INFERTILITY IN THE OCCUPIED PALESTINIAN TERRITORIES:

WOMEN'S NARRATIVES

Submitted by

Danyah A. Jaber

to the University of Exeter, Institute of Arab and Islamic Studies

as a thesis for the degree of

Doctor of Philosophy in Middle East Politics

September 2019

I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signature:

Abstract

This thesis traces the experiences and analyses the narratives of infertile Palestinian women living in the occupied Palestinian territories (oPt). Women in the oPt face psychological, economical, social and political difficulties, which, when coupled with infertility, create an ambiguous state. As previous research in gender studies suggests, the physiological state of infertile women undoubtedly does not conform to societal norms. As such, researching infertile women in Palestine is an imperative aspect of providing a neoteric approach to areas of enquiry around the influence of settler colonialism on the female self.

In an attempt to unravel the struggle between settler colonial policies and women in an infertile state, I examine the interconnected nature of the macro-level political and socioeconomic contexts, as well as the micro-level contexts of household framings, individual meanings and everyday challenges in the lives of infertile Palestinian women. This study adopts a gendered approach for researching Palestine as a setter colonial case study enabling me to analyse, in a gender-focused framework, the narratives on infertility as told by the women themselves and as treated by their society. My case study is the area of Bethlehem where I conducted my field work for a period of seven months.

The findings of this thesis indicate that motherhood within the confines of marriage is critical to womanhood, legitimacy and relevance in the oPt. As infertile Palestinian women, the inability to achieve the status of motherhood creates economical, social and interpersonal losses. Infertility was also found to be particularly challenging for the affected women, and was considered an important health problem in the wider community as they experienced a range of moral and biological experiences due to their infertile state. Furthermore, the absence of children arguably de-stabilises marriages and social relations, as problems result directly from infertility. Coupled with these findings, this research locates Zionist settler colonialism as a main determinant in women's reproductive inabilities.

Table of Contents

PART THREE
THE SOCIAL AND EMBODIED SELF

Acknowledgements

I would like to take this opportunity to thank the individuals who offered me support and guidance throughout this journey in their unique ways.

First and foremost, I owe a debt of gratitude to the Palestinian women who generously shared their valuable time and stories in the hope of extending the understanding of their life experiences.

I was fortunate to work under the supervision of Professor Ilan Pappé. I will always be thankful for his guidance, support and the time he spent, in spite of his busy schedule, reading and editing my drafts. I also wish to thank Dr. Nadia Naser-Najjab for offering her invaluable insights and expertise assisting me in completing this thesis. I am particularly thankful for your assistance in helping with my fieldwork.

Special thanks to my dear friends, Gabriel Polley and Rasmieyh Abdelnabi, for their constructive feedback, editing and continuous support. I would not have been able to complete this dissertation without their time and effort.

I also wish to thank my colleagues and friends at Exeter for keeping me sane. To the Palestinian women who are forces to be reckoned with, Malaka, Yara and Ayat, I thank you for being your unapologetic selves. To Vicky, Gabriel, Francesco, Jehad, Gertjan and Marc, thank you for friendships. To William and Katie, thank you for trusting me to teach your students and teaching me to be a better educator and listener in the process.

I would be remiss if I did not say thank you to my friends in London for providing me an escape from my research. To my Kurdish sisters, Joan and Kiki Avan, you have opened not only your home but your hearts to me. I will forever be thankful for all your love. To CLIQUE, your friendship is one of a kind. You have all sustained me spiritually and emotionally. To Hanan and James, thank you for being by my side and travelling across the pond when I needed you both.

Also, I would not have started, continued or completed this thesis without the continuous support and encouragement of my family and closest friends. To my parents, Ali and Naheel, you both worked hard to provide me the ability to pursue education and for that I am forever indebted. To my siblings, Hana, Mohammed, Hadeel and Ameer, thank you for all the joy, love and sibling quarrels a girl can ask for. To Jehad and Hana, thank you for bringing into this world the most precious human being. Janna, I love you. To my aunts who supported me and helped raise me, Najah and Fadia, I love you both endlessly. To my best friend Saida, thank you for dealing with and helping me overcome my anxiety. To Yousef and Soukaina, thank you for the laughter filled nights. And, of course, to my partner, Musab, your enthusiasm for my project and future have sustained me through many moments of panic and despair. Thank you for never giving up on my research even when I wanted to.

Finally, to two of the strongest women I have known, who unexpectedly passed away before seeing me finish this journey. Thalia Jaber and Alice Melton, I will forever be grateful for all the love, support and wisdom you both have instilled in me.

Glossary

Fertility	The physiological ability to reproduce
Infertility	The inability of to achieve pregnancy after twelve months of regular, unprotected sexual intercourse
Fecundity	The physiological ability to reproduce
Patrilineal	Recognising kinship through male descendants
Patrilocal	Marriage in which the couple settles in the husband's home or community
Polygyny	A type of polygamous relationship in which a man is married to more than one wife at once

List of Arabic Terms

‘athab	Torment
‘adm alqudrh ‘lā al’njāb	The physiological inability to have children
’iblyny	Grant me; this term has a negative connotation
’iṭ‘amny	Feed me
‘uqm	The physiological inability to have children
Alhamdulillah	Thank God
Bismillah	In the name of God
Haram	1. Forbidden 2. To be pitied
InSha’Allah	God willing
Jihad	Struggle
Khalas	That is it
Khūfh	Fear
Malhūf	Lovelorn
MaSha’Allah	As God has willed
Maẓlūma	Oppressed/Maltreated
Naṣyb	Destiny
Ṭawl rūḥak	Lengthen your soul, connoting to have patience

Acronyms and Abbreviations

ART	Assisted Reproductive Technology
PA	Palestinian Authority
PCOS	Polycystic Ovary Syndrome
PMOH	Palestinian Ministry of Health
oPt	Occupied Palestinian Territories

PART ONE

BACKGROUND TO THE RESEARCH

CHAPTER I: BACKGROUND

Since the introduction of assisted reproductive technologies (hereafter, ARTs) in the mid-twentieth century, a growing body of research from a wide range of disciplines has emerged exploring the aspects of infertility: medicalisation and treatment, population and demography, gender identity and individuality, and health care and accessibility, as well as political and economic influences in general. Women's infertility in particular has become the locus of much research, as the rise in labelling, medicalising and institutionalising infertility has brought infertile women to the forefront of not only the medical gaze, but also discussions of kinship and 'womanhood'. Furthermore, the medicalisation of female infertility has lead to the concealment of political and structural issues 'prevent[ing] researchers from locating the experience of involuntary childlessness within wider systems of power, privilege, and suffering' (Loughran and Davis, 2017: 6).

Consequently, this study seeks to uncover these political and structural issues of female infertility, in relation to the influence of infertility as a female issue affecting women's embodied selves. It includes the consideration of holistic influences on the lives of infertile women that are not limited to the medical field or domestic issues. Furthermore, this research focuses on the case study of female infertility in the occupied Palestinian territories (hereafter, oPt) [1] as a site of settler colonialism. Considering the sparse literature on infertility in the oPt, this research, although not seeking to make a statistical contribution, explores how infertile Palestinian women situate social and interpersonal suffering in relation to political, economic and familial relations of power.

Accordingly, this research explores the most pertinent concerns of female infertility in the oPt, forming a matrix linking the diverse concerns of infertility, which have been influenced and, in a few instances, been prevented from being overcome by physical and intangible barriers associated with Israel's military occupation, with specific regard to their relevance to the paradigms of gender and settler colonialism.

Settler colonial cases are often assumed to belong to a past time with implications not relevant to the present (see, Wolfe, 2006), leading to the danger of overlooking dynamics that are still at work. This leads to a failure of understanding, particularly in problems such as identity and existence. The main conceptual question this research addresses is whether a gendered analysis may be developed to evaluate the different experiences of infertility among Indigenous women within settler colonial structures and, if so, whether settler colonialism plays a role in their experiences.

In a context in which mainstream feminist theories have elicited the exclusion of the imperative nature of settler colonialism and its ability to permeate daily realities, this study will utilise the theory of Native/Indigenous feminism. This theory evolved in the late twentieth century, and although fairly new to gender and women's studies, it provides a holistic, encompassing approach to the lives of Indigenous individuals particularly on their subjectivity to conceptual

[1] The occupied Palestinian territories consist of the West Bank, East Jerusalem and the Gaza Strip.

and spatial erasures (Arvin, Tuck, and Morrill, 2013). Its application provides a deeper understanding of the position of not only women within society, but also the overall aspects of society, including societal norms, gender relations, economics, culture and politics.

The oPt provides an appropriate case study for this particular research question for three principal reasons. First, literature on women within the oPt minimally engages infertile women, causing a marginalisation of their voice. Second, the Zionist settler colonial project has deeply affected the whole structure of Palestinian society, from the macro-level such as economics, to the micro-level such as household relations. Third, the economic situation in Palestine creates difficulties among infertile women and men alike to obtain fertility treatments. Infertile Palestinian women have become a battleground of settler colonialism, a condition compounded by the hardships of politics, society and economy.

Therefore, the case of female infertility in the oPt provides a complex structure of indigeneity and infertility within a situation of ongoing settler colonialism and violent conflict. As such, understanding female infertility in the oPt requires an analysis from both the macro and micro as well as individual level of the multifaceted matrix of political, socio-economic, cultural and social relationships in which these women are situated. As each women's experience of infertility is unique, it is necessary to interpret the realities of their immediate (social and cultural) and general (political and socio-economic) environment all while undertaking a gender-sensitive analysis.

1. Thesis Structure

The thesis is divided into four parts. Part one provides an analytical background to the research, inclusive of the literature review, conceptual framework and methodology. The rest of chapter one will provide an overview of the questions this research hopes to answer, and its academic salience. Chapter two illustrates and rationalises the methods applied to collect, analyse and frame the data. This chapter also includes a discussion on my positionality with the research. Chapter three consists of the literature review, which examines the causes of infertility, the factors associated with infertility, and the utilisation of biopolitics, as well as the positionality of infertility within gender studies. The literature review provides a critical analysis of the academic theories pertaining to this research, identifying the gaps in the literary works and where my research fits. Chapter four outlines the conceptual framework of the research, which underpins the methodology, and correlates it to the literature review. It conceptualises the terms 'political fertility' and 'political infertility', providing the basis for considering settler colonialism's impacts on infertility. The political, historical and social context of the oPt, with a focus on the understanding of Zionism as settler colonialism, is also outlined.

Part two of this research takes a 'top-down' approach, setting the context by presenting the political atmosphere within which Palestinian infertile women live. It traces the embeddedness and influence of military occupation on reproductive (in)abilities. Chapter five discusses the the methods through which 'political fertility' are employed. Chapters six and seven further the understanding of the latter concept, political infertility, discussing the influence of Zionism on the causation of infertility and the prevention of overcoming it. Chapter six discusses the circumstances of healthcare and the healthcare system with particular focus on reproductive health. Subsequently, chapter seven discusses the detrimental economic state of the oPt and its affects on infertile women's lives.

Part three provides a 'bottom up' approach, focusing on the daily lives and personal encounters of Palestinian women with their infertility. Chapter eight discusses the articulation of kinship inclusive of socially valued fertility, as well as the situation of marital in/stability among infertile women. Chapter nine presents the discussions primarily evolving from interviews, including undergoing and, at times, overcoming the pressure to undergo fertility treatments, as well as the coping methods the women engage in. Additionally, this chapter focuses on the language used by the women during the interviews.

Part four presents the concluding aspects of this research. Chapter ten will provide an analysis of the case study, discussing themes and topics narrated by the women. It will also highlight advice from the infertile women in this study to society, particularly fertile women. In this chapter, I will discuss challenges relating to the research as a whole and suggestions for future work. These suggestions include possible points for future research to advance on, primarily on the intersectionality between (in)fertility and settler colonialism, and points to include and circumstances to avoid in future research.

2. Aims and Objects

Researching infertile women in Palestine is imperative for providing a neoteric approach to areas of enquiry around the affects of settler colonialism on daily life. Moreover, it provides a divergence from the generic notion of Palestinian women as nationalistic symbols and child bearers for demographic purposes. To trace the critical perspectives of Palestinian infertile women, I have selected the following questions to enable my study to focus on the main issues:

1. How does the Zionist settler colonial project affect infertile Palestinian women;
2. What constitutes infertility locally, and how do individuals, couples and the wider community respond to infertility; and
3. What are the beliefs, experiences and coping strategies of infertile Palestinian women?

The main aim of this research is to provide a link between the three overarching themes of infertility, gender and settler colonialism. It synchronises with the increasing interest in pursuing Native feminist theories to reclaim the understanding of gender in settler colonial settings. It also provides a caveat to the present literature on the general understanding of the embodied self of infertile women. The case study of infertile Palestinian women in the oPt will demonstrate the applicability of this link. In addition, it is hoped that this research may be a model for future case studies. Another contribution of this research is that it may add insights from gender and feminism to settler colonial cases in general. My aim is not to compare the situation in the oPt to other settler colonial sites, such as Australia; rather I ask, what does the Palestinian context of settler colonialism, and the specificities of the Palestinian context, tell us, or help us in terms of rethinking how settler colonialism works? What does it add to the theorisation of settler colonialism?

Overall, the analytical framework is based on existing Native feminist literature dealing with the daily permeation of settler colonialism on the lives of women, providing the frame of reference to the case study of Palestinian infertile.

3. Academic Salience

Women in the oPt face psychological, economic, social and political difficulties, which, when coupled with infertility, create an ambiguous state. As previous research suggests, infertile women's gender identity undoubtedly does not conform to societal norms. As such, researching infertile women in Palestine is an imperative aspect of providing a neoteric approach to areas of enquiry around the influence of settler colonialism on the female self. This research hopes to address the less visible aspects of Zionist oppression through analysing the strategies of the settler colonial regime and its interventions into the medical, social and economic field as a political intervention, but also the forms of resistance and agency that Palestinians find within this context. The research will also give voice to a category of women who are not dealt with in the current body of literature on Palestine, and the research may create a contribution to developing works on infertility in the social sciences, coupled with gender and settler colonial studies.

As settler colonialism is a relatively new field of inquiry, theorists of settler colonialism are at a point where they can build a field in which reproduction, particularly infertility, is an essential analytic, not a minor concern, supplemented with the example of gender and sexuality as a method to demonstrate intimate politics and micro-politics. Settler colonialism is a relatively new theoretical framework used in this thesis to explore how settlers implement a structure that is embedded in the everyday lives of Indigenous peoples influencing their reproductive abilities. In order to do so, I provide empirical evidences on the affect of Israel as a settler colonial on Palestinian women's inability to biologically reproduce, by examining how the objectives of Native elimination are embedded in the economy, health and mobility of the these women to prevent future Palestinians from being born. Therefore, the academic salience of my research is including infertility within the discussion of settler colonialism through a top-down approach, all the while acknowledging gender, sexuality and reproduction. I hope this research will lead to the de-marginalisation and centring of Indigenous infertile women within literature and discussions of settler de-colonisation.

CHAPTER II: RESEARCH QUESTIONS AND METHODOLOGY

The intent of this research is to capture the everyday experiences of infertile Palestinian women. The theoretical framework of the research is settler colonialism, as it provides a crucial nuance to infertility within the social sciences relevant to experiences according to a person's society and class structure. The use of settler colonialism as a theoretical framework on the reproductive issues Palestinian women face includes one pivotal weakness: the lack of interdisciplinary literature on infertility and settler colonialism. Nevertheless, this framework prevents the researcher from slipping into Orientalist assumptions by studying the Palestinian experience of infertility as a broadly typical reproductive issue within the Arab world. Rather, it enables me to discuss the lives of Palestinian infertile women in the wider context of boundaries faced in their everyday life, allowing for the ability to 'make sense of peoples' lives and the forces that structure them' within a historical and political context (Abu-Lughod, 1986).

A different factor is that this was not my first time conducting field research in Palestine. Therefore, I did not encounter hardships understanding the culture once I arrived for fieldwork, allowing me the preference of not being led into 'culture shock or anomie' (Altorki and El-Solh, 1988: 8). Previous experience also provided me the ability to follow security procedures and not be taken aback by the strong presence of occupying forces and security checkpoints. Furthermore, I was well aware of the political atmosphere, allowing me to navigate my way around conversations regarding my own political views that may have hindered the outcome of interviews.

My present field research was difficult due to there being minimal scholarly work on infertility among both women and men in Palestine. With little to rely on, I conducted the fieldwork in two separate stages: a three-month sampling period, and a four-month fieldwork period, during 2016 and 2017. This chapter presents the study's research methodology, which utilises qualitative methods. Primary qualitative data collection involved in-depth interviews with infertile women, expert interviews, and making observations and field notes, lasting for seven months, unmerged. The research was conducted by myself in Arabic using semi-structured interviews, allowing for acquiring more 'depth' in the research (Blaxter, Hughes, and Tight, 2010: 65; see also Emerson, Fretz and Shaw, 2001). More specifically, when studying infertility, a qualitative approach is one of the most successful in enabling the focus of the study to be on the infertile person, offering a suitable picture (Sandelowski and de Lacey, 2002).

Secondary data was retrieved through desk research using various academic books and journals, scholarly articles and newspaper articles written by and/or on Palestinians and on the societal perspective of (in)fertility and reproduction. My research seeks to describe and explain the daily struggles of infertile Palestinian women on an individual level through the utilization of a narrative approach, all the while reassessing the intersection of individuality with the complex dynamics of race, class, power, and privilege at play in the oPt.

1. Pilot Fieldwork

Three months of pilot work was carried out in the summer of 2016. The main purpose of the pilot stage of my field research was to provide a better understanding on the societal perceptions of infertility, the motivations for childbearing, the range of couples it affects, and the opportunities available for infertile women.

In doing so, I sampled the area and ensured my access to two fertility clinics for the second stage. Sampling was conducted through a 'snowball' strategy of trust and 'link-tracing', allowing me to access the vulnerable social group of infertile Palestinian women (Atkinson and Flint, 2001). This stage incorporated interviews with three public health specialists, three fertility specialists and five staff members at fertility clinics. Later, I found that this stage had been crucial to developing and establishing trust, credibility and rapport between the participants and myself (*see* Inhorn, 2004).

2. In-depth Fieldwork

One year subsequent to the pilot stage, I returned to Palestine for an in-depth field research lasting four-months. During this four-month period, I conducted participatory observations in two fertility clinics (one in Ramallah and one in Bethlehem), as well as interviews with infertile Palestinian women located within the Bethlehem region. Research was conducted in the West Bank municipality of Bethlehem. I choose this area in order not to duplicate the findings of a pilot study conducted by Birzeit University in Ramallah and Nablus (Hammoudeh et al., 2013). Due to security obstacles and an ongoing military siege, I was unable to do research in Gaza, but in my overall analysis I have referred to scholarly research, articles and blogs on the issue of female infertility in Gaza.

