). Leone et al. attribute this to the fact that distance to health services is typically longer in the West Bank and thus travel presents more risks for soldiers at checkpoints. The fear of sexual assault, humiliation, miscarriage due to teargas or any violation of honor keeps many women confined to the home. When interviewing youths in the West Bank, Dana and Walker (2014) found that young women often ended schooling prematurely due to their families’ concerns around their safety when crossing checkpoints on their way to school. As Dr. Shalhoub-Kevorkian describes, Israel “invades [Palestinian] women’s daily movements” and being bound to the home increases the chances of familial abuse from which women have little escape (2009). In response, the Palestinian feminist organization Tal’at, referenced in the introduction of this thesis, articulates, “Free women need a free country in which they can move freely” (Palestinian Youth Movement, 2020).

Injured and imprisoned relatives

Palestinian women are often the sole caretaker of children due to the widespread absence of their husbands. Owing to the devastatingly high unemployment rates in both Gaza and the

West Bank, 47% and 15% respectively, oftentimes women's husbands must travel far for work—or the route takes longer to traverse due to the separate road system for Palestinians—and thus offer little help to their wives in the few hours that they are home. In addition, since the military occupation of the West Bank and Gaza began in 1967, approximately 40% of the Palestinian male population has been imprisoned by Israel (Erakat, 2019). Many political prisoners, targeted for their leadership or simply participation in political protest, are detained indefinitely under what's called administrative detention. This requires no formal charge nor trial, and Palestinians are tried in military courts with a 99% conviction rate (Erakat, 2019). Even for the men who are allowed to return home eventually, many may have become disabled or so severely traumatized during their prison sentence from notorious Israeli torture tactics that they are unable to assist their wives with childcare and housework at best or, more realistically, may need constant assistance from their wives.

Furthermore, Palestinian women are responsible for caring for relatives who have been maimed by Israeli military operations. The Israeli Defense Forces (IDF) is one of the most technologically advanced militaries in the world and, as mentioned in the previous section, the IDF's 'shoot to injure' policy (which has taken the place of 'shoot to kill') has led to an increasing number of Palestinians permanently injured and in need of constant care (Puar, 2017). In 2018, for example, 33,000 Palestinians were injured by the IDF— a statistic that only includes those who received medical attention (OCHA, 2020). Caring for disabled relatives adds yet more physically and emotionally challenging work for women. Jennifer Leaning, the director of Harvard University's Center for Health and Human Rights, notes that the separate statistics recorded after armed conflict that differentiate "the number of dead and the number of wounded convey the *false impression that the wounded are going to be okay*" (Puar, 2017; emphasis

mine). This false impression is neither true for chronically injured Palestinians nor the women in their lives who are obligated to care for them. For those left not ‘okay,’ a tragic portion do not survive their injuries, and thus women are often left burdened under the stress of losing a loved one and, more often than not, a male breadwinner in the family. The pain, depression, and overwhelming responsibility of caring for her severely injured children on her own emanates from the words of Shireen Abu Ita, a 36-year-old mother of four who lost her husband when Israel bombed Gaza for 50 days in 2014:

“We have gone through five years [after his death]. I am exhausted, I’ve lost my appetite and I am very irritable. I feel alone without [my husband] Mohammed. The responsibility I have is very great. I have become father and mother. I lost his compassion for me and for the children. Mohammed was everything in my life. My life ended when he departed” (*Haaretz*, 2019).

This is quantified in “Quality of Life among Postpartum Palestinian Women” as Hammoudeh et al. (2009) find that women who reported loss of a relative due to Israeli occupation violence had significantly lower scores on most quality of life metrics used.

Gendered caring labor also underlies the duties of the wives and mothers of Palestinian political prisoners. In “‘Our life is a prison:’ Triple Captivity of Wives and Mothers of Palestinian Political Prisoners,” researchers Giacaman and Johnson study the effects of mass incarceration in Palestine on insufficiently studied and underappreciated actors: the women—mothers and wives—who function as the lifeline and often the sole connection to the outside world for Palestinian prisoners locked away (2013). Like mass incarceration in the U.S., the imprisonment of Palestinian political prisoners is profoundly traumatic not only to the individual prisoners, but also to the communities from which they have been ripped. Giacaman and Johnson interview sixteen wives and mothers of political prisoners and find that given the conditions of strict laws Israel imposes through military occupation, many of the Palestinian women

interviewed consider themselves to be prisoners as well; as one woman stated plainly, “[Living] outside [of Israel’s prisons] is no better than in” (2013).

To sustain connectivity and honor the prisoners who are directly confronting the occupier on a daily basis, families of the political prisoners have a moral obligation to visit their imprisoned kin. It is largely women and children who are tasked with this duty because historically they, as opposed to adult males, have been able to pass through checkpoints more easily (OCHA, 2018). It is a heavy burden which oftentimes leads to *ta’baneh* (exhaustion), but it is viewed as a necessity. Prior to 2005, no one between 16 and 46 years old was allowed to visit except for the mothers and wives of those imprisoned (Giacaman and Johnson, 2013). The interviewees describe the humiliation they subject themselves to, the harassment at checkpoints and full-body searches at the prison itself. But ultimately, the women emphasize their commitment to improving the welfare of their family, especially children who either long to see their relatives or are imprisoned (Giacaman and Johnson, 2013).