Participatory observation allowed me to assume a role in the fertility clinics as a researcher, enabling a more detailed level of notes on the behaviour and activities of individuals and the facility as a whole (Creswell, 2003: 185-186). Permission was granted by the respective fertility clinics. No audio recordings or note-taking was utilised, given that audio recording might pick up sensitive information, and note-taking on the site would distract the clinicians due to constant writing. As such, once I left the respective clinics, I would return home and write down everything that was transcribed to me orally, and include detailed information about the setting.

Due to the time constraints, only one interview per woman was conducted. For interviews, in order to provide the utmost comfort to the infertile women participants, note-taking during the interviews was never utilised. All interviews were conducted in Arabic except occasions during the pilot study, which were conducted in English. Audio recording was conducted when permission was granted, which was in all the interviews.

The interviews were conducted in one of two modes: active and passive. An active mode was used with scholars, physicians and government officials within the field providing a more professional, strict and guided interview. At times, with the infertile Palestine women interviewees, I used a passive mode in order not to create a hierarchy between the interviewee and me, in addition to allowing for an interview that is 'richer in emotional and social detail' (Joseph, 1988: 40). I do not take for granted the complex understanding between researcher and researched, and the unfortunate fact that there will always be a hierarchy in place, which a passive mode cannot totally eliminate; however, it did allow for greater trust and better rapport between the interviewee and myself.

It is important to note that in order to not only build rapport but also trust between the Palestinian women and I, there needed to be a mutual exchange of information. Therefore, I provided complete information about my research, as well as specific personal information that was asked of me. This is contrary to the 'proper' paradigm of interviewing that appeals to

values such as objectivity and detachment, yet in order to prevent a 'sense of subordination' by the interviewer on the interviewee, I did not follow this paradigm (Oakley, 1981: 38).

The interviews were translated word for word, with the inclusion of pauses, laughter and other features demonstrated in the conversations. Several commonly used words, metaphors and phrases with no exact equivalent in English, shed light on local categories and concepts underlying fertility and gender. Some of these words, metaphors and phrases in question are provided in the list of Arabic terms at the start of the thesis, while others will be recounted and explained throughout the chapters.

2.1. Interviewees

The female interviewees unable to conceive or carry a pregnancy to live birth are described in this research as being infertile. It is important to note that these women do not define themselves as infertile (see chapter nine) rather they actively disassociate themselves and reject the term infertile/infertility. The reason behind utilising infertile/infertility is its ability to provide a vantage point for analysing the political, social and economic difficulties these women undergo. Furthermore, it will hopefully allow for future political and policy changes.

A total of thirteen interviews with infertile Palestinian women in the Bethlehem area, however, I only incorporated ten of the interviewees into this research (inclusive of Faten's, see section 3.2 in this chapter). I also conducted one interview with a woman, Lamis, who was the only Christian interviewee and not infertile, attended the fertility clinic for gender selection. At least four interviewees had refugee status meanwhile all of the infertile women interviewed were Muslims. The interviewees' ages ranged from nineteen to forty-six with the predominant infertility diagnosis being polycystic ovary syndrome (PCOS) and/or unexplained factors. All of the women consulted with a fertility specialist with their first visit ranging from less than one year to six years after marriage. Access to fertility care was difficult to obtain due to limited financial

All the interviews were in a marital relationship except two women (one was divorced and the other was a widow). The duration of their marriages at the time of the interviews ranged from two years to twenty-six years. The education level of the women also ranged from completing secondary school to receiving a Bachelor's degree. One two of the women had a full-time job, however, all of the women had a low to lower-middle socioeconomic status. Limited financial resources and lack fertility care provided by the governmental healthcare system created difficulties and restrictions on the women's access to reproductive health care.

3. Narrative analysis as a Native feminist approach

The interviews with infertile Palestinian women were conducted through an autonomous narrative method in which minimal questions were asked by myself and other individuals sitting in on the interview,[2] therefore allowing the women to discuss the issues they found most

[2] In a majority of the interviews conducted, there was at least one other person present in the space. With interviews conducted at women's homes, the accompaniment of a mutual female friend who was well-versed in the infertile woman's life history, provided a method of building rapport and a relaxed setting. In cases of private one-on-one interviews (not taking into account interviews in fertility clinics), there were women present in an adjacent room within the household.

pertinent to their infertile position. As such, a 'free-narrative approach' based on 'listening' and 'conversation' is utilised (Callahan and Elliot, 1996: 110). In these interviews, complex marital, economic, residential, and health histories were discussed. The interviews facilitated the construction of a narrative form of 'everyday' knowledge and everyday meanings providing a more trustworthy insight into how infertility is experienced, interpreted and responded to (see Callahan and Elliot, 1996; and, Gijsels, Mgalla and Wambura, 2001).

During the interviews, however, there were no clear temporal boundaries or flow from beginning, middle and end, but rather a 'temporal ambiguity'. This ambiguity is found particularly in illness narratives inclusive of infertility, which are 'seldom linear' given that '[i]llness by its very nature disrupts any pretense of temporal continuity, for it lacks the coherence that permits us to identify linkages between cause and effect, before and after' (Riessman, 2015: 1057). Nonetheless, the ruptures condition the individual form and create the individuation (Butler, 2004: 27).

As such, the field text was interpreted through a narrative analysis utilizing the holistic-content approach, which involves the 'restorying' of the raw data (Ollerenshaw and Creswell, 2002). There are multiple approaches to narrative analysis, the one I utilise is similar to Reissman (2013), which encompasses the presentation and reliance on detailed transcripts of interview excerpts to study personal experiences and meanings. This method 'takes as its object of investigation the story itself' with 'detailed transcripts of speech so that readers can, to a greater degree, see stories apart from their analysis. The selves of storyteller and analyst then remain separate' (Reissman, 2013: 169, 176). This type of research, according to Reissman, is appropriate only for studies with a handful of interviewees, as this study.

Furthermore, the narrative analysis provides strength in its ability to discuss the complex nature of a subject without oversimplification, allowing for common themes while still maintaining the integrity of each participant (Kirkman and Rosenthal, 1999: 33). It is also argued to be the 'ideal way of attempting to understand the vicissitudes of infertility' (Kirkman and Rosenthal, 1999: 19). Shigley (2017), for example, describes her 'yearning to hear and tell stories that put the longing [of wanting a baby] into words. I wanted permission to feel the anger and the ambivalence as well as the wonder and the hope' (ibid.: 52). Therefore, the narratives presented in this research are formulated as lengthy excerpts to provide uninterrupted space for these women to voice their concerns and formulate their understanding of living with and through infertility. Subsequent to providing these women their rightful space in this thesis, the topics discussed within the narratives will be reviewed and discussed thematically.

In a Native feminist perspective, narratives provide affect and emotions allowing for a 'felt analysis… that creates a context for a more complex "telling"' (Million, 2009: 54). Although, Native feminism is still a developing framework without one set definition or way of *doing* Native feminist analysis (Goeman and Denetdale, 2009; see also Ramirez, 2007) it is defined by Morrill (2017) as

> *the academic and activist practices and theories of Native women and other working actively against settler colonialism and heteropatriarchy and toward decolonization, recognition and revitalization of Native women and communities*… It is a methodology that involves reading against disappearances; it involves reading futures yet in store for Native lives' (Morrill, 2017: 15 italics in original).

This is in line with the arguments made by Palestinian scholars on utilising Palestinian women's narratives as 'enabl[ing] a more optimistic reconceptualization of women's suffering' (Shalhoub-Kevorkian, 2009: 37) and 'preserv[ing] them from oblivion' by allowing them to build their identity as well as future legacy (Kassem, 2011: 94).

Native feminist theories and Native women's voices are ontologically, epistemologically and axiologically valuable providing a potent tool to counter and deconstruct knowledge (see Moreton-Robinson, 2013). However, Native voices and experiences are segregated from White academia and challenged 'as a "feminine" experience, as polemic, or at worst as not knowledge at all' (Million, 2009: 54) because, according to Million 'Our [Native women's] voices rock the boat and perhaps the world. They are dangerous' (Million, 2009: 54).

Following Million's articulation of voices being perceived as dangerous as they counter the comprehensibility of settlers, I recalled a talk by Kilomba (2015) explaining the importance of the speaking subject, as one who is listened to, becomes one who belongs:

> the act of speaking is like a negotiation between those who speak and those who listen. I can only become the speaking subject if you accept to be the listener. The listener who is ready to listen. Listening is in this sense the act of authorisation towards the speaker. I can only speak if my voice is listened to. But it is more than that. Being listened to goes beyond this dialectic between both of us. Being listened to also means belonging. We all know that those who belong are those who are listened to and we all know that those who are not listened to are those who do not belong. (ibid.)

In this respect, Native epistemologies and ontologies are limited if they are not recognized and become a critical part of academia. For decolonisation to occur, social scientists need to recognise Indigenous theorists and peoples by not only centring, listening and reading but also by incorporating and acknowledging marginalised voices within academia (Todd, 2016).

Lastly, due to the distress caused by the impact of infertility on women's lives, there is great difficulty in 'negotiating a serviceable autobiographical narrative', which 'must not be underestimated' (Kirkman, 2001: 534). This led to me asking myself when interpreting the interviews, what information is gained from the interviews, and what is not? What kind of information are these women ready to offer and not to offer given the sensitivities of the topic?

Initially, I believed that it was very important that the data collected and the sayings of these women were critically assessed. However, I came across Muylart et al.'s (2014) work, in which the authors state,

> narratives are considered representations and interpretations of the world and therefore, are not open to evidence and cannot be judged as true or false, they express the truth of a point of view in a particular time, space and socio-historic context […] the objective of narrative interviews is not only to reconstruct the life history of the informant, but to understand the contexts in which these biographies were constructed and the factors that produce change and motivate the actions of informants. (ibid.: 186, 187)

Thus, realising the "truth" behind these women's words was not important; rather, I became more focused on the situational context, which led these women to provide the stories they did (see Miller, 2005). Also, the study of settler colonialism 'demands the experience of indigenous peoples be taken seriously' (Pulido, 2017: 2). It is for this reason that the socio-cultural context, as well as political context of settler colonialism, is an important determinant on infertile

women's personal and social realities. As such, the narratives presented in this research are not only limited to issues pertaining to the physiological and medical aspects of Palestinian women's infertility. It will address any issues they discussed, which, at times, the women believed were pertinent to their lives as infertile Indigenous peoples and which defined their current state of being.

4. Fieldwork Complications

4.1. Visa

As a United States citizen, when I returned for extensive field research in April of 2017, I received the usual three-month tourist visa when entering Israel. However, when my visa neared its end, I left to Amman, Jordan for a week, which coincided with Eid, the Islamic holiday. Upon my return to continue fieldwork, I was held in a waiting room for approximately four hours. I was subsequently questioned by an Israeli border officer, who accused me of wanting to live in Israel. I explained to him that my job and studies were all abroad, and I had no intention of living in Israel. From prior experience, the extensive wait period and questioning was not unusual for me, a Palestinian Muslim female who wears the headscarf. It is also to some extent the norm, as the U.S. Consulate General in Jerusalem's website states, '[t]hose whom Israeli authorities suspect of being of Arab, Middle Eastern, or Muslim origin […] may face additional, often time-consuming, and probing questioning by immigration and border authorities, or may even be denied entry into Israel or the West Bank' (U.S. Consulate General in Jerusalem, 2018). However, this was the first time a border officer refused to acknowledge my claims, and as a 'precaution' only provided me a one-month visa. Therefore, my extensive field research of six months was limited to four months.

As a Palestinian with family in Israel/Palestine, including a fiancé with a Jerusalem residency permit, I feared being refused a subsequent visa, and, as such, I did not return for further field research. It was brought to my attention that electronic resources such as Skype could be an option for further interviews; however, given the sensitivity of the subject of infertility, this may have only hindered my findings and caused discomfort for the interviewees.

Nonetheless, I am aware that there is a need in my research for further primary data, causing the arguments presented to not be as strong as if there were more primary data collated; however, this is the unfortunate fate of Palestinian researchers in the diaspora conducting research in Palestine. As such, this should not detract my research, but rather should give it added value, given the extent to which Israel's settler colonial project seeks to ensure the elimination of the Native from Palestine through means such as denying descendants of Palestinians to return to or live in Palestine.

4.2. Interviews

Notwithstanding my fieldwork being shortened, I also experienced difficulty acquiring willing infertile women to participate in interviews. Given the novelty of qualitative research on infertility in the oPt, the method I used to gain interviewees was experimental. I originally started my field research (pilot) discussing with public health specialists, fertility specialists and staff members at fertility clinics. I believed and was informed that the most accessible method for meeting with and interviewing infertile women in Palestine would be through fertility clinics. I conducted six interviews in one fertility clinic based in Bethlehem. However, these interviews, except two, were not in-depth, and the interviewees were typically

accompanied by their husbands, leading the women to be less talkative and seeking validation from their husbands for statements made. I did not incorporate three of these interviews as they only lasted two to five minutes most of which were greetings and introductions. To present a picture of these interactions, below is the lengthiest of these three interviews at the fertility clinic with an infertile woman named Faten,

> A couple had been sitting across from me waiting for their turn to see the physician. Finally, after almost an hour's wait, the nurse called the woman's name, asking her to follow her to a nearby room. I watched as the woman got up and went with the nurse. Her husband did not. After almost twenty-five minutes, the same nurse returned with the patient to introduce us. The nurse informed me, 'Faten would like to answer any questions you have.' Delighted to have another person to speak to I replied, 'of course, thank you.'
>
> The nurse led us to an empty room in the back of the office. Once we sat down, I provided her further details on my research, as the nurse had given her a basic jist of it. The first question I asked Faten was, 'how old are you?' As she replied, 'twenty-one', her husband walked into the room and we exchanged brief greetings. I subsequently asked her about her fertility journey. Faten informed me, 'I have been married for four years but only came to a fertility clinic about six months ago. So, we waited three-and-a-half years. We tried the *natural* way, however it did not work.'
>
> We then briefly discussed the role society plays in her fertility journey, which Faten reported was no role: 'I come to this clinic for myself and not for others.' She then informed me of her medical condition, stating, 'unlike many of the other patients, I have a particular condition that requires specific types of medication, which are a bit more expensive. Yet, it is okay. It is *okay*. It does not exceed what we are capable of paying.'

With this last comment and without any further explanation, Faten excused herself and her husband, stating they were in a hurry and had to go. This would be the last interview I had in a clinic. There were multiple issues deriving from clinical interviewees, such as their lack of time and the lack of prior notice. Very few women with primary infertility were seen and/or accepted to be interviewed. Moreover, although Faten's husband's presence had an open and helpful affect, it was a hastily conducted interview with little substance, and his presence led Faten to frequently look to him, possibly for reassurance or confirmation.

Aiming for inclusivity, in order to prevent the invisibility of the experience of women not attending infertility clinics,[3] I contacted a well-respected, female university professor from one of Bethlehem's refugee camps who introduced me to a handful of women who were willing to be interviewed. However, a majority of the women she spoke to refused to be interviewed on the basis of rejecting their infertile status, fear of familial and social repercussion of discussing infertility, and/or sensitivity towards the subject. These are arguably aspects of silencing (e.g. Allison, 2011).

Moreover, during interviews, references to sexuality and specific discussions of infertility pertaining to sexual activities were suppressed. In one instance, Karima, when discussing her husband's diagnosis of varicoceles, refrained from utilising the term 'scrotum', but rather

---

[3] Recent scholarly work addresses the necessity to focus on infertility in non-Western locales and to take into account infertile individuals not seeking, and/or unable to seek, assisted reproduction, to provide a better understanding of infertility juxtaposed to the medical definition. See, for example, Greil and McQuillan, 2010.

hesitated, became flustered and began to blush as she explained 'varicose veins not in his legs, in his [stutters and pauses] in the [pauses] well it is understood, the area that controls everything.' This may be due to multiple reasons, such as the age gap between her and I (49 and 25, respectively), coupled with my lack of being in a marital relationship. Sayigh (1998) interpreted the suppression of sexual references in her interviews with Palestinian women as 'the rule of most everyday speech in camps' (ibid.: 171). This perspective of sexual references being suppressed can be noted in the narratives of refugee, as well as non-refugee, women I interviewed.

Additionally, when conducting my field research, I deliberately interviewed heterosexual females experiencing infertility. Due to the sensitivities regarding homosexuality and the lack of its visibility within Palestinian society, it was not feasible to interview infertile persons who are/were not in a heterosexual relationship. While I am aware of the prevalence of male infertility in the oPt, my research focuses on female infertility. To echo Lougran and Davis (2017), '[i]nfertility is an intimate matter, subject to any and all of the taboos surrounding sexuality and reproduction in a given culture. More than this, it is a marker of the failure of reproduction, of sexuality gone awry' (ibid.: 10). Due to this intimacy and sensitivity, it would have been difficult as a single Palestinian female researcher to retrieve access to infertile men and/or men in an infertile relationship within the limited time span provided. Marcia Inhorn, a medical anthropologist and specialist on infertility in the Middle East, describes the reluctance of men in Lebanese fertility clinics to participate in her study as a 'surprise' recalling even in her studies from the early 1990s 'never once did a woman refuse to participate' regardless of class (Inhorn, 2012: 72). Comparing her experience with my own of infertile Palestinian women refusing to participate in my study, sheds light on the lack of discussion surrounding infertility in the oPt possibly due to stigmatization and individual disassociation. Therefore, as a female researcher interviewing infertile men and/or men in an infertile relationship would have led to a larger amount of interview rejections requiring a more time consuming field research, which I unfortunately was unable to conduct.

4.3. Positionality: Locating Myself

As a Palestinian *mughtaribi*[4] researcher studying her own country of origin, I had, as Suad Joseph (1988) states, 'the opportunity to combine the personal and professional in a way that others may not'. Therefore, this research is close to home for me, intermingling the professional and personal, arguably causing a richer study and a stronger commitment to giving the Palestinian infertile women a voice in attempts to promote greater public understanding and compassion towards their daily struggles (Balen and Inhorn, 2002). This did create a few challenges before, during and after my fieldwork, therefore, it is pivotal to put myself to some extent into the study, at least for reflective purposes. This section discusses my positionality and questions that were brought forth due to this positionality, including: how was I perceived by the women I interviewed and interacted with? With this perception, what information did I receive, and what were they offering or not offering me?

Firstly, as a Palestinian engaged to be married, I am aware of the social pressures to bear children. I have been on the receiving end of comments such as 'you have been engaged for three years? You could have had two children by now'; 'hurry up and get married so you can

[4] An Arabic term for a person in the diaspora returning to their country of origin to conduct fieldwork (Joseph, 1988).

have a child before you are thirty'; and, 'try to get pregnant within the first year of marriage because if you wait, your womb will dry up and you will be infertile'. Nonetheless, I am only engaged, therefore, I lack the understanding what it is like to be in a marital relationship and experience the pressures to bear children. Therefore, it was necessary for me to force myself to critically examine as well as deconstruct my values and ideas in order to ensure they did not hinder my fieldwork, cause bias in the analysis of the research findings, and limit Orientalist perspectives on gender in the Middle East (Shami, 1988; Abu-Lughod, 1989; and Elie, 2004).

Secondly, throughout my fieldwork I had an interchangeable status of being an insider/outsider, as well as the interchangeability of being the subject/object, allowing for my personal experience to have relevance in the research, in addition to allowing for a more balanced analysis (see Joseph, 1988; Altorki, 1988). Thus, while in the field, I had to focus on my 'situated self', constantly raising the issue of my identity and the power dynamics at play (El-Kholy and Al-Ali, 1999).

As a female interviewing another female, I could establish a social bond unattainable by a male researcher (see Oakley, 1981; Williams and Heikes, 1993). The challenge came about as a researcher with an 'insider' status, due to interviewees feeling threatened with possible exposure and judgement that I might reveal their personal information to the wider community (Altorki, 1988). Therefore, I would continuously ensure them all the information provided is and will remain private and only for research purposes.

Thirdly, once trust was established, as a Palestinian woman interviewing Palestinian women, social interactions were inevitable, creating a lack of caveat in the information being provided to me. In order to ensure I did not use information exposed to me for non-research purposes, I had to remind the women of my role as a researcher, and would receive consent for information retrieved through interviews.

4.4. The Limits

The limitations to be discussed concern the generalisability and scope of the research's findings. Firstly, the findings of my study are strictly limited to the Bethlehem area of the oPt, and to a specific subset of women (refugee women and/or of low to lower-middle socioeconomic status). The findings may not be applicable to women throughout the oPt, particularly elite class women of higher socioeconomic backgrounds as they may higher accessibility to reproductive health care and the social implications of their infertile status may not be the same.

Secondly, my findings should not be read as evidence for every settler colonial setting, as each settler colony imposes varying policies and practices onto the indigenous population, although the common rationale through which these policies and practices are carried, serving the end goal for settlers, is the logic of elimination. As infertility may be influenced and perceived differently in every location, it is unlikely the findings in this study will be exactly the same for other areas in the oPt and women of higher socioeconomic backgrounds, let alone other settler colonial settings.

Thirdly, the strategy for acquiring interviewees was curtailed by the sensitivity of the topic, and misguidance on my end when I initially started interviewing women in fertility clinics. The latter led me to come across cases of women in marital relationships where the male counterpart was infertile or the female had secondary infertility with at least one child. These interviewees

arguably have a different experience to female-caused primary infertility (See, for example, Inhorn and Balen, 2002). Furthermore, interviews in fertility clinics were held within a limited timeframe to build rapport and have in-depth discussions. The limitations deriving from sensitivity and misguidance were expounded by the limited time span my visa provided to undergo the field research. Therefore, the women interviewed represent just one bounded perspective in time, of female infertility in Bethlehem.

As a consequence of the third limitation came about the fourth. The demographics of the interviewees did not provide me the ability to determine whether the analyses and understandings of infertility located in this research are similar in women of higher socioeconomic backgrounds and/or different religious beliefs. Due to the lack of diversity among my interviewees, this study cannot be certain that infertility provokes a social and individual response different than that of fertility. Furthermore, the depth of analyses of the everyday experience of female infertility in the oPt could have been improved if I was able to employ more ethnographic methods, such as living in the Bethlehem area for a longer period of time and carrying out more participant observation as well as group discussions with infertile women.

5. Ethical Considerations

My research was not short of obstacles to the proper and ethical way of conducting interviews with a psychologically and emotionally vulnerable group of Palestinian women. There were four ethical challenges that I have tried my best to handle sensitively or overcome: informed consent, privacy, harm, and exploitation. I do not claim to have absolutely overcome these ethical challenges, or to clarify the proper standards of ethical research. Ethical standards are still a contentious issue, and debates continue to persist not only relating to the actions taken in my research, but in all forms of social research connected to human activity (Hammersley and Atkinson, 1995: 263-287; see also Murphy and Dingwall, 2001; Wood, 2006). Ethical approval was obtained from the Ethical Committee at the College of Social Sciences & International Studies at the University of Exeter.

5.1. Sensitivity/Care

Sensitivity and care for the participants was taken into significant consideration. Opening a dialogue into a sensitive topic may create anxiety (Hammersley and Atkinson, 1995: 268-273) leading to an invalid and unproductive interview. Therefore, careful considerations and precautions were taken before and during and after interviews.

The interviews conducted in my pilot study, provided an understanding on the psychological state of infertile women in the oPt as well as ways to approach infertile women in interviews. For example, I was informed by the nurses at fertility clinics that if the women were getting emotional during the interview the ideal manner to approach the situation would be to console them and ask if they wanted to take a break or end the interview. This method later proved effective by not only allowing the participants to take their time and not feel pressured into the interview but also led to the building of greater rapport as it established trust and emotional understanding between the participants and myself.

Additionally, prior to the interviews, participants were recommended through two different respects. Firstly, interviewees were recommended to me by their respective physicians, who identified whether the prospective participants were psychologically capable of being

interviewed. Secondly, women I interviewed and/or my field informant, Leila, would inform me of their friends who were struggling with infertility, and were willing (even at times wanting) to be interviewed in order to discuss what was on their minds.

During the interviews, I introduced myself to the participants as a Palestinian PhD student, which, as previously discussed in this chapter, carries an insider/outsider status, researching the state of childlessness in the oPt. I utilised the term childlessness rather than infertility due to the emotional baggage the term carried. Furthermore, when the term infertility was brought up in conversation, a few participants would relate that they are not infertile (see chapter nine).

In almost all of the interviews, my marital status was brought into question early in the interview. The participants asked this question as a way to learn about my fertility state. I informed the interviewees that I was engaged and not previously married. My unmarried state and undetermined fertility state allowed for an open conversation about childlessness and the unknown state of the future of childbearing.

Considering the lack of literature on infertile experiences in the oPt and my positionality as an unmarried Palestinian woman, ethical approaches to interviewing the women were taken into consideration. As means to care for the sensitivity and vulnerability of the participants' experiences and what they felt was most pivotal when discussing infertility in the oPt, the interviews themselves were open-ended without a prepared list of questions. This method allowed participants to guide me in exploring new avenues of research and topics. It allowed the participants themselves to guide my research questions and provoke discussions not previously discussed in the oPt.

Furthermore, in many instances, towards the end of the interviews, the women would relate to me the relief they found in being able to speak to someone outside of their community regarding their struggle with infertility and the toll it has taken on them. Therefore, the interviews became an outlet for their need to discuss their feelings about infertility without having to be cautious and feared of being labelled as 'depressed'.

One outcome of the interviews I was unprepared for was my emotional state following the field research. Before, during and after my field research, I took into great consideration the sensitivity and care needed when discussing infertility with the participants themselves, in the analysis and when presenting the findings. However, not for one moment did I think of the emotional impact it would have on myself.[5] Following the completion of analysing and writing up my field research findings, I found myself questioning my fertility state, particularly after getting married. When discussions of childbearing are brought up, I dismiss the topic not because I do not want children but rather for the fear of thinking about, imagining and longing for a child that I might not have. Infertility was not a fear or a possibility prior to my research. Thankfully though the women's strengths and resilience throughout their infertility is brought to mind when I worry about the possibility of being childless.

5.2. Informed Consent

[5] Researcher's self-emotional preparedness is not usually taken into account when researching sensitive topics, for more, see Fenge et al. (2019).

As a means to provide each interviewee their human rights of autonomy and dignity to the fullest extent, informed, unconstrained consent was acquired (Hammersley and Atkinson, 1995: 264-266; *see also* Inhorn, 2004). Informed consent was acquired orally from the participants and followed the ethical procedures of previous qualitative studies, which include the right to participate voluntarily, the right to withdraw at any time, full knowledge on the purpose of the study, knowledge on the procedures of the study, the right to ask questions, the right to obtain a copy of the results, and the right to have their privacy respected (see Creswell, 2003: 62-67; Wood, 2006). Oral consent was needed due to the political situation in Palestine, and fear for my well-being as well as the participants' well-being if discovered with consent forms by the Israeli military.

5.3. Privacy

Pseudonyms were used to replace the names of clinics and interviewees, necessary to conceal participants' identities (Inhorn, 2004). Moreover, personal information, most particularly relating to interview data, is the private ownership of the interviewee, who had the final say as to whether or not they wanted particular information to be shared. As a result, at the end of each interview, interviewees had the chance to omit or conceal information as private only for my benefit, or for no use at all in any part of the research (Hammersley and Atkinson, 1995: 267-268).

5.4. Exploitation

My research attempts to provide benefits to both the research and the participants. As a researcher and fellow Palestinian woman, the assessed benefits I have personally acquired from the fieldwork is a portion of the strength and resilience found in the women whom I had the chance to interview. As an interviewee, I hope that the benefits they acquired were emotional support and a platform to discuss their issues and empower themselves, in addition to informing the international community about their daily struggles. Moreover, the focus on participatory observations is to help these women 'free themselves' from societal perceptions (Creswell, 2003).

6. Conclusion

The overall goal of this research is to produce the knowledge needed in order to provide a truthful and accurate account of the lives of Palestinian women struggling with infertility as a social phenomenon, and the implications of being infertile within a settler colonial society. It is by no means for the 'improvement of professional practice or the pursuit of political goals' (Hammersley and Atkinson, 1995: 263). Qualitative methods allowed for the exploration of local conceptions of infertility and reproduction, to acquire insight into complex and sensitive developments, and to interpret outcomes in a way that may challenge existing assumptions.

Infertility cannot be hidden due to the social and political pressure for Palestinian women to conceive children. Despite this visibility, infertility in the oPt has rarely been studied by medical, social or historical scholars. Infertile women's voices have been marginalised; therefore, allowing for a narrative approach will provide an uncensored platform of self-representation. The analysis of these narratives is perceptive of the situational contexts of interviews. This allowed for the interpretation of interviewees' accounts to be understood as a version of social reality shedding light on observations and urgencies relating to infertility.

CHAPTER III: LITERATURE REVIEW

This chapter reviews literature on infertility from social and anthropological perspectives to help understand what infertility is, as well as how the lived experiences of infertile persons differ according to locality. After the discussion on infertility, this chapter will also briefly engage with the literature on Middle East that discusses the influence of politics on gender, bodies and power as well as relate it to Palestine-specific work on reproduction.

First, this chapter begins by providing the multiple definitions of the term *infertility* as well as its possible causes and the statistics on infertile person globally. Second, it reviews the literature on reproduction as gendered arguing although reproduction and the inability to reproduce children affects both males and females, it considered a female issue as the female is the one who physically becomes pregnant leading society to associate pregnancy with the female counterpart of a relationship. It also brings forth the discussion of the medical field's reproductive treatments predominantly focusing on the female body, which also in turn influences society's view of infertility as a female issue. Third, I review the literature pertaining to the consequences of reproduction as a female issue on women's self-identity. Fourth, following the discussion of the previous two sections, I present the debate in the literature on the physiological inability to produce and it influence or lack there of on women's psychology. Fifth, I briefly cover the literature on biopolitcs and reproduction, which will be expanded on in the conceptual framework. The final portion on the literature pertaining to infertility takes a socio-economic approach reviewing the economic aspects of accessing reproductive technologies and its influence on societies' attitude towards infertile women. It also correlates a weak economic and health care system with infertility.

After this lengthy review of literature on infertility, I build on the discussions of reproduction as a gendered and a biopolitical tool of nation-building. It focuses on reproduction in the Middle East as a political and gendered tool. In doing so, it traces through the colonial history of the Middle East and its subsequent quest for nation-building. It also briefly examines the modern impacts of colonialism and nation-building on gendered relationships and gendered roles, particularly the role of female reproduction. Following this discussion, a section on masculinity and patriarchy in the Middle East as it pertains to women's roles and kin will be presented to provide context to the discussions in this thesis, particularly those explored in chapter eight. After this portion, I review the literature pertaining to Palestinian reproduction as a biopolitical and gendered tool utilised as a tool for political power.

1. Infertility

The term infertility is defined differently across disciplines. In demography, infertility is the 'inability to bear any children either due to the inability to conceive or due to the inability to carry a pregnancy to a live birth after several years of exposure to the risk of pregnancy' (Serour, 2008: 35). In medical terminology, infertility is the inability of to achieve pregnancy after twelve months of regular, unprotected sexual intercourse (WHO, 2017). There are two types of predominantly recognised infertility: *primary infertility* (pregnancy has never occurred) and *secondary infertility* (one or both members of a couple have previously conceived) (Inhorn, 2012: 340).

With the use of medical technology, the first case of infertility to have been overcome was in 1945 with the success of the first artificial insemination using donated semen (AID), followed by the introduction of oocyte induction, succeeding with the birth of Louise Brown in 1978

(e.g., Pfeffer, 2001; Balen, 2002). Procedures aiding the reproductive system to overcome its 'disease' and 'failure' are known as assisted reproductive technologies (ARTs). Since the birth of Louise Brown and the globalisation of ARTs, the proportion of infertile individuals around the world has risen, which is due to multiple factors including women delaying childbirth, changes in reproductive health (for example, prevalence of STDs) and the social visibility of infertility (Reminnick, 2000).

Furthermore, the increasing production and dissemination of ARTs to overcome challenges of reproduction are leading to the commodification of infertile persons through various treatments and procedures geared towards involuntary childlessness. The term infertility, coupled with ARTs, has influenced societies to reposition their perspective on involuntarily childless women, insisting women undergo treatments in order to fulfil the role of 'womanhood'. However, infertility is and has always been part of normal human biology existing throughout history, although it is predominantly defined and propagated by Western scholars providing a viewpoint that underestimates the uniqueness of the locality of suffering by infertile women (Balen and Inhorn, 2002).

Globally, there are 48.5 million people facing infertility, which is approximately 15% of couples (Agarwal, 2015). The term infertility is argued by social scientists to have been discursively created with the introduction of IVF and the birth of Baby Louise, causing the possibility of '*in*-fertility' to become a connotation of a 'medically and socially liminal state in which affected persons hover between reproductive incapacity and capacity: that is, "not yet pregnant"' (Sandelowski and de Lacey, 2002: 34-35).

This research utilises the definition of infertility within demography (as mentioned above). Ultimately though, there is no way to ascertain where the cause of infertility lies (male and/or female causes) in addition to whether or not the women interviewed were infecund (unable to conceive). Therefore, women described as infertile in this study were those who self-defined themselves as having fertility problems and experienced infertility.

It is difficult to discern the causes of involuntary infertility, as they are complex and multifarious. Nonetheless, as the primary focus of this research is on infertility, it is imperative to briefly describe a few of the leading causes of medical infertility, before developing a literature review on the characteristics associated with infertility.

Cook, Dickens and Fathalla (2003) divide the causes of infertility into two groups, core and acquired. Core causes pertain to unpreventable, untreatable or unknown reasons. On the other hand, acquired causes are derived due to an infertile person's environment and lifestyle. Acquired infertility is usually preventable and occasionally treatable, for instance, infertility deriving from sexually transmitted disease, unsafe abortion or puerperal (Cook, Dickens and Fathalla, 2003: 30).

According to Hemmings (2007),

> The first, core infertility (chromosomal, congenital, hormonal and endocrinological abnormalities), is largely untreatable, especially in resource-poor settings, as it is due to damaged sexual organs, or sperm or egg production. The second, acquired infertility, is both preventable and often treatable (ibid.: 22).

Causes of core infertility in females includes 'tubal blockage, abnormal ovulation, congenital malformation and endometriosis'; meanwhile, causes of core infertility in males includes

'sperm count, motility, quantity and ejaculatory functions' (Ofovwe and Agbontaen-Eghafona, 2009: 2328). Causes of acquired infertility include lifestyle factors (e.g. Fassino et al., 2003), occupational hazards (e.g. Ashiru and Odusanya, 2009) and, but not limited to, environmental hazards (e.g. Forman, Gilmour-White and Forman, 1996: 124-146).

1.1. Reproduction as gendered

A human body is not simply a living organism. It is formulated within the understandings of sexuality and gender constructions through which gender roles and identities are retrieved. This section briefly provides a gendered approach to the understanding of reproduction and sexuality and the ways in which they affect infertile persons. Kanaaneh and Nusair assert that gender is traced through male and female bodies in relation to their relative position in society as well as the gender ideologies that are at play, which are all embedded in the social, economic, and political contexts (Kanaaneh and Nusair, 2010: 12; see also Thapan, 2010).

In the case of Indigenous communities, there is no autonomous economic and political setting that is not intertwined with the subjugation of subordination by the settler society. This lack of autonomy, coupled with the intrinsic nature of biopolitics and the ways through which it plays out in reproduction and sexuality, is bound to create a rippling effect on Native notions of gender, gendered relations, gender roles and, of course, identity. Thus, gender in Indigenous societies is created, formulated and understood through the structure embedded by settlers.

Joan Scott defines gender as 'a constitutive element of social relationships based on perceived differences between the sexes', in which gender is the 'primary way of signifying relationships of power' (Kandiyoti, 1996: 6). Gender is thus socially constructed and differs according to historical time and locality. Each society has its own set of gender roles and identities that are in turn individually implemented through the societal structures of the defined gender norm and normalised gender role.

Moreover, gender as a social construction requires 'a constellation of signifying practices that the sexed body learns to perform during socialization' (Rubenberg, 2001: 10). Therefore, no two societies are identical in the way they define and value females, as 'gender assumes different guises depending on the needs and priorities of particular societies' (Davison, 1997: 95-135). It is also gender that determines who is visible and who is invisible in society (Sharoni, 1995: 20).

This understanding is in line with Lawrence's definition of gender identity as being 'intrinsically an individual issue', but 'also relational, juxtaposed with others' identities, with how they see themselves and see others' (Lawrence, 2003: 4). Lawrence also adds that gender identities are embedded in systems of power based on race, class and gender, causing it to be a highly political issue.