As described in “For the Love of Palestine: Stories of Women, Imprisonment and Resistance,” an informational pamphlet put together by Addameer Prisoner Support and Human Rights Association, Samidoun Palestinian Prisoner Solidarity Network, and The Freedom Archives, women travel for 10-15 hours each way in order to see their child, husband, or relative for “half an hour through a plexiglass window,” and only if “no arbitrary circumstance [due to restrictions on travel] prevented the visit from happening” (2016). In the Giacaman and Johnson study, participants agreed that the cultural ‘value’ of political prisoners in Palestinian society has plummeted in recent years. In other words, political prisoners once widely valorized as heroes and political actors tend to be considered victims now in the post-Oslo climate of a demobilized grassroots movement and dwindled solidarity (2013). As a result, women undergo taxing

journeys, from the unnerving checkpoint crossings to the devastation of seeing their loved one worn down from the most extreme form of Israeli-imposed deprivation and confinement. And yet, many women are met with little social support. They carry the weight separate from men and increasingly separate from each other.

Conclusion

Basic metrics of women's health would lead one to believe that Palestinian women are doing just fine: maternal mortality is low, infant mortality is not increasing, Palestinian women have some of the highest literacy rates in the region, antenatal coverage is abundant, and UNRWA provides health services for refugee camps (Leone et al., 2019). Moreover, women are typically not the peaceful protesters nor the militants who are targeted for immediate injury or death by the Israeli military. Between life and death, however, Palestinian women bear suffering that resembles a slow death—lifetimes underresourced by the Israeli occupation and overworked by patriarchal norms which task women with the impossible duty of caregiving in antithetical conditions. Since the initial uprooting and restructuring of Palestinian society in 1948, women have been largely confined to the home and their roles have been condensed into caregiving and mothering. Though these roles provide support and purpose in extreme social and geographical isolation, they also prescribe exhaustion and enable abuse. These are the morbidities less apparent through biomedical measurements of health, but they are no less severe nor deadly.

Uncertainty and lack of control over resources, movement, and safety characterize the collective trauma which began more than 70 years ago and is remade every day as Israeli settlements proliferate on Palestinian land. As discussed in the case of Deir Yassin, violence against women has historically furthered the mass expulsion of Palestinians by making life unbearable and culturally reprehensible. In turn, today the biopolitical regulation of Palestinian women's lives and bodies is maintained by the Israeli occupation, a symptom of settler colonialism. It is land confiscation, home demolitions, resource deprivation, restricted movement, military bombardments, mass incarceration, and compounded patriarchy. It is also freezing in the cold of winter when the electricity is out; watching a relative never walk again

after an aerial strike; fearing that you will miscarry when soldiers release teargas at a checkpoint; and not recognizing your detained child (“Father of Captive,” 2020).⁵

In 2014, Ayelet Shaked, Israel’s former Minister of Justice, openly called for the murder of Palestinian mothers because of their role in birthing and raising “little snakes”: Palestinian children (Abunimah, 2015). I will not read into her genocidal logic too much, but it is worth noting how Shaked recognizes (and registers as a threat) just how fundamental caregiving labor is to sustaining Palestinian life. The networks of care that Palestinians maintain proliferate both survival and political resistance in genocidal conditions. They are alternative structures, largely independent from both the Israeli state and the Palestinian governing bodies which have grown passive in letting the occupation continue; similar to the popular committees which functioned as the backbone of the First Intifada. These networks are a testament to women’s resilience and tremendous labor, however, the family structure as it exists now is not sustainable for women, especially as conditions of life worsen— home demolitions have continued during the Covid-19 pandemic and the Israeli military recently confiscated materials in place for a Palestinian field clinic (“Coronavirus Crisis,” 2020).

In her recent critique of the women’s movement, Eileen Kuttab, Director of the Institute of Women's Studies at Birzeit University, identifies the depoliticization of women’s activism into separate, atomized rights-based issues (e.g. passport rights) as opposed to challenges linked more broadly to the larger issues of Israeli occupation and settler colonialism (2010). Kuttab poses: “One wonders how the women’s movement can acquire legitimacy when the agenda

⁵ This phrasing draws inspiration from Gregg Bordowitz, an artist whose work on AIDS has sought to politicize *and* personalize the pain of the epidemic, much like Rita Giacaman calls to “personalize war and politicize health” in Palestine (2018). Bordowitz writes, “AIDS is a disease or an epidemic that’s caused by the structural failure of capitalism to address the health needs of subjugated people, ostracized people, and poor people. That would be the historical materialist’s analysis. But there’s another way of thinking about materialism, in the sense of what AIDS is about. It’s about vomit, diarrhea, stench, body image, infection, and compromised sexuality. That would be the material, felt aspects of living with the disease” (2014).

excludes issues surrounding unemployment, refugees, prisoners, martyrs' families, children traumatized by the reinvasions of their villages and camps" (2010). Through this statement, Kuttab emphasizes the need to make women's issues Palestinian society's issues, because as we have seen throughout this thesis, women have certainly contested occupation in their daily and home lives. It seems that, given the political meaning many Palestinians attach to their health-related traumas (Giacaman, 2018), the sort of "politicized health and personalized war" research coming out of the Institute for Community and Public Health is an ideal crossroads for the politicization Kuttab prescribes. Such health data, beyond the aforementioned basic metrics, allow us to systematically determine the most pronounced suffering and morbidities that women face (disaggregated by locality, class, etc.). These points can then become areas from which to mobilize women and all invested in nationalist aspirations; to uplift the interconnections in the origins of suffering, such as the political determinants covered in this paper, as they relate to interconnected freedoms from patriarchy and colonialism. In Gaza, as in all of occupied Palestine, health research and community collaboration can pave the way to more than a 'livable' future, but a thriving society of healthy women on freed land.

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