Although gender identity is formed locally through interpersonal relations, political influence, cultural meanings and societal influences, fulfilling motherhood is entrenched in the global perspective as a necessary life course transition. Consequently, the norm associated with female gender norms and gender identity revolves to a great extent around the idea of femininity and reproduction. Reproduction is a way through which women, unlike men, are able to demonstrate their femininity and "femaleness" (e.g., Dudgeon and Inhorn, 2003; Remennick, 2000; Morgan, 1985).

In Nigeria, couples are put on a 'social, religious and physical map of the community' with women being perceived as 'full person[s]' only once they become mothers. If a woman is infertile then she may be consequently socially ostracised from the community, and suffer consequences including losing her rights to land, threats of either abandonment and/or divorce, with verbal abuse, negative stigma and ridicule faced from both families as well as the community as a whole (Ofovwe and Agbontaen-Eghafona, 2009). Meanwhile, in Madagascar, Malagasy women derive authority from becoming mothers, and fertility is linked to the guarantee of human well-being (Woolley, 2002).

In other cultures, mythical stories portray women as the creators and 'birthers' of the earth, with fertile women epitomised as the light of goodness, love and being missed after death. All the while, these same myths portray involuntarily childless women as destructive and evil (Blystad, 1999) or as an 'envious, childless women' (Kaare, 1999). The Iraqw people in north-central Tanzania locate a woman's prestige and identity as bound by her becoming a wife and a mother; therefore, if a wife is childless, whilst her husband or kin will not abandon her, her husband will most likely re-marry for offspring in the interest of lineage, with the childless woman not holding the same status or respect compared with mothers (Snyder, 1999).

Cultural and social identification of gender play a role in a society's view of infertile women. Infertility, however, is a topic that has only recently been pushed into gender studies, with scholars such as Marcia Inhorn. Arguably, the rise in labelling and institutionalising infertility with the presence of ARTs has brought involuntarily childless women to the forefront of not only the medical gaze, but also the discussion of kinship and 'womanhood'. Only recently, within the past four decades and with assistance from the feminist movement, have social scientists begun to pay attention to infertility and women's experiences of social construction and cultural elaboration relating to reproduction (Balen and Inhorn, 2002). However, there is no consensus among feminist scholars. On the one hand, feminists form the prime group of scholars seeking to understand the burden of involuntary childlessness, while on the other some have had difficulty understanding and supporting women that want to undertake infertility treatments, lending (in the eyes of some feminists) support to conventional gender roles and gender stratification (Thompson, 2002).

Similarly, although infertility affects both men and women, the majority of ART procedures place the sole blame for infertility on the female counterpart of an infertile relationship. Studies have exhibited that, regardless of geography and class, women are the main carriers of the burden of infertility. In this vein, women experience a higher degree of biological, social and personal difficulties (e.g., Greil, 2002; Balen and Inhorn, 2002; Pfeffer, 1993; Pfeffer, 2001; Wischmann et al., 2001; Remennick, 2000; Clarke, Martin-Mathews and Mathews, 2006).

Women being the focal point of ARTs, particularly when they are not biologically infertile, leads to the assumption that the medical field may be using their bodies as reasons to continue ongoing procedures irrelevant of their outcomes, for the sole purpose of monetary income and for scientific reasons regardless of the consequences. This produces the gender bias of the female body being used for personal and medical gain. Moreover, communities subsequently perceive these medical acts, reinforcing their belief that infertility is in fact solely a women's issue. This is evident in countries where childlessness is already frowned upon; thus, coupled with physicians prescribing treatments to women, the stigmatisation of infertile women results in them being seen as 'cursed' or less of a human, causing the women to be ostracised from the community (WHO, 2010).

The paradigms of reproduction and reproductive (in)abilities are inherently gendered. Infertile women globally face similar obstacles of not yet being able to become biological mothers and transition into the life course of 'adulthood'; however, the pressure to conform to gender norms and a specific gender identity varies. This variance is heavily dependent on locality, the availability of reproductive health care, societal formulations of gender roles, history and politics, as well as being linked to a woman's race and class.

1.2. The failed body of the female gendered self

Whether diagnosed with core or acquired infertility, being infertile is an overwhelming state causing 'existential chaos' (Allan, 2007). Furthermore, this chaos is elevated, as the state of infertility is no longer accepted as being unchangeable, as reproductive technologies confront infertile persons with the choice to pursue or refuse their 'tentative condition' (Woliver, 2002: 40). However, the visibility and access to reproductive technologies is intimately intertwined with a person's locality as well as race, class and privilege. This section expands on the concept of medical infertility as '*covertly gendered*' (Steinberg, 1990: 91 italics in original) and constituting an assumption that 'operate[s] to hide political and structural issues' affecting the experience of and research on infertility (Loughran and Davis, 2017: 6).

Female infertility has a detrimental relationship with the gendered self, body and daily life. It disrupts the normalised life course transition into adulthood, particularly biological motherhood. It erodes the boundaries between home and society. Also, with the introduction and globalisation of ARTs, infertility is becoming increasingly present. Ginsburg and Rapp suggest 'local social arrangements within which reproductive relations are embedded may be viewed as inherently political' (Ginsburg and Rapp, 1991: 313). Accordingly, research on infertility demands careful attention to how infertile women describe as well as position their experiences with infertility in relation to society, politics, culture and economics.

The dynamics of fertility are argued not to be reliant on individual decision-making, but rather they are interdependent on local social interactions of social institutions, norms, cultural traditions and history formalising the distribution of knowledge, establishment of collective behaviour, and transformation of social norms and institutions, thus changing the 'aggregate' fertility level and incentives for reproduction (Kohler, 2001). Coupled with the inherent interdependency of reproduction, women are perceived as being the sole carriers of the burden of infertility, potentially leading to personal anxiety, marital duress and social stigma (Inhorn and Balen, 2002). The degree to which female infertility affects a women's experience and understanding of self, body and daily life experiences varies not only with the country of residence, but also within the same society due to class (e.g. Wiersema et al., 2006), religion (e.g., Neff, 1994), and rural-urban location (e.g. Nahar and Richters, 2011).[6] This section reviews literature discussing the causal relationship between the burden of female infertility with the conceptualisation of the failed body experience.

The physiological state of being infertile frequently creates a feeling of failure. Loftus and Andriot (2012) report that infertility forcefully prevents the normalised life trajectory of transitioning into adult development, particularly adulthood as distinctly gendered, with motherhood being considered necessary for the life course transition into adulthood. Without

[6] For a comparison between the influence of infertility on the lives of female infertile persons compared to male infertile persons, see Ola (2014) and Clarke, Martin-Mathews and Mathews (2006).

this transition, infertile women feel as though they lead a 'failed' life, with the inability to be normal adult woman due to their infertility. Loftus and Andriot state that infertility is a period of destabilisation, due to the idea that within many societies, becoming a parent is an expected transition. Therefore, infertile individuals undergo alterations to their social interactions inclusive of community seclusion, causing the socially constructed 'self' to inevitably change with the 'failed' transition of the gendered life course.

Clarke, Martin-Mathews and Mathews (2006) further relate biology and mind, through the concepts of self and individuality as well as infertility. They conclude that individual perceptions of the 'failing' body lead to perceptions of self-image and identity as also failures, in so much as it is incomplete and inconsistent with dominant discourses, particularly pro-natalist social norms. A study carried out in Bulgaria by Todorova and Kotzeva (2006) discovered that several individuals doubted their identity due to infertility, in relation to the professional world, social relations, and rights as a citizen within the terms of equality with others. Drastically, overall the participants identified themselves as separate, autonomous and agentic, locating themselves in an individualistic construction. This also affects involuntarily childless women's relationship with fertile women, society as a whole and even themselves (Todorova and Kotzeva, 2006; see also Ulrich and Weatherall, 2000).

However, McLeod and Ponesse (2008) position infertility within the idea of 'biological luck', insomuch as while one has no control over core infertility, it is however in their control to perceive their physiologically infertile state as good or bad luck. The authors discuss three causes behind the self-blame infertile women have: society blaming infertile women for their biological luck and thus women in turn blaming themselves; pro-natalist social norms; and, lastly, infertile women blaming themselves for causally being responsible for infertility. Self-blame is an interesting concept, as it is also examined as a self-coping mechanism. However, regret for being infertile is analysed as 'appropriate and required' for a woman to counter societal perspectives of sexist and pro-natalist mind-sets that have probably been entrenched in her own understanding of herself. Thus, self-blame includes a notion of bad moral luck, while regret provides a perceived vision of good moral luck.

Society constructs the concept of infertility as a women's responsibility, leading them to internalise this notion and causing self-blame and lack of ability to identify with other members of society. Infertile women are therefore also portrayed by society as emotional beings, leading to negative institutional, individual and practical consequences, such as loss of respect, dignity, autonomy and the incapability of making legal decisions such as informed consent (Madeira, 2012).

Within societal constructions, Letherby (2002a) researches the varying experiences of infertility, stating that there needs to be further understanding of its complexity rather than the stereotyped, one-dimensional view of desperation and having an unfulfilled need. She claims women are able to construct their own identity resisting stereotypes, yet women 'reexperience' the painful feelings of childlessness once they grow older.

Alongside Letherby, Riessman (2002) tackles the question of whether women can construct their own individualised gender identities as a means to overcome stigmatisation when they are unable to be mothers. She suggests that in order to do so, it is necessary to have ease and confidence in constructing one's own independent role and identity which varies according to age, with it being more difficult for younger infertile women compared to older infertile

women, as well as varying according to social status. Nonetheless, Riessman portrays the stigma and image of infertility as one that can be resisted and reconstructed by infertile women.

Conclusively, a critical requirement to overcoming the stigma of infertility and constructing a gendered self-identity apart from the norm is removing the cloak over infertility, and introducing research that demarginalises, makes visible and creates discussions around infertility. Upton (2001) highlights the perception of high fertility in Botswanan society as creating the invisibility of infertile individuals leading to the causation and contribution to the social and cultural construction of gender and, moreover, the removal of these individuals from societal discussions including, most detrimentally, the discussions of demographers and policy makers.

The lack of discussion not only among demographers and policy makers but also in wider society, creates the inability to counter mainstream discourse on the issue of fertility, leading fertility to be the biological norm. Jill Allison's (2011) study in Ireland positions this silencing as a historical influence on society, stating that a history of silence on matters not only including infertility, but rather sex, sexuality and procreation as a whole, leads infertile couples to undergo social suffering due to exclusion and isolation. This leads to a grave issue of silence as being detrimental preventing any change in the rhetoric, causing perceptions of infertility to stagnate (see also Benninghaus, 2017).

In the Middle East, infertility is highly prevalent with between 10% to 15% of couples unable to biologically reproduce with the main cause being females with tubal and pelvic infertility (Serour, 2008: 35). Although infertility is highly prevalent, there are few studies on infertility among Arabs in the Middle East causing a lack of studies that 'comprehensively describe what infertile Arab couples prefer, need, and value' (Webair, Ismail and Ismail, 2018: 13; see also, Eldib and Tashani, 2018). The few studies that are present have similar findings to the literature previously discussed, which are infertility is stigmatised in the Middle East as a female problem causing women to be the carriers of the burden of infertility regardless of their biological reproductive capabilities (see, for example, Fido and Zahid, 2004; Inhorn, 1996; Katwsa, 2013; Serour, 2008). However, Inhorn and Patrzio (2015) argue the increasing availability of ARTs in the Middle East are leading to a decrease in gender stigmatizations as well as causing males to acknowledge their infertility. Yet, this is only represented among the infertile population that has the economic and geographical means to access ARTs.

1.3. Physiology as psychology

With regards to infertility, the effects of the associated psychological factors are contested. The debate on the psychological results puts into question an individual's perception of the embodied infertile self as being real or imagined. Furthermore, considering infertility as influencing one's psychological state has a negative influence on the way society perceives infertile persons. The debates surrounding the positionality of infertility as a physiological state affecting an individual's psychological state are discussed below.

On the one hand, childlessness in and of itself is positioned as the source of much psychological difficulty. This, coupled with seeking repetitive medical examinations and treatments, brings a baggage of physical and psychological pain to infertile couples (e.g., Balen, 2002; Greil, Slauson-Blevins, and McQuillan, 2010; Khodarahimi, Hosseinmirzaei and Bruno, 2014; Verhaak et al., 2001; Monga et al., 2004). The way to overcome these psychological effects

and to gain power in resisting them has been shown to be through organisation and empowerment among patients, as well as counselling and support from families (Balen, 2002).

This outlook, found predominantly in the West, posits discovering one's infertile status and later undergoing ART procedures as the basis of psychological distress; thus, a new treatment necessary for infertile persons is counselling. Infertile couples with unexplained reasons are often informed the lack of conception is due to their psychology, and once they 'relax, then [they] will conceive', thus putting pressure mainly on the female counterpart due to her body's inability to become pregnant weighing heavily and creating even more stress and anxiety (Jones, 1989). Due to the use of hormones in treatments, and the mindset of being childless, it is only plausible that psychological and physical effects may show. Infertility is thus rightly perceived to cause stress and a change in hormones. However, the commodification of infertility by psychologists and therapists makes it difficult for one to assess the definite psychological effects of infertility, as well as positioning infertility as a definite psychological matter other than a lapse in the moment of initial discovery of infertility and undergoing of ARTs.

On the other hand, infertility is positioned by scholars as a biological fact that is socially and economically constructed, leading infertile couples to believe they are 'unfit' to be parents, which in turn affects their sexuality, self-image and self-esteem (Morgan, 1985). Additionally, Remennick (2000) argues that self-stigmatising as a psychological response is determined by the amount of conformity the infertile have towards the dominant norms, specifically among women who identify motherhood as a norm and expectation. The latter arguments on the psychological state of infertile individuals, places infertility not within the spectrum of a psychological dysfunction but rather as a norm that, due to societal and economic factors, leads infertile individuals to question their state of being.

Moreover, positioning infertility as a cause of psychological dysfunction has repercussions. First, infertile women are consequently portrayed by society as emotional beings, leading to negative institutional and individual consequences as well as practical consequences. For example, infertile women are portrayed as being incapable of conducting legal decisions such as signing a medical informed consent form not only relating to ARTs, thus leading to the loss of respect, dignity and autonomy (Madeira, 2012). Second is the commodification of infertile individuals and couples. Through the ability to label them as needing psychological help, one is then prompting them to see a psychologist or possibly even a psychiatrist. This is particularly evident in Western countries (Sandelowski and de Lacey, 2002). Therefore, infertility does not only affect the realm of a person's finance, but also their agency.

1.4. Biopolitical approach

Infertility and reproduction are not private matters. Commonly, infertility is primarily approached as a household issue, notwithstanding the consideration that the household is part of a wider world inclusive of the political and economic structures surrounding it, which in turn frame infertile persons' lives (Carsten, 2004: 50). In order to better understand how these structures frame infertile persons' lives, this section will argue that biopolitics is pivotal in determining the reproductive (in)abilities of individuals inclusive of infertile persons.

Biopolitics is captured by philosopher Michel Foucault as the understanding of the body being 'directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to preform ceremonies, to emit

signs' (Peteet, 1994: 32). It is the ability to control a population through the manipulation and power over individual bodies. Foucault further asserts that demographics is a means and essential factor for bio-power and the emergence of biopolitics (Shalhoub-Kevorkian, 2009: 118).

Biopolitics, as such, is understood to aid in nation-building and subject making. It is for this purpose of the body being intrinsically tied into the power relations of politics, that Agamben finds biopolitics intrinsic to Western law and deliberately used to legitimise policies that are directed to compartmentalising and restricting daily life (Shalhoub-Kevorkian, 2009: 117).

Foucault's perception of the body as inherently political, and Agamben's of biopolitics being institutionalised through Western law, are in line with Morgensen's (2011) argument of biopolitics being conducted through the use of hierarchy, and restructuring Indigenous social interactions with the utilisation of laws and governmental acts, such as the institutionalisation of Western laws of white supremacist political economy, in order to continuously eliminate Indigenous peoples (see also, Moreton-Robinson, 2007). For example, Morgensen notes that 'the function of governmentality to "make life" is compatible with the state of exception remaining intrinsic to law, as consigning certain subjects to a state of bare life ("let die") re-establishes a power to produce and defend life among those who remain' (ibid.: 55). In settler colonial settings, this perspective provides the basis for settlers to apply laws within intimate institutional settings in order to focus 'on transforming bodies, desires, and relations to eliminate indigenous national identity and achieve assimilation' (ibid: 11).

In line with biopolitics being used to transform bodies, Fassin (2009) positions biopolitics as not only limited to the ability of governments to make and take life, but also about the influence it has on people's lives. Fassin explains,

> Etymologically apprehended biopolitics is not merely a politics of population but is about life and more specifically about inequalities in life which we could call bio-inequalities […] it is about not only normalizing people's lives, but also deciding the sort of life people may or may not live (ibid: 49).

Biopolitics, accordingly, is not only a mechanism of governing who lives and who dies; rather it expands to encompass the methods in which people live their lives. Krause and de Zordo (2012) identify that

> women, as the main target of reproductive policies, are often stigmatized regardless of their behaviors: for postponing motherhood, for embracing childlessness, or for having children. Even so, women are not 'docile bodies'. On the ground, biopolitics rarely go unnoticed and uncontested (ibid.: 139-140).

As an approach to understanding the framing of the lives of infertile persons, biopolitics provides a 'tool to analyze the forms of power that write themselves onto and into bodies' (ibid.: 141). A biopolitical approach must build on Foucault's understanding due to its inclusivity of sexuality as an apparatus through which policies and practices that seek to control reproduction and sexuality are situated. However, Foucault does not take into account the varying forms and ways through which biopower functions differently within different gendered bodies. Nonetheless, gender as a form of biopower within the biopolitical approach should be considered as a primary apparatus (see, Repo, 2015).

1.5. Socio-economic approach

As research by Balen and Inhorn (2002) reports, ARTs and reproductive medicines are being exported globally in a very rapid manner from developed countries in the West to developing countries in the East.[7] Presently, in vitro fertilisation (IVF) is the most common ART procedure undergone internationally by infertile women. It consists of a woman being treated with hormones or chemicals necessary to stimulate oocyte (egg production) which are then fertilised in a clinic outside of the body with the successfully fertilised eggs placed in the womb. Although the leading international procedure, its success rate is only 30 percent (Eich, 2008). Despite the ever-increasing presence of IVF and ART in general, the ability to acquire infertility treatments is heavily dependent on a woman's healthcare access, race, economics and the political situation. It is only the elite in a number of developing countries that can afford IVF or any other type of reproductive assistance, leading to class-based medical exclusions leading to infertile couples who cannot access these technologies to experience increasing frustration and resentment (Balen and Inhorn, 2002).

States that do not cover or subsidise IVF and/or other ART procedures cause these treatments to only be acquirable and to benefit a small, elite population, with very little access for non-elite women. In Uganda, for example, where the government does not cover or subsidise ART procedures, one cycle of IVF can cost the recipient about $4,900. In Egypt, which offers subsidies, it costs $600 (WHO, 2010). In Vietnam, undergoing any type of ART must be self-funded with the cost being around $3,000, which most infertile Vietnamese women cannot afford, thus having to resort to selling their homes for one round of treatment (Dyer and Patel, 2012). The stagnating cost of ARTs in countries lacking adequate reproductive healthcare for infertile individuals produces financial tensions, particularly between couples that pay hefty prices to undergo unsuccessful treatments.

Moreover, hierarchy and class strongly influence a society's approach to the discussion of infertility. As discussed in the previous section, the lack of an adequate and accessible healthcare sector produces a barrier between infertile persons and fertile persons. Particularly in developing countries, the economic situation of the majority of the population (the elite group aside) is unstable or deprived, and the added burden of infertility leads to a 'medical and social poverty trap' (Dyer and Patel, 2012). The most obvious economic disadvantage of infertility is the requirement to pay for an ART procedure with a minimal guarantee of its success. This payment may lead to the selling of land and/or homes for only one treatment, and after one or multiple unsuccessful procedures, women remain childless.

Due to the lack of social security systems, elderly people are dependent on their children economically, with stigmatisation of infertile women leading to isolation, physical and psychological violence, polygamy and being ignored (e.g., Ombelet et al., 2008; Jones, 1989; Ying, Wu, and Loke, 2015). These pressures are stronger on women who have less education and a lack of a career and aspirations (Remennick, 2000). Khaerul Umam Noer's (2012) case study of exiled women from Madura, Indonesia, shows that in some societies, biology and economics go hand in hand. An infertile woman is seen as a burden on the economy, given her inability to ensure her "destiny" of maintaining the family's needs, the continuity of generations and economic sustainability. This lack of fulfilment leads to infertile women's social exclusion from societal activities and routines as a punishment and a lesson to other

[7] On the globalisation of reproductive technologies and medicines in the Middle East, see Inhorn, 2011.

women. At times, these societal exclusions are too much pressure for infertile women, causing them to go into self-exile in order to find some happiness.

Infertile women are blamed by society for their physiological state. This blame is fuelled and navigated by the lack of or poor reproductive health care that is present in economically-deprived as well as war-torn states, which already contribute to disruption within marriages due to their ability to have 'stable and predictable' lives (Pashigian, 2009: 38). Ofovwe and Agbontaen-Eghafona (2009) state that a way to overcome and solve issues detrimental to infertile women, specifically gender-based violence, is through national policies and strategies including the improvement of women's social and economic status, and integrating ARTs as part of primary health care.

This access barrier leads infertile women in many non-Western and developing countries to face a very different as well as difficult situation compared to Western women. Furthermore, the mere lack of an appropriate healthcare system may not only lead to the lack of infertility treatments, but to infertility itself. It is suggested that roughly 10% of infertile women are born sterile; meanwhile, 90% acquire sterility through preventable causes in connection to the lack of medical education and research priorities of studying infertility. This is reflective of the low status women are provided within society, having little to no social and economic power (Morgan, 1985: 225). The preventable factors leading to infertility need to be addressed through adequate healthcare systems as well as education programmes in every society in order to put a stop to such occurrences.

Further, on the correlation between poor health care and infertility, researchers have identified Chlamydia trachomatis, a preventable sexually transmitted disease (STD), as causing infertility among women, and being prevalent in developing countries such as India and Palestine due to the lack of adequate healthcare and screening processes (e.g., Dhawan et al., 2014; Hajikhani et al., 2013; El Qouqa et al., 2009). Additionally, polycystic ovary syndrome (PCOS), a preventable syndrome, affects one in every five women of reproductive age. PCOS is known to alter the ability of the reproductive system to conceive with symptoms including menstrual irregularities, obesity, hair loss and acne. These symptoms may lead women to feel unfeminine and disrupt towards their 'womanhood' leading to issues with their sexual functioning (Amiri et al., 2014).[8]

However, economics is not always the reason for preventable infertility. Settler colonial economic and territorial hierarchies between settlers and Natives may also be a factor causing acquired infertility. Kildea and Bowden (2000) studied an Indigenous community in a remote community of Northern Australia in which they found poor reproductive health, high infertility (primary, secondary and resolved), and high levels of sexually transmitted infections. Their research located higher rates of infertility among the Indigenous population in comparison to the non-Indigenous/settler population. They concluded that the poor reproductive health was due to the absence of clinical and public health centres, resulting from the structural, social and economic barriers faced by Indigenous peoples in Australia.[9] Meanwhile in Alberta, Canada,

[8] For an in-depth discussion of PCOS including its signs, symptoms and possible treatments, see Balen, 2017.

[9] To ensure the reproduction of a certain type of "Australian" national identity, biopolitical policies have promoted reproduction in certain Australian communities and imposed regulations to minimise unwanted national identities. See Cover, 2011.

Indigenous communities were previously sterilised in order to prevent reproduction through a state of infertility (Grekul, Krahn and Odynak, 2004).

The roles that reproductive healthcare and the health sector in general play in a women's ability to become infertile, as well as her ability to overcome infertility, leads to the causation of various other factors in a woman's life. A review of the health sector in states, particularly those with the ability to provide adequate healthcare but which are dismissive about certain communities among their population (e.g. Australia, as shown by the case above), is crucial. In other states lacking the financial means, the medical field and international community need to address the issue of the stagnating costs of ARTs, their effectiveness, and the question of whether it is truly necessary for a female to undergo a treatment rather than her male counterpart doing so. Unless these issues are addressed, there will be a continuation of the commodification of female bodies, individuals being economically crippled due to their medical state, and an overall increase in the presence of infertile individuals.

2. Politics Gender and Power in the Middle East

A contemporary view of the Middle Eastern society with its gender relations and gender roles is a result of its colonial history. Narin Hassan articulates that the structures and impacts of colonialism create modern tensions of not only nation but also gender as 'meanings of gender were shaped, challenged, and re-articulated through colonial encounters' (Hassan, 2016: 1). Similarly, Leila Ahmed (1992) situates that until the present day, colonial domination affects all Middle Eastern societies. Colonialism is a crucial and divisive apparatus that evokes concerns of power and subordination in regards to gender relations and roles. Its long-term impacts in the Middle East, has resulted in political unrest, conflicts and political transformations that are and continue to be pivotal in producing gender relations and gender roles.

Before moving on, let us briefly recall the meaning of the term gender. Gender is socially, culturally and politically produced as are feminine and masculine characteristics and roles. In this respect, gender is fluid and ever-changing. It is, as Judith Lorber explains, an institution that 'establishes patterns of expectations for individuals, orders the processes of everyday life, is built into the major social organizations of society, such as economy, ideology, the family and politics, and is also an entity in and of itself' (Lorber, 1994: 1). The institution of gender has historically side-lined and marginalised women's roles and issues from the political arena as they were viewed as part of the private sphere that should be excluded from politics and arranged in the home. This marginalisation becomes increasingly difficult to maintain in times of conflict and political changes as the home becomes the frontline. Consequently, this lack of maintenance leads to the hindering or promotion of women's status and roles.

2.1. Women's Role in the Nation-building Process

In the post-colonial era of the Middle East, countries were undergoing political unrest and scrambling to create independent nations resulting in intense nation-building process. The usage of gender as a tool for political power success is not unprecedented. Women have historically been utilised as a tool to attain political, economic and social success. For instance, Western imperialism in the Middle East during the late twentieth century was achieved through 'the undermining of religion and culture, mediated through women' (Najmabadi, 2000: 30).

Prior to reviewing the influence and subsequent nation-building policies on gender and reproduction, it is essential to recognise that the Middle East is not uniformed. The Middle East as Shereen El Feki describes,

> The term Middle East is even more of a geographical blender, mashing together not only the Arabic-speaking countries of North Africa, the Arabian Peninsula, and the eastern Mediterranean but also non-Arab Turkey, Iran, Afghanistan, and occasionally Pakistan thrown in for good measure. (El Feki, 2013: 12)

Therefore, not all Middle Eastern countries experience the same gender ideologies and roles nonetheless gender with an emphasis on biopolitics and reproduction.

In general, however, nation-building in the Middle East during the turn of the twentieth century is categorised as a nationalist, postcolonial, modernist movement that shaped gender roles and policies through politicisation and exploitation. In the ground-breaking edited book by Palestinian-American anthropologist, Lila Abu-Lughod (1998a), titled *Remaking women: Feminism and Modernity in the Middle East*, the authors trace the ideas of modernity as a policy of nation-building, which is argued to have been embedded in the Middle East by the West as a means to support politics and class relations. This embedding, however, was ambivalent to the effects of modernity on women's lives.

In her introduction, Abu-Lughod states, '[t]he forms of feminism in the Middle East tied to modernity ushered in new forms of gendered subjection (in the double sense of subject-positions for women and forms of domination) as well as new experiences and possibilities' (Abu-Lughod, 1998b: 13). It called for modern subjects that accept individuality rather than kinship. Abu-Lughod states this modernity did not benefit Middle Eastern women rather it was contradictory, replacing old patriarchal power and forms into new ones.

In the same edited book, Najmabadi (1998) describes Iran's twentieth century quest for nation-building utilised the promotion and dissemination of the ideal, modern female as an educated woman who manages and is the 'manager' of the household. Women were to be educated housewives who can educate their children and, in turn, the country. Therefore, women's prescribed roles were to bring society forward women, which was seen as 'a regulating and an empowering moment' (ibid.: 102). This policy later revealed to be a containment policy in which women were only educated in the 'discourse of domesticity' (ibid.: 109).

Another 'modernising' policy of nation-building discussed by Moghadam (2003) is the modernisation of the workforce by creating developments in the labour market to include women. This inclusion formulated another type of modern woman, a woman in the public workforce rather than in the private, domesticate sphere. However, this inclusion demanded that a working women's main priority still be the household. Although 'modernity' in the Middle East has influenced some women to become educated, managers of the household while it has influenced others to join the labour force; regardless of the chosen path, 'modernised' women, principally their reproductive bodies, were and continue to be regulated for nation-building purposes through biopolitical tactics.

Through biopolitical practices subsumed under the auspice of nation-building policies, women's reproductive abilities became the centre of nationalist politics. In her book, historian Omnia El-Shakry (2007) traces the creation of the concept of subjecthood in Egypt as it sought to modernise in late nineteenth and twentieth century during colonialism and post-colonialism. El-Shakry situates '[t]he modernization of reproduction was a crucial component of the

nationalist ideology of social planning and scientific progress' (ibid.: 167). In a later book, El-Shakry (2016) discusses gender, reproduction and demographic mandates of modern Egypt in which she observes two biopolitical regimes in Egypt. The first she defines as lasting from the 1930s to the 1960s and the second from the 1970s throughout the rest of the twentieth century. She argues biopolitics has led to the

> the intrusion of the modernizing nation-state into the everyday life of its citizens has continually expanded throughout the twentieth century. Both state and nonstate actors have been complicit in this process, including nongovernmental organizations and religious institutions and figures (ibid.: 181).

These modernizing intrusions of reproduction deployed as a method of biopolitics has made it 'clear that women have functioned as the fulcrum of population policies' (ibid.). Similarly, Israel's population policy that 'encourages Jews to have more children and Palestinians to have fewer, continues to locate the site of political contest in women's wombs' utilising a variety of biopolitical measures to control Palestinian population (Kanaaneh, 2002: 17).

Another example of the biopolitics of reproduction is situated in the discussion of citizenship. Suad Joseph, an American-Lebanese anthropologist, discusses citizenship as gendered in the Middle East stating,

> Given the centrality of patriarchal connectivity, relational rights, and the kin contract in many Middle Eastern political, economic, religious, and social cultures, this implies the transportation of gendered and aged discourses and practices into citizenship discourses and practices (Joseph, 2005: 157).

Essentially, to be part of the nation and receive citizenship, a woman has to belong to a male defined kin-group, established through male genealogy and contribute to it. Joseph's (2000a) edited volume *Gender and Citizenship in the Middle East* discusses the wide-ranging policies Middle Eastern states implemented to gender citizenship causing it to be based off of patrilineal kinship with the exception of Israel. In her introduction, Joseph situates that patriarchal ideologies and patrilineality are often embraced and sustained by religion as '[t]he patrilineal acquisition of religious status has underwritten the patrilineal acquisition of many rights and privileges' even when religions such as Judaism follow matrilineality of Jewish identity, in Israel, Jewish identity descends both father and mother (Joseph, 2000b: 13) arguably for political reasons (see the following chapter). For example, nationality laws in Morocco and Tunisia are based off of kin connectivity (Charrad, 2000).

On the topic of Israeli citizenship, Abdo (2011) analyses it as a 'historically specific case' of an engendering policy as well as composing of a socio-economic and racial component that seeks to benefit the nation-building goals of Israel as a Jewish-majority country. Abdo positions the importance of 'investigating culture, tradition and familialism in a manner which refuses to see them as independent, immutable, or ahistorical categories, but which instead understands them as institutions affecting, and affected by, state policies and practices' (ibid.: 189, 190). For example, Palestinians in Israel are gradually moving away from having a large (over four children) family to a smaller (under three children) family. This is arguably a result of Israel's Ministry of Health's family planning services that utilise the concept of modernity to limit the increase of Palestinian citizens of Israel. Through propaganda methods Palestinians are persuaded that a smaller family creates a modern, Middle-class Westernized family (Kanaaneh, 2002). Rhoda Kanaaneh states '[t]he proximity of the Israeli state, its deep incursions and insertions into day-to-day life is a central factor in the salience of narratives of modernization

(and of antimodernization) among Palestinians' (ibid.: 252). As a result, '[f]or Palestinians under Israeli rule this binary opposition [modern versus traditional] has entered daily life and shaped their negotiations of reproductive decisions.' Ibid.: 165). These manipulative policies Maryam Hawari (2020) argues have been successful in reducing Palestinian's birth rates, particularly in the 1948 territories.

The politics of nation-building and maintaining the desired number as well as type of citizen is complicated, intertwined and dependent on every level of power from the micro-politics of everyday life to the macro-politics of policy making. This research discusses the multi-layered influence of micro and macro-politics on the lives of infertile Palestinian women living in an occupied territory that is constantly attempting to seek independence and overcome it occupiers on land that is constantly in a state of political unrest. This section reviewed the literature related to nation-building as a biopolitical practice that utilises the female body as a means of achieving its goal. The following section will discuss the nuances of gender, power and bodies that are found in the everyday lives of these female bodies as they try to navigate and attain power within this framework of nation-building.

2.2. Gender, Power and Bodies

When discussing the impact of politics on gender relations, power and bodies, with an emphasis on women's bodies, it is important to understand the terms masculinity and patriarchy. Masculinity coupled with patriarchy produce gender relations through which the framing of power and corporeal agency are authorised. Masculinity is 'never singular' as 'various models of masculinity coexist and inform one another' as well as 'are hierarchal and compete for hegemony' yet 'share a formidable interest in maintain patriarchal and heterosexist principle' (Sa'ar and Yahia-Younis, 2008: 306). Masculinities are socially constructed relationships of power; they are manifest and reinforced by individuals and institutions (e.g. socio-cultural institution of family, nation-state building, culture as in honour patrlineality patriarchy and patrilocality; military and conflict).

Anthropologist Farha Ghannam (2013) observes the meaning of embodied masculinities in Urban Egypt finding embodied interactions lead not to

> a unidirectional flow of power (male powerful/female powerless, male makes/female made) but a complex web of signification and multiple flows of power that structure how masculinity (and, for that matter, femininity) are embodied, reproduced, and transformed in various contexts and over time (ibid.: 104-105).

The second term to address when discussing gender relations and power is patriarchy. This term is 'characterized by relations of power and authority of males over females' and, therefore, 'women's subordination is first experienced–sometimes subtly, sometimes profoundly–within the family, which serves as a template for the reproduction of patriarchal relations in other realms of social life' (Inhorn, 1996: 4). Patriarchy and its influence on kinship are imperative to the discussion of infertility.

Generally, the Middle East is a region relying on kin-based patriarchy with the family being the most important social institution. Feminist scholar and sociologist, Valentine Moghadam relates that patriarchy 'should not be conflated with Islam but rather should be understood in social-structural and developmental terms' with its ability to be 'intensified as a result of political and economic changes' as she explains is the experience in Palestine (Moghadam, 2003: 123, 124). In the setting of resistance in Palestine against Israel's occupation and in the

process of state-building, Palestinian women struggle to acquire status. Social anthropologist, Rosemary Sayigh (1998) explains,

> The tendency of anticolonialist nationalisms to construct an "inner level" or "inner domain" as sanctuary against alien domination has implications for women, identifying them with home and cultural authenticity. As part of the same process, gender ideology is exempted from historic change, becoming part of a reconstructed "traditional identity" preserved fossil-like within a modernizing nationalist program (ibid.: 166).

Resulting from this construct, Palestinian national narrative integrates gender imaginaries by referring to the land of Palestine as female/female body being raped, possessed by others and conquered becoming paralleled with the defeat of manhood and masculinity.

Coupled with the politicisation of gender imaginaries in Palestine, Palestinian women have become biological and cultural reproducers of the nation. Both nationalist and Islamist conceptions of nation-building relies on the conception of women as "guardians of tradition" (Jad, 2011: 76) through traditional familial roles. Women's role as biological reproducers of the nation allows for the maintain of national security in the context of maintaining the desired population and demography.

Amireh explains, '[i]n the sixties and seventies, fertility became an actual weapon for the Palestinians who remained inside Israel' (Amireh, 2003: 755). Sacrifices of birthing the nation to secure the homeland align with heteropatriarchal norms (Das, 2008). Palestinian women, however, are not bystanders and/or powerless to the call for 'birthing the nation' rather they use their reproductive abilities and roles as mothers to oppose Zionism and patriarchy as well as to increase their status. As Kananeeh positions, '[w]omen are not passive bystanders of a struggle between Palestinian and Israeli men, but active participants (in delimited ways) in these constructions of nation and reproduction' (Kanaaneh, 2002: 66). Similarly, in war-torn Afghanistan, men are seen as the providers and protectors of the family, particularly its honour, which in turn justifies greater male rights and privileges. Afghani women who are dependent on men forgo their autonomy and bargaining capacities when men do not live up to their end (Kabeer, Khan and Adlparvar, 2011).

With the discussion of honour, Baxter (2007) explains that honour ideology reinforces male privilege but also puts responsibilities on men, furthermore, women in communities of honour have power, status and influence. They are not passive bystanders to male privileges and patriarchy rather, if honour is upheld correctly with the responsibilities it entails, the women appreciate it. As Weeks explains, '[h]uman beings are not slaves of the flesh, not passive recipients of social messages. Through human practice they are actively agents in making their lives and transforming their bodies' (Weeks, 2011: 21). Interpersonal patriarchal relations are used by women to reduce vulnerability and lead to overcoming socio-economic and political oppression (El-Kholy, 2002). Women are, therefore, not passive pawns and recipients but they also assume these discourses. They oppose, challenge and re-embrace patriarchy and male dominance by negotiating them for their own interests (Najambadi, 2000).

Accordingly, in Naila Kabeer's article on women's empowerment through gender relations as

> multi-stranded: they embody ideas, values, and identities; they allocate labour between different tasks, activities, and domains; they determine the distribution of resources; and they assign authority, agency, and decision-making power. This means that gender inequalities are multi-dimensional and cannot be reduced to some single and universally agreed set of priorities (Kabeer, 2005: 23).

Similarly, Sabiha Allouche (2019) presents the power of romantic love in Lebanon as 'the entanglement of love with power constructs spaces and opportunities for undermining or contesting preexisting patriarchal values' (ibid.: 173).

In the Middle East, the influence of kin-based patriarchy coupled with family as the central social institution. Accordingly, on a daily basis Middle Eastern women are intertwined in embodied masculinities and interpersonal patriarchal relations, however, these relationships are complicated and irreducible to one particular notion. These relationships are also ever-changing and being influenced by not only the political atmosphere but also as Allouche mentioned, by love. Love, as I will discuss in part three of this thesis, is critical to marital in/stability, which in turn provides political, social and economic in/stability.

3. Palestinian Reproduction: a biopolitical and gendered tool of power politics

In order to understand politics, gender and gendered relations within the context of the oPt, it is necessary to analyse the implications of the Zionist settler project. It is also important to discern that Palestinian women's bodies are framed in relation to the social construction of an idealised role of women as maternal female bodies. With this, we can then understand how Palestinian women become subjects to Israeli power (Ryan, 2015: 51-52). This section, therefore, seeks to analyse the ways through which settler colonialism affects gender, gendered roles of reproduction, and kinship dynamics.

Gender violence is a primary tool of colonialism, as colonisers do not just kill Indigenous peoples but always accompany this with sexual mutilation and rape: 'the goal of colonialism is not just to kill colonized peoples, but to destroy their sense of being people' (Smith, 2008: 312). In the case of Palestine, theft of Palestinian land by Zionist forces was not secured only by military means, 'but also by laws that sanctioned the terrorising of indigenous Palestinian girls and women and subjected them to the technologies of sexual harassment, intimidation, punishment, and death', including the utilisation of Palestinian women to break local patriarchal rule and facilitate their settler colonial rule (Krebs and Olwan, 2012: 146-147).

Additionally, as an area of political conflict and in many respects an ongoing war zone, Palestine has become a 'legitimized space' with the 'political and social license to rape, gang rape, and to commit sexual abuse and torture terrorizes both women and their societies', which in turn destroys their capabilities of reproduction (Shalhoub-Kevorkian, 2009: 132). However, due to an increase in international scrutiny, sexual violence is not as prevalent as other types of gender violence in the oPt (Wood, 2009: 129).

Gender violence stems from the biopolitical tactic, identified by Frantz Fanon, of 'the targeting and collective punishment of women [as] 'a precise political doctrine', one that is intended to break the political and social fabric of a colonised society and diminish its capacity for resistance' (Krebs and Olwan, 2012: 147). In a study on Palestinian women in the oPt, Rubenberg (2001) interviewed a Palestinian woman living in a refugee camp in the West Bank, who stated

> *The root causes of women's problems in this society are the political situation–the continuing occupation and the economic situation. No one, men or women, has freedom here. There are no jobs for men, or women. Poverty is women's greatest oppressor. Violence, early marriage, lack of education, too many children – all of these have their root causes in the political economy of poverty. Even women's lack of freedom is a consequence of the occupation –*

> *families rightly fear for their daughter's safety and honor when they must confront foreign soldiers whenever they leave their home* (ibid.: 119, italics in original).

These root causes effectively subjugate Palestinian women to double patriarchal rule, through the susceptibility of violence in the public sphere inclusive of roadblocks[10], body searches, settler violence and so forth, as well as in the public sphere through the necessity of having to 'cope under conditions of tremendous anxiety and incertitude to ensure family survival' (Krebs and Olwan, 2012: 147).[11] Subjecting Native communities, such as Palestinian women, to patriarchy is considered 'essential' to establish rule, as patriarchy 'naturalizes social hierarchy' enabling colonial rule (Smith and Kauanui, 2008: 241).

Richter-Devroe (2012) explains how culturally-specific gender norms based on traditional norms have evolved being impacted and changed by 'the occupation, but also the dynamics of capitalism, globalization, aid dependency, etc.'. Yet, although, there was a brief emergence of alternative gender models in recent Palestinian history,

> the general lack of security established the family and local community structures as important social and political institutions to provide protection, thus reinforcing women's domestic, nurturing and caring roles as mothers (particularly, but not exclusively, through newly arising Islamic gender models). (ibid.: 38, 186).

This reinforcement of the patriarchal role, which posits women as maternal female bodies and caretakers, continues to be strengthened through the conceptualisation of the 'demographic race'. The settler colonial project in Palestine, due to the sizable Native population in relation to the settler population, is causing demographic anxieties within both settler and Indigenous communities (Veracini, 2006: 19). Zionism in Israel is defined on the basis of a Jewish-majority demography; therefore, the 'demographic race' with the Palestinians has been prominent in Israel's history (Yuval-Davis, 1997: 30). For example, Shimon Peres while Foreign Minister stated that '[p]olitics is a matter of demography, not geography' (ibid.).

Appropriately, Courbage (1999) states,

> Israel's Jewish population is very fertile: while their living standards and educational level are comparable to those in Europe, they tend to have three children instead of the standard two in the West. There are several reasons for this. In addition to serving as a kind of insurance against losing a child in a situation of conflict, there is also pressure on Jewish women, irrespective of educational level, to compete against Palestinian women in the "war of the cradles." Zionist militancy, religious and secular, also favors high fertility on political grounds. (ibid.: 26)

The Israeli government encourages Jewish women to reproduce through policies of child allowance, maternity leave and, for a period, having a 'heroine mothers' award to whomever had ten or more children (Yuval-Davis, 1997: 30). Consequently, Israel's state-sponsored pro-natalism emphasises reproduction for the continuity of the Jewish peoples and their political survival (Birenbaum-Carmeli and Dirnfeld, 2008: 183).

---

[10] As of 2018, the United Nations Office for the Coordination of Humanitarian Affairs (2018) documented 705 permanent road obstacles such as road gates, earth mounds and checkpoints 'restricting and controlling' Palestinian movement in the West Bank.

[11] There have been numerous countering methods used by Palestinian women, such as everyday resistance against Israeli-imposed occupation strategies and policies of violence. See, for example, Richter-Devroe, 2018.

Israel further seeks commitment to the concept of the Jewish 'natural family' for religious, ideological and political reasons, especially through biological ties, making family relations through means such as adoption not an option (Birenbaum-Carmeli, 2009; see also, Kahn, 2000). Endorsing the 'natural family' has played a significant role in Israel's reproductive measures, inclusive of it having the world's highest rate of IVF and ICSI cycles per capita (Birenbaum-Carmeli and Inhorn, 2009: 25-26).[12]

Furthermore, Greil and McQuillan (2010) position assisted reproduction as 'economically and racially stratified' (ibid.: 150). The ideological and political incentives behind stratified assisted reproduction, coupled with the emphasis on Jewish continuity, are inherently selective. This selective assisted reproduction is part and parcel of Colen's concept of stratified reproduction, in which

> physical and social reproductive tasks are accomplished differently according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status and that are structured by social, economic, and political factors. (ibid., 1995: 78)

Stratified reproduction addresses the intersections of reproduction and stratification, acknowledging the power dynamics within reproductive politics.

An example of stratified reproduction is the promotion of family planning as a method of decreasing reproductive tendencies among Palestinians within the 1948 borders of Israel, as well as non-Ashkenazi (western) Jews such as Mizrahi (Oriental) and Ethiopian Jews (Kanaaneh, 2002). Israeli officials have 'admitted that the state sometimes administered long-term contraceptives to women of Ethiopian descent without their knowledge or consent' (Lee, 2014: 2001).

Simultaneously, as reproduction is considered a women's issue, women's politics commonly follows national politics (Abdo and Yuval-Davis, 1995: 313). Accordingly,

> it is not uncommon for women to state that it is their national duty to bear many children to replenish the human losses incurred during wars. Women do not actually bear children for the nation, but by conceiving of and talking about fertility and reproduction in these terms they gain a sense of contribution to the national struggle (Peteet, 1991: 184).

High fertility in the oPt is often highlighted as politically-driven (political fertility) in reaction to the 'demographic race' with Israel's Jewish population (Hansson, 2012). Oral Palestinian narratives demonstrate that 'the mother's role is to bring sons into this world; to train, socialize, and protect them; and to offer them as sacrifices for the common cause of Palestinian societies', in comparison to birthing daughters who are 'weak and vulnerable' (Kanaana, 1988: 133). This "mother-son team" basically plays on the notion of a woman's role to have sons who are courageous, fight the Zionist entity and possibly even becoming a martyr or *shahid*, as arguably 'a Palestinian woman naturally has the right to be proud of her male infants because they are known to start the struggle against the Israeli soldiers even before leaving their mothers' wombs' (ibid.: 126-127). Peteet (1997) situates the configuration of Palestinian women as icons of the nation as a cultural construct, through which 'mothering in this specific national

[12] An in-depth analysis of fertility, infertility and reproductive technologies in Israel may be found in Birenbaum-Carmeli and Carmeli's edited volume (2010).

and class context gives agency but simultaneously embodies and delimits its space and meaning' (ibid.: 127).

The relationship between gender and nationalism is summed up by Yuval-Davis and Anthias in the conclusion that 'women produce the nation biologically, culturally, and symbolically' (Shalhoub-Kevorkian, 2009: 122). In line with this understanding, Palestinian women are epitomised as the birthers of the nation (Kanaaneh, 2002). This "role" gained further significance at the beginning of the First Intifada in 1987 (Sharoni, 1995: 35). This is argued to be the result of the politicisation of motherhood within nationalist discourses, consequently elevating 'mothers as social, cultural and biological reproducers of the nation' (Richter-Devroe, 2012: 192; see also Segalo, 2013). This has created a strong pro-natalist society within Palestine. The pressures to have or not to have children relate to being members of specific national collectives (Yuval-Davis, 1997: 22).

It is important to note that prior to 1948 Palestine was a pro-natalist society with patriarchal tendencies (see, Granqvist, 1935 and 1947). However, pro-natalism, particularly women's roles as mothers, was again strengthened during the Second Intifada, during which the mothers of martyrs became 'a primary symbol of resistance, heightening the significance of women as bearers of fighters' (Allen, 2009: 41). Similarly, the maternal identity of fertile Palestinian women with Israeli citizenship is 'rooted in both their personal status in the family and community and their contribution to the collective good of the nation, mainly by reproducing the ranks of men–breadwinners and potential fighters for the Palestinian cause' (Remennick, 2010: 325). Until presently, Palestinian women are being labelled as "mothers" and "reproducers" of the nation (Richter-Devroe, 2012: 181-201).

Furthermore, Najmabadi (1997) discusses the perception and production of the homeland as a female body, which is clearly evident in Palestinian literature and art (Richter-Devroe, 2012), creating the 'discourse of protection of woman – a body that needs protection against alien designs, intrusion, and penetration – and defense of honor available to nationalism' (Najmabadi, 1997: 445). This idea of homeland as a womanly body 'contribute[s] to the reconstitution of concepts of motherhood' (ibid.: 446).

Overall, Palestinian society may be understood as a pro-natalist society, which 'refers to a set of representations, practices, beliefs and constructions around the centrality of motherhood to women's lives' (Malson and Swann, 2003: 198). These pro-natalist ideologies in Palestine are disseminated by the national movement and the media (Khawaja, 2003: 2). Moreover, discourses surrounding Palestinian fertility and the positioning of women's bodies as the bearers of the reproductive role, have become the locus of continuity and overcoming the Zionist settler colonial project (Kanaaneh, 2002).

These various conceptualisations of motherhood have influenced the understanding of reproduction. As such, it is critical to understand that 'one cannot dichotomize between "natural" and "controlled" reproduction: all so-called natural biological reproduction takes place in the specific social, political and economic context which construct it' (Yuval-Davis, 1997: 26, quoting Tabet, 1996). As with reproduction, Woollett (1996) conceptualises infertility as being diverse and incapable of being represented by a singular or homogenous term. Its meaning is subjective and varies according to locality (Balen and Inhorn, 2002). The case of the oPt as a site of settler colonialism with its underpinning of biopolitics provides no exception to this understanding and conceptualisation of infertility.

4. Conclusion

This thesis contributes to the literature on politics, gender and reproduction through the analysis of infertility as a political and/or biological inability that in turn affects and is affected by ones embodied self, social status and economic standing. This neoteric approach with relation to literature on Palestine will add to the present scholarship on women's reproductive bodies in Palestine and may be extended to the Middle East as a political, social and economic arena in which women struggle to formulate their biological autonomy or, at times, seek to pursue and hope for motherhood to abide by patriarchal ideologies. In the case of infertility, this research furthers the present literature on reproduction as affecting women more than men due to the constructs of motherhood as the epitome of femininity intertwined with its social and economic benefits in centres of political unrest; as capable of having a psychological effect on infertile women, if they pursue the desire to abide by societal norms of motherhood; and, that reproduction is a bio-political strategy used by states to formulate populations based on their preferred race and class. This thesis, however, challenges the assumption that infertility is merely a physiological inability to reproduce children. Rather it positions that infertility and the inability to reproduce children as being manipulated by the political apparatuses in which women's reproductive bodies are located. These manipulations, principally biopolitical strategies, assist political powers in limiting the lineage of an undesired race, specifically in settler colonial settings where settlers' end goal is the elimination of the Indigenous population, which will be conceptually expanded on in the following chapter. Overall, this thesis positions politic powers operate through the economic, health care, social and mobility apparatuses to influence and shape reproductive (in)abilities, which in turn construct and shape their everyday lives, primarily self, familial and kinship relations.

CHAPTER IV: CONCEPTUAL FRAMEWORK

1. Settler Colonialism and the Elimination of the Native

In 2011, the first issue of the journal *Settler Colonial Studies* was published in an open access format by way of volunteer labour; however, within two years of its publication, the journal moved to the international academic publisher Taylor & Francis (Edmonds and Carey, 2013). The journal's publication coupled with and, in particular, its move institutionalised settler colonialism as a field of study.

In this first issue, one of the burgeoning scholars in the field of settler colonialism, Lorenzo Veracini (2011), eloquently differentiates the concept of settler colonialism from colonialism. The latter Veracini explains is defined by exogenous domination that is determined to exploit and subordinate the colonised people, while the former seeks to set up an independent nation and erase the Indigenous people from the land. Similarly, Barker (2012) describes settler colonialism as 'a distinct method of colonising involving the creation and consumption of a whole array of spaces by settler collectives that claim and transform places through the exercise of their sovereign capacity'.

A means of exercising their sovereign capacity to create and consume spaces, Wolfe (2006) argues is through settlers' belief that there needs to be a requisite to deployment of actions and policies by settlers towards the elimination of the Natives as necessary for their colonies' survival. Native elimination is necessary not for racial reason but for territoriality as '[l]and is life–or, at least, land is necessary for life. Thus contests for land can be – indeed, often are – contests for life' (Wolfe, 2006: 387). The necessity of native elimination also stems from the predominant perception of settler colonies that there is no envisioning of the settlers ever returning to their countries of origin; rather, they transform the new colony into their "home" (Glenn, 2015: 55).

The tactics carried out to eliminate the Indigenous population are justified by the fears of the settler population and 'on the basis of the expectation for its [settler colonialism's] future demise' (Veracini, 2011: 3). This allows for the preservation of the settlers and their ability 'to stay' (Wolfe, 1999). In this understanding, not only is staying the goal of the settlers, but they also seek 'to make [themselves] seem natural, without origin (and without end), and inevitable' (Veracini, 2011: 3). This involves the elimination of the Native/Indigenous societies in order to replace them, as well as the claim of settler indigeneity to the land. Through native elimination is the formation of *settler common sense*, which is used to describe 'the ways the legal and political structures that enable non-native access to Indigenous territories come to be lived as given, as simply the unmarked, generic conditions of possibility for occupancy, association, history, and personhood' (Rifkin, 2014: xvi).

Settler colonialism is, therefore, a specific political formation consisting of processes that require different means for the colony to ultimately acquire a 'final "settled" status', which include a demand for the disappearance of the Indigenous people in the 'settled' land, a goal completely different from those of colonialism. In their uniqueness, settler colonial societies implement different policies and actions that may be similar to colonialism in some respects, but in turn provide different outcomes.

The settler colonial outcome follows Wolfe's (2006) logic of elimination theory, which extends to incorporate the the structural processes of settler colonialism framing the invasion of the settler colony not as an event but rather as a structure. The elimination process is carried out

through multiple ongoing explicit and implicit tactics. These tactics may include, yet are not limited to, genocide of the Native population. Wolfe states that 'settler colonialism does not simply replace native society *tout court*. Rather, the process of replacement maintains the refractory imprint of the native counter-claim' (ibid.: 389). This process of elimination for the means of replacement is coordinated through a 'comprehensive range of agencies, from the metropolitan centre to the frontier encampment' (ibid.: 393).

Kauanui (2016) expresses native elimination as not solely the physical elimination of the body but also the cultural 'elimination of the native as *native*'. As Zaragocin (2018) explains,

> Death embedded and embodied through territory is what the settler colonialism's logic of elimination evokes… where territory invariably is tied to processes of elimination understood as territorial processes that result in racialised, gendered and sexualised death in both physical and cultural registrars (Zaragocin, 2018: 388).

Meanwhile, Svirsky and Ben-Arie (2019) also complicate the concept of native elimination by referring to native elimination conducted by Zionism as 'double elimination'. The authors argue that eliminating natives from the land they are on is not the only form of elimination as 'rather a crucial aspect of elimination was conducted through racialisation and erasing the established ways of life between Arab-Jewish shared life. As Arabs and Jews maintained a shared way of life, early Zionism established

> [t]he engineering of racial Jewish enclaves meant that not only the Arab natives could not reproduce their ways of life as in the past, nor could Arabs and Oriental Jews continue their shared everyday practices…
>
> The dispossession and displacement of the Arabs of Palestine became a necessary but insufficient condition in the Zionist settler project. Arab–Jewish shared life had to go as much as the Arabs of Palestine had to go. From the viewpoint of the present, Arab life in Palestine has been placed under never-ending siege and destruction by the settler colonial machines of the State of Israel, and Arab–Jewish shared life has been made to disappear. Zionism is founded on a double elimination (Svirsky and Ben-Arie, 2019: 483).

Zionist destruction of Arab-Jewish shared life and the construction of the settler identity through a racialisation process is argued to be a necessary prerequisite for the success of Zionism.

These tactics of native elimination are a result of settler colonies implementing engendered logics, tenets and identities that formulate and shape race, gender, class and sexual formation (Glenn, 2015). Likewise, Snelgrove, Dhamoon and Corntassel (2014) frame the conceptualisation of settler colonialism as

> intrinsically shaped by and shaping interactive relations of coloniality, racism, gender, class, sexuality and desire, capitalism, and ableism. This multi-dimensional understanding of settler colonialism enables specificity in the ways to which place, culture, and relations of power are approached; reflects the ways in which the State has governed subjects differently; and emphasizes that the disruption of settler colonialism necessitates the disruption of intersecting forces of power colonialism, heteropatriarchy and capitalism' (Snelgrove, Dhamoon and Corntassel, 2014: 2).

These everyday embedded tactics of native elimination and settler colonial structural processes create a permanent and on-going process (see, Glenn, 2015; Bateman and Pilkington, 2011; and, Wolfe, 2006).

Settler colonialism operates through *external* colonisation meaning the expropriation of Indigenous resources such as lands and animals to create capital for the settlers typically through the means of military operations (Tuck and Yang, 2012: 4) It also operates in the form of *internal* colonialism meaning the 'biopolitical and geopolitical management of people, land, flora and fauna' through

> modes of control, imprisonment, and involuntary transport of the human beings across borders - ghettos, their policing, their economic divestiture, and their dislocatability - are at work to authorize the metropole and conscribe her periphery. Strategies of internal colonialism, such as segregation, divestment, surveillance, and criminalization, are both structural and interpersonal (ibid: 5).

Settler colonialism modes of *internal* colonialism are inherently eliminatory but not necessarily genocidal (Wolfe, 2006), necessitating an understanding of the modes through which this elimination process is conducted.

Thus, the utilisation of the concept of settler colonialism as summed up as an ongoing structure, not a historical event provides a framework to analyse the on-going realities faced by Indigenous peoples in settler colonies. As the settled land is envisioned to be populated with only the settlers through the strategic coordination of eliminating the Native population it results in the disappearance of the Native population to varying degrees across settler colonial contexts, whilst the remaining population undergoes a cultural, economic and political subordination (Lloyd and Pulido, 2010: 797). The following critical concepts highlight the perspectives of settler colonialism as a biopolitical, gendered and permeating structure influencing the everyday life of Indigenous peoples. Also, section three discusses the importance of utilising Native feminist theory within the framework of settler colonialism to ensure the demarginalisation of Indigenous peoples and scholars. These concepts will be utilised throughout this research as a framework to analyse the implications of settler colonialism on the everyday lives of Palestinian women from the macro-level (part two) to the micro-level (part three). The final portion of this chapter will include a brief discussion on why I chose to utilised the concepts of indigeneity and occupation in this research.

2. The Biopolitics of Intimacy, Race and Population

To grasp the embedded nature of settler colonialism's biopolitical tactics in indigenous peoples' everyday lives, it is pivotal to not only understand what is biopolitcs but also its effects on the intimate, race and population. This framework is imperative to the conceptualisation of political infertility, which will be explored in the Palestinian case study.

The doyen of biopolitics, Michael Foucault, defines it as government's 'power to "make" live and "let" die' Foucault (2003: 241). Anthropologist Ann Stoler considers biopolitics as an 'analytical tool for asking grounded questions about whose bodies and selves were made vulnerable, when, why, and how—and whose were not' (Stoler, 2006a: 14). Biopolitics is operated through biopower, which according to Foucault, is essentially racist. Foucault posits race as an 'indispensable precondition' granting the state power to kill arguing that '[o]nce the State functions in the biopower mode, racism alone can justify the murderous function of the State' (Foucault, 2003: 256). Foucault goes on to clarify,

> [w]hen I say "killing," I obviously do not mean simply murder as such, but also every form of indirect murder: the fact of exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on (Foucault, 2003: 256).

In settler colonies, biopolitics provided settlers the ability to utilise modes of biopower to decrease the Indigenous population. Similar to Foucault, Wolfe's logic of elimination as not inherently genocidal is implemented in the indirect forms of murder. This type of killing is present in the removal of Native Americans from their lands and the expulsion of Palestinians from theirs (see, Salaita, 2016).

In his earlier work, Foucault states '[i]f genocide is indeed the dream of modern powers, this is not because of a recent return of the ancient right to kill; it is because power is situated and exercised at the level of life, the species, the race, and the large-scale phenomena of population' (Foucault, 1978: 137). This infiltration of power and the right to 'kill' by settler colonial entities is not only powerful because it is embedded and institutionalised, but because the body is the most personal and intimate realm of self, thus making it the easiest target as a site for inscription of power and encoding culture (Peteet, 1994: 32). This provides the basis by which settler colonial entities utilise biopolitics as common practices, and operate through 'extreme forms of human suffering and injustices' (Lloyd and Pulido, 2010: 796).

Violence removes the barrier between the public and private, therefore, causing there to be no private spaces. Consequently, domains of the intimate become a strategic site for colonial power as well as for understanding how colonialism operates. Stoler, one of the most prominent anthropologists on empire and the intimate, explains the domains of the intimate as

> 'strategic for exploring two related but often discretely understood sources of colonial control: one that works through the requisition of *bodies* – those of both colonials and colonized – and a second that molds new "structures of feelings" – new habits of heart and mind that enable those categories of difference and subject formation' (Stoler, 2006a: 2, italics in original)

As an example, Stoler explores the racial affiliations used by the colonialists to bar the colonized from citizenship, marriage and mobility as is present in "mixed-blood" or "half caste" Indigenous peoples for whom 'a demonstrated disaffection for one's native culture and native mother were critical gatekeeping criteria for European membership' (ibid.: 3).

In another piece, Stoler asserts 'it was in the gendered and racialized intimacies of the everyday that women, men, and children were turned into subjects of particular kinds' (Stoler, 2006b: 57). This is echoed in the historical research carried out by Margaret Jacobs (2009) locating the forcible removal of Indigenous children form their families and into institutions in the US and Australia led to them being handled as 'inmates' as a means of colonising their bodies (ibid.). The targeting of children in Australia through the child removal policies are settler colonial methods of cultural genocide (van Krieken, 2004).

The utilisation of children to implement biopolitics as a means to diminish Indigenous peoples' futures in intimate spheres is not new to settler colonialism neither is it a one-time event limited to Australia. Shalhoub-Kevorkian (2019) exposes Israel utilisation of biopolitical practices including military occupation towards Palestinian children. These practices are arguably a means to govern and transform children's intimate spaces of childhood. This transformation is conceptualised by Shalhoub-Kevorkian as a method of 'unchilding', which is defined as a 'form of war that aims to annihilate the future generation of the Native' (Shalhoub-Kevorkian, 2019: 17).

Subsequent to childhood being manipulated for settler colonial end goals, adulthood, particularly marriage is also manipulated. Racialized governance of the intimate is maintained by seeping into 'the details of the everyday–who bedded and wedded with whom, where, and

when' (Stoler, 2016: 314). These non-discrete forms of sexual political governance operate 'in the slippage between sexuality, intimacy, and bodily care where biopolitical interventions find their support and quotidian force' (ibid.: 310). This is clearly portrayed in Israel's marital policies towards Palestinian that make it increasingly difficult for Palestinians within Israel to marry Palestinians from the oPt often forcing them to live in overcrowded towns like Kufr 'Aqab just to be together or causing each spouse to live in separate areas, which is done strategically to ensure Palestinians from the oPt do not take up residency in Israel as well as to create a case for Palestinians from Israel who decide to live in the oPt with their spouse to have their Jerusalem residency permit or, at times, their Israeli citizenship revoked (see, Hammoudeh, Hamayel and Welchman, 2016).

Stoler views these types of colonial intimacies as taking on 'directly destructive and ruinous forms' to 'ensure that no place is safe; the familiar is treacherous; and no place is home' (Stoler, 2016: 327). Reviewing Israel's measure onto the Palestinian people, Stoler states there is a 'wider berth of intimate encounters predicated on humiliation, trespass, and intrusion–the sort that checkpoint, strip searches, interrogations, and midnight raids on homes foist on those subject to them. These are part of the modern apparatus of colonial governance' (Stoler, 2016: 328). These measures, particularly checkpoints, inclusive with the previously discussed policies of Palestinian marriages creates the prohibition of contact, which Stoler examines in the case of Algeria as '[s]hattered possibilities to bear a child' (ibid.: 322). These shattered possibilities will be revisited in this chapter as a form of political infertility.

Colonial security measures that lead to the shattered possibilities to bear a child are not coincidental. Rather, as positioned by Foucault in *The History of Sexuality* (1978), sexuality is a biopolitical governmentality in effect. It is positioned at 'the pivot of the two axes along which developed the entire political technology of life' overlapping with the disciplining of the body and the regulation of populations promoting 'an entire micro-power concerned with the body' fostered through 'comprehensive measures, statistical assessments, and interventions aimed at the entire social body or at groups taken as a whole' (ibid.: 145, 146). As a result, 'sex became a crucial target of a power organized around the management of life rather than the menace of death' (ibid.: 147).

Furthermore, in *Society Must Be Defended*, Foucault (2003) defines biopolitics as 'deal[ing] with the population, with the population as political problem, as a problem that is at once scientific and political, as a biological problem and as power's problem' (ibid.: 245) A central concern of a colonial power becomes the surveillance and regulation of not only sexuality but also fertility and reproduction. This concern gave rise to the emergence of demographers, natalist policies and interventions into birth rates (ibid.: 243).

Historically, biopolitics and the concept of racial reproduction have been employed by colonial powers as a means to gain power and advance politically. For instance, in the United States after the Reconstruction Era and throughout the Progressive Era, the politics of racial value was actively used through culture, medicine and literature, to encourage white women to produce and 'mother the race' (Berg, 2002). President Theodore Roosevelt at the time asserted in his annual message to Congress in 1906 that the 'chastised middle-class, white American women' and their 'wilful sterility', are 'the one sin for which the penalty is national death, race death' (ibid.: 1).

Contemporarily, a state's ability to maintain its ethnic population, statistically, aside from migration, is for every woman to have two or more children (Therborn, 2004: 229). Therefore,

several states implement governmental programs to incite a racial drive encouraging reproduction and birthing children. In Germany, for example, national tensions and body politics due to the ever growing population of non-ethnic Germans, particularly Turks, are the reason ethnic Germans are being pressured by the government to undergo reproductive treatments at no cost Turks (Vanderlinden, 2009). However, Rubinstein and Lane (2002) note that populations are also manipulated in ethnic conflicts through a range of practices, inclusive of mass killing to the ideological encouragement of sterilization. These practices along with a lengthier discussion on colonial power's, in this case settler colonial power's, to utilise biopolitics as a method to manipulate population through racial reproduction will be discussed later in this chapter. Overall, biopolitics plays a pivotal role in the domains of the intimate, racial hierarchies, reproductive (in)abilities and the demographic character of a settler colony.

3. Gender and Native Feminist Theory

Biopolitics circles around the conduction of tactics through hierarchy and restructuring Indigenous social interactions through laws and governmental acts. This then has a ripple effect on the gender relations within the Indigenous societies. Once gendered relations are restructured or at least reformulated for the settlers' purpose, there is bound to be a change in daily life for the Indigenous person.

This permeation of settler colonialism in daily life follows Glenn's (2015) notion of settler colonists as not only implementing laws, but also utilising race and gender to create a hierarchy allowing for the ability to make Indigenous peoples less than human and justifying 'dispossessing them and rendering them expendable and/or invisible'. In this understanding, it is evident that 'the logic, tenets, and identities engendered by settler colonialism persist and continue to shape race, gender, class, and sexual formations into the present' (ibid.: 55). These formations, as well as the subordination of Indigenous culture, economics, politics and self, consequently permeate all levels of society.

A number of studies have investigated the effects of settler colonialism on the lives of women. Due to the social construction of women, Moane, as well as Bahun and Rajan, provide a more psychological analysis of conflicts and politics. Moane (2010) discusses the roles of women as varying within every society, but becoming increasingly complex in territories of conflict where oppressive social conditions impact women and in turn feed into an 'internalized oppression', hindering their daily lives through the interconnected nature of psyche and society. Bahun and Rajan (2008) provide the perspective that the 'personal is political', which in turn creates a caveat for women, despite all psychological effects, to become a symbol of stability within the family as well as greater society, leading to the politicization of female bodies.

Although these are not issues specific to settler colonial contexts, these authors demonstrate that the negative effects are the result of settler colonialism's structure, inherently reflected in women's psyches. This reflection may be due to the surrounding violence, or the utilisation of a woman's body as being a tool for demographic politics. With this permeation and affects on the psyches of women, it is important to understand the concept of reproduction for this research.

Reproduction as a gender role is dependent on a person's locality, given their social relations and constructions. Malson and Swann (2003) place reproduction, in particular women's 'reproductive' bodies, as deserving of consideration as part of 'socio-historically specific, discursive constructions, rather than as "natural" referents about which we have more or less

accurate, liberating or oppressive knowledges' (ibid.: 192). Reproduction occupies a place in women's lives, and even if they do not reproduce they are inescapably defined by their non-reproductive status (ibid.: 192). In line with this, Janus (2013) argues that fertility is highly dependent on political factors.

These perspectives relate reproduction as a concept similar to gender, which is particular to the society. Therefore, being a woman does not necessarily make an individual a biological producer of another human being, but rather the term is part of a discourse through which societies seek to fulfil their wants and/or needs.

National reproduction is a concept that is used for political purposes, and in turn it signifies the use of female bodies as the particular reproducers. Yuval-Davis reflects on the particularities of societies framing women as being the producers of nations culturally, biologically and symbolically. Moreover, in settler societies, 'the call has been to "populate or perish"' (Yuval-Davis, 1997: 29). This call is often reflected in Indigenous societies as a counter tactic to the settler colonial tactics of elimination. Arvin, Tuck, and Morrill provide the claim that choosing to not have children amongst Indigenous peoples is not only seen as privileged choice, but also 'rehashing' settler colonial tactics of "no future" through the elimination of the Natives (Arvin, Tuck, and Morrill, 2013: 24).

The study of gender uncovers 'the ways in which all aspects of human society, culture and relationships are gendered' (Kandiyoti, 1996: 6). In gender analysis, there are imperative questions to be asked 'about a complex set of behaviours, social norms, systems of meaning, ways of thinking, and relationships that affect how we experience, understand, and represent ourselves as men and women' (Sharoni, 1995: 15).

Settler colonialism refers to the 'structure of a society', which is arguably an inherently gendered process of social and political formations that utilises heteropatriarchy and heteropaternalism, which are patriarchal and paternalist expressions reliant on constricted definitions of male/female binaries, to employ powerful and detrimental effects on Indigenous peoples (Arvin, Tuck, and Morrill, 2013). Morgensen (2012) states that settler colonialism and gender/sexuality are overwhelmingly co-constitutive, particularly with regards to the understanding of elimination of the Native as being a gendered and sexualised process; therefore, the theorisation of settler colonialism is incomplete if it does not investigate the social, political and economic structures as gendered.

Additionally, Smith (2007) relates that gender violence is introduced by settler colonial entities as a strategy against Indigenous communities. Native feminism challenges the conceptualisation of Indigenous sovereignty and the nation-state system of heteropatriarchy that in turn leads to a heteronormative gender binary system. Furthermore, 'private acts of violence are shaped by public, historical, and political circumstances' (Krebs and Olwan, 2012: 147). For instance, the suffering of physical violence by Israeli soldiers against Palestinian boys' bodies, was commonly referred to in Palestinian society in heroic terms, providing a rite of passage to manhood which in turn led to the reproduction of men's authority and physical domination in the Palestinian family (Peteet, 1994). Therefore, the utilisation of sexual, gendered and racial power by settlers onto Indigenous peoples creates as well as naturalises hierarchies (Smith, 2005).

However, Peteet (1994) conveys that Israel has been constantly attentive to changes in Palestinian cultural categories and social relations, realising the ways applying bodily violence and imprisonment have led to the empowerment of resistance. As a counter measure, Israel has

changed their interrogation procedures to include sexual practices, which thus thwart the agency of physical violence forming a rite of passage to masculinity, and causing rape as a form of interrogation not discussable among young men who return from prison, given that it violates the most intimate realm of gendered selfhood.

Additionally, Katrak (1996) argues that the 'political' aspects of colonised states have

> not only an obvious and narrowly political dimension in terms, for instance, of economic exploitation, but also include, particularly for women, the arena of sexual politics, and other issues where the personal is the political. Politics does not entail a narrow definition of participation in government. Politics is the stuff of women's daily lives and resistances to their oppressions conducted at times from spaces like the kitchen, bedroom, classroom, and so on. (Katrak, 1996: 274)

With this understanding of a permeation of all levels of society and multifaceted 'politics', Native feminism provides the rationale to understanding the challenges faced by Indigenous peoples with regards to their gender identity.

Indigenous women feel as though mainstream feminism marginalises or eliminates their voices from discussion. These women situate mainstream feminism as including the assumption that an Indigenous woman should identify with her gender first, while identities such as race and indigeneity come second (Arvin, Tuck, and Morrill, 2013: 17). Despite this, very few models of gender and women's studies factor in settler colonialism, and its effects as a structure rather than a secondary factor or part of history (Morgensen, 2012, see also Glenn, 2015). Moreover, Indigenous women argue that mainstream feminism conflicts with self-determination and sovereignty, and therefore the utilisation of the theory of Native feminism is better suited as it provides Indigenous peoples voices within feminism, without disregarding and rather providing a means for self-determination, liberation and the creation of a nation-state (Smith and Kauanui, 2008; see also Simpson, 2016).

Nonetheless, Indigenous women's experiences and intellectual contributions to gender studies have not been marginalised, but rather have been at the centre, albeit invisible and hidden under the framework of gendered logics and settler colonialism (Arvin, Tuck, and Morrill, 2013: 14). This has led to the creation of Native feminist theory in the late twentieth century, for the primary focus of decolonisation in colonial settings. Smith (2008) positions Native feminists as not only critical of the nation-state, but also of the logics of heteropatriarchy, explaining that,

> when colonists first came to this land, they saw the necessity of instilling patriarchy in Native communities, because they realized that indigenous peoples would not accept colonial domination if their own indigenous societies were not structured on the basis of social hierarchy. Patriarchy in turn rests on a binary gender system; hence it is not a coincidence that colonizers also targeted indigenous peoples who did not t within this binary model. In addition, gender violence is a primary tool of colonialism and white supremacy. Colonizers did not just kill off indigenous peoples in this land, but Native massacres were always accompanied by sexual mutilation and rape […] the goal of colonialism is not just to kill colonized peoples, but also to destroy their sense of being people. It is through sexual violence that a colonizing group attempts to render a colonized peoples as inherently rapable, their lands inherently invadable, and their resources inherently extractable (ibid.: 313).

Moving forward from Smith's positionality of Native feminism as a post-colonial discourse, scholars are presently utilising the theory within the conceptualisation of settler colonialism,

highlighting that '[i]ndigenous elimination manifestly proceeds through settler regulation of sexual relations, gender identity, marriage, reproduction, and genealogy, and all similar means for restricting resistant indigenous national difference' (Morgensen, 2012). Additionally, Simpson (2016) argues that settler colonial projects make it difficult for Indigenous peoples, particularly women, to locate their bodies and self within one specific norm, due to their being subject to settler colonial processes and practices.

Moreover, Macoun and Strakosch (2013) argue that the present field of settler colonialism is conducted through a primarily settler framework, which marginalises Indigenous voices (see also, Snelgrove, Dhamoon and Corntassel, 2014). As such, the newly formulated Native feminist theory departs from discussions of colonialism to settler colonialism, seeking to understand contemporary gender and race issues within Native societies as a tool for decolonisation (Smith, 2007). Thus, Morgensen (2012) urges contributors to settler colonial studies to build a space wherein gender is not a secondary or additive phenomena separate from settler colonialism, but rather to consider gender and settler colonialism as profoundly co-constitutive.

As such, the utilisation of Native feminist theories offers a new way of thinking about the impacts settler colonialism has on Indigenous and settler communities through compound issues of gender, sexuality, race, indignity, and nation (Arvin, Tuck, and Morrill, 2013). It provides 'valuable insights and analyses for gender and women's studies, yet are subject to conceptual and spatial erasures […] precisely because settler colonialism as a contemporary social order and structure has been invisibilized' (ibid.: 13; see also Veracini, 2010). Furthermore, Native feminists seek not to discuss these issues, particularly 'nation' and 'gender', as separate, or the liberation/decolonisation of the nation as the primary goal while gender takes a backseat until this goal is complete. Overall, Native feminist theory creates a platform for Indigenous women to discuss their prospectives not isolated from the liberation process, but rather as very much intertwined with the decolonisation of settler colonies.

4. The Case Study of Palestine

The case study of Palestine is well-suited to provide an analysis of infertility within a settler colonial setting. It provides an example for tracing demographics and evolving biopolitical policies, particularly towards (in)fertility, and potential for understanding infertility among Indigenous peoples. While, of course, not representative of other Indigenous populations, the Palestine case nevertheless constitutes a critical and imperative example that could offer alternative perspectives and raise new questions relevant for other settler colonial contexts. This section will briefly discuss (in)fertility in the oPt as well as three inextricably interconnected factors that affect the lives of infertile women in the oPt: settler colonialism, gender relations, and the post-Oslo situation.

4.1. Biopolitics on (in)fertility

In Kanaaneh's opening chapter to her imperative discussion on Palestinian women's reproductive and body politics in Israel, she reflects on the *Nakba*[13], the 'catastrophe', in 1948 as 'a watershed year, after which everything changed' (Kanaaneh, 2002: 7). The *Nakba* reflects

[13] Rouhana and Sabbagh-Khoury (2019) discuss the silencing of the *Nakba* until the mid-1990s as a result of Israel's settler colonial policies.

the actions of the Zionist forces as they expelled over half of the Native Palestinian population (nearly 750,000 people) and destroyed over 500 villages (see, Khalidi, 1988; Masalha, 1992; and, Pappé, 1992). This time period, however, is not an isolated event in history. Rather, it was the beginning stages of the Zionist settler colonial project[14] of Native elimination and continues to have rippling effects.

Meanwhile, Zinngrebe positions Palestinian women's bodies as the 'the primary targets of Zionist violence' since the *Nakba* as their bodies are 'threatening' given 'their ability to reproduce future generations of the indigenous nation' (Zinngrebe, 2019: 124). Accordingly, women's experiences of infertility in the oPt cannot be isolated from the geo-political context of the area. Below I briefly discuss how the geographic and political context of Zionism, and its utilisation of biopolitics, relates to the experience of everyday life in the oPt. As this research focuses on the oPt, I will review the literature pertaining to the beginning of settler colonialism in Palestine to the current situation of Israel's military occupation in the oPt.

Almost twenty years after the *Nakba*, Israel militarily occupied the West Bank and the Gaza Strip in 1967 (Gordon, 2008) causing political, economical and social effects that are elaborated on in following chapter. This territorial expansion into the oPt caused it also to become a site of settler colonialism. Israel's military rule has led to the oppression of Palestinians through 'unelaborated exercise of force', leading them to become dispensable and the oPt to become 'less like Bantustans and more and more like reservations (or, for that matter, like the Warsaw Ghetto)', in which '[p]orous borders do not offer a way out' (Wolfe, 2006: 404).

Zionism is 'an expansionist settler-colonial project based on the ethnic cleansing of the native population' (Salih and Richter-Devroe, 2018: 2). In order to reach the goal of Palestinian elimination, Zionist settler colonial practices and policies are embedded in a political, social and economic structure, which in turn influences the everyday life of the Indigenous Palestinian population, conditioning all aspects of their political, economic and cultural practices, particularly through biopolitical practices and policies. Settler colonialists have the ability to utilise race and gender to create a hierarchy that makes Indigenous peoples less than human, and justifies 'dispossessing them and rendering them expendable and/or invisible' (Glenn, 2015: 58).

Similarly, Zionism defines and outlines the geographical measures and ease of livelihood for Palestinians. This follows Fanon's (1963) argument of the materialisation and formulation of colonisation through violent structures as a means to acquire spatiality of territory, and the fear of Indigenous peoples encroaching on the colonised/settler territory. Accordingly, Zureik (2001) argues that '[l]and and demography are at the heart of the Palestinian-Israeli conflict' (Zureik, 2001: 227).

A range of measures have caused every part of Palestinian people's lives to be intertwined with Zionist policies, for instance, drawing on Agamben's theory of biopolitics, the camp settings of compartmentalisation and restricted daily life. Israel compartmentalises Palestine 'in closed enclaves […] being an extended concentration camp', and its control over Palestinians' 'time, water, electricity, and their economy' is a deliberate effort to de-develop Palestine,

[14] On the question of Zionism as a settler colonial project, see Abdo and Yuval-Davis, 1995; Veracini, 2006; Makdisi, 2011; and Lloyd, 2012.

demonstrating the 'racialized character of the Palestinian body, a body that is denied rights or liberties, and the 'legitimized' policies directed towards that body' (Shalhoub-Kevorkian, 2009: 117).[15] It is this type of colonial military power that 'carves its strength and inscribes its boundaries on the most personal realms of individual women's lives, bodies, families, sexuality, homes, spaces, and gender relations' (ibid.: 2).

Likewise, Peteet (1994) references the violence on Palestinian bodies:

> The daily inscription of power on the unwilling bodies of Palestinians, almost a routine occurrence, is an attempt to embed power in them as a means of fashioning a domesticated subject whose terrorized silence would confirm the mythical Zionist landscape of an empty Palestine. Through bodily violence, the occupier desires not just to fashion a labourer but equally to assure a quiescent population, one sufficiently terrorized so as not to engaged in acts of rebellion […] The walking embodiment of power, the Israeli soldier, totes the modern technology of violence–automatic rifle, pistol, grenade, hand-cuffs, tear-gas canisters, and batons (ibid.: 33, 36).

This bodily violence was illustrated in the January 2009 assault on Gaza, named Operation Cast Lead, during which Israeli forces killed over 1,400 Palestinians, of which more than 1,100 were civilians (Lloyd and Pulido, 2010: 795). The ultimate rationalisation of this assault, and many others, was on the basis that Israel is a "civilized" nation and as such is normal conduct this idea is embedded in Orientalist ideologies of Israel 'transforming the desert into a garden' (Lloyd and Pulido, 2010: 795). After Operation Cast Lead, Israeli soldiers designed and distributed t-shirts with an image of a pregnant Palestinian women in the crosshairs of a gun, with the phrase "one shot, two kills" (Vertommen, 2017a: 210).

Palestinians undergo direct and indirect threats to their survival as well as the well-being of their psychological and social security. Direct threats include gunfire or home demolition, while indirect threats include economic restrictions which lead to widespread poverty (Batniji et al., 2009). Indirect threats stem from geospatial fragmentations and constrictions inclusive of an 'interlocking web of checkpoint, barriers, border closures, curfews, and the permit system imposed by Israel' (Batniji et al., 2009: 1138; see also Parizot, 2017 and Peteet, 2018). Israeli acts of military occupation are the strongest and most unanimous characteristic of Palestinian daily life, and have a severely negative influence on the quality of their life (Giacaman et al., 2007).

These threats and systematic violence are utilised by settlers as a method to silence Indigenous identities and cripple their well-being. Discussing settler violence within the context of the the Canadian government's attempts to reconcile with Natives, Simpson states

> Force qualified as violence moves through us, trying to empty us out, transiting through moving to the flesh that is the subsurface of "identity" as peoples possessing bodies with living histories of relatedness to territory that is constantly being violated, harmed, ignored – allowing some of us to be devalued to the point where we are denied bodily integrity, denied philosophical integrity, flattened, sometimes killed (Simpson, 2016: 25-26).

---

[15] Literature on Palestinians within Israel is also utilised in this study, as settler colonialism affects all indigenous peoples within historic Palestine, and the tactics used by Zionist settler colonialism, as well as the political boundaries set by it, are arguably porous (Kanaaneh, 2002, 256).

Therefore, Simpson considers settler violence as 'historical, bodily and heuristic violence' that is 'impossible to forget let alone forgive' (ibid.: 26).

Inclusive in violence, settler laws are also meant to define and control indigeneity by 'distort[ing] and disrupt[ing] older Indigenous ways of identifying the self in relation not only to collective identity but also to the land' (Lawrence, 2003: 4; see also, Morgensen, 2011). Take the case of Israel's Citizenship Law, which

> bars residency or citizenship to Palestinians from the occupied territories who become spouse to Israeli citizens (Palestinians or otherwise), thereby attempting to police state borders and Palestinian ties through marriage. For this law conforms to more constitutive settler-colonial efforts to produce Israel as a racial state by denying Palestinians the right of return: a denial that reclassifies refugee descendants as subjects of foreign governments, thereby pre-empting land claims that would be defensible by invoking the integrity of Palestinian familial ties and descent (Morgensen, 2012: 11).

This stripping away of Indigenous identity and association with the land, coupled with bodily violence, are exploited by Zionist biopolitical policies to disrupt the everyday lives of Palestinians. The following section will discuss this disruption in relation to its influence on gender and reproduction. Thereafter, a more detailed examination of the oPt will be made within the framework of the post-Oslo period.

4.2. Post-Oslo Era

This research situates itself within the post-Oslo period, which for Palestinians has been characterised by particular oppression, poverty and deprivation. This section will briefly discuss the Oslo Accords, focusing primarily on the status of the oPt post-Oslo. A more expansive analysis with particular regards to the economic state will be discussed in part two of this thesis.

The 1993 Oslo Accords were meant to acknowledge the demands for statehood by the Palestinian Liberation Organisation, through the creation of the Palestinian Authority (hereafter, PA) in allegedly autonomous regions of the West Bank and Gaza Strip, with the hope of a future final settlement for the Palestinian question (Kawar, 1998: 233). In its quest for a final settlement, the PA built 'interim' systems, as the agreement stated that a final settlement would be achieved in five years (Wick, 2011: 536).

In reality, the Oslo Accords transferred powers and the responsibility for welfare, from Israel as the occupying force, to the PA. Turner describes the new role of the PA as a 'non-sovereign entity whose existence is subject to continuous negotiations with its occupier, Israel, *and* with the donors', continuing 'Israel's already-existing control over external borders and key factors of production (including land, water and the movement of labour) [which] did not deter Israel's practices of land grabbing and settlement expansion' (Turner, 2014: 39, 34). Therefore, in the post-Oslo era, Israel has deployed necropolitics, which are 'contemporary forms of subjugation of life to the power of death' (Mbembe, 2003: 39), as well as has outsourced part of its biopower 'of managing the population and producing governable subjects, to the Palestinian Authority' (Giacaman and Johnson, 2013: 57-58).[16]

[16] For more on the outsourcing of the occupation to the Palestinian population, see Gordon, 2008.

The understanding of the current post-Oslo era is crucial for this research, as the economic, social and political powers at play structure the everyday lives of Palestinian women. Since Oslo, the oPt has witnessed a more detrimental and prolonged form of occupation, which 'threatens the core structure of the social and economic system, and not merely its surface manifestations' (Abed, 2015: 8). The present Palestinian conditions 'are complex and protracted so much so that many Palestinians have lived all their lives as refugees, or have been subjected to living conditions intertwined with chronic conflict and periods of acute violent conflict' (Giacaman et al., 2004: 289).

Shalhoub-Kevorkian (2009) claims the PA 'failed to control political violence and began flexing its power in the Palestinian streets, and therefore needed the help and support of informal (family and tribal) religious, patriarchal power holders in order to preserve its limited power', therefore, leading to the 'increasing patriarchalization of the leadership (both formal and informal) and social practices [which] marginalized women's roles and voices, questioned the acts of women activists, and resulted in the creation of additional restrictions on women's lives, activism, and mobility' (ibid.: 16). Moreover, Hamas and paramilitary bands of young men were frustrated by the failings of the PA and international solutions that were causing even more human, political, and economic losses, and therefore began utilising religious and local methods to expand their political power (ibid.: 16).

Kawar (1998) argues that, given the lack of political parties in Palestine post-Oslo, women's activists moved from politics to NGOs which allowed them a platform. The Palestinian Legislative Council (PLC) and establishment of the PA became entities which women, although limited in number, had to utilise in order to influence future legislation and politics of gender roles. Nonetheless, Kawar also argues that the rise of Islamic movements impacted female activists by slowing down their progress and reinstalling conservative gender roles (ibid.: 234-235).

During a conversation I had with with the director of the organisation Juzoor for Health and Social Development, Dr. Salwa Najjab expressed,

> in the 1970s and 1980s, over half of the Palestinian population lived in villages. Many people went to Israel to work then returned home to their villages. However, in the present day, particularly after the formation of the PA, there has been an increase in urbanised areas. Cities have doubled in population due to Israeli checkpoints, the wall, and displacement. Families tend to be more nuclear, no more extended families living in close proximity like previously. Additionally, unemployment has increased and there are more slum-like areas. Also poverty leads people to undergo dangerous behaviour like drugs and violence.

All efforts post-Oslo have failed at improving conditions for Palestinians, and in general economic and political conditions have even worsened (Barber et al., 2014: 91). Furthermore, scholars consider that negotiations such as Oslo have been a tactic of settler colonialism (Krebs and Olwan, 2012: 150; see also Meari, 2015a). They are another method of constraining Indigenous peoples through the belief that their territory is under Indigenous governance, and that they have acquired sovereignty, when in reality it is another apparatus of colonial rule allowing for the continuation of previously present power structures (Morgensen, 2011: 64).

4.3. Statistics on in/fertility

In the oPt, during the time period of 1983-1994, there was a steady decline in fertility rates among the West Bank population. However, according to Marwan Khawaja, Chief of the

Demographic and Social Statistics section of the United Nation's Economic and Social Commission for Western Asia (UN-ESCWA) and one of the few scholars researching infertility in the oPt, this decline in fertility was not seen in the Gaza Strip; rather, fertility rates increased there due to early marriage being favoured during the First Intifada (Khawaja, 2003). At one point during this period, in 1991, the birth rate in Gaza was the highest ever recorded in Palestine's history, with on average eight children per women (Khawaja, 2000: 331). Although fertility levels are high among Palestinian women, they are beginning to decline everywhere but in Gaza due to the postponing of marriage and increase in the number of women remaining single (Khawaja, 2003). Subsequently, in 2014, according to the Palestinian Census Bureau of Statistics (hereafter, PCBS) (2017), the average fertility rate was 3.7 children per woman in the West Bank and 4.5 children per woman in the Gaza Strip.

Statistically, the higher the level of education a woman has, the less children she will have; however, this is not the case in the oPt. A recent decline in fertility rates is seen among the least the least educated women, while that for the most educated women has remained stable (Memmi and Du Loû, 2015: 290).

Accordingly, these high fertility rates are characterised as a 'demographic puzzle' when compared to other global context of women with similar positionalities of 'relatively high levels of female education, low levels of infant mortality, and high levels of urbanization' (Khawaja, 2000: 344). Frequently, this 'demographic puzzle' of high fertility levels and reproductive incentives is presented 'as either a threat to Israelis, or as a weapon of resistance by Palestinians', yet it must be taken into consideration that there are other reasons and considerations, such as the lack of state benefits in old age, leading to children functioning as a type of social security (Giacaman et al., 2008: 84).

Compared to fertility, infertility in the oPt has rarely been studied. According to a 2004 analysis by the Demographic and Health Survey, the OPT has an estimated 7% infertility rate, which effectively causes an estimated 56,000 women/couples to be impacted by a lack of fertility care, which is not 'a number that is not unimportant', yet, unfortunately, is under researched (Giacaman et al., 2008: 84, footnote #1).

Subsequent to this finding, a 2010 PCBS report revealed that out of every hundred married women, five of them reported primary infertility, resulting in the figures of 8.4% of women in the West Bank and 8.3% of women in Gaza married between the ages 15-49 being infertile, with primary infertility being at 4.5% in West Bank and 5.2% in Gaza, and secondary infertility being at 3.9% in West Bank and 3.1% in Gaza (Katwsa, 2013: 9).

4.4. Politics of Reproduction

As I sat around a kitchen table in my family friend's home in Jerusalem, a mother holding her one-month old baby walks into the room. One of the women asks, 'how was your doctor's [gynaecologist] appointment?' To which the new mother replied, 'it went great. The doctor offered and actually encouraged I put in an IUD[17]. I told him 'that's the reason I made this appointment''. A similar situation occurred two months later when I went to congratulate another Jerusalem-resident mother who gave birth a few weeks prior. She was discussing breastfeeding and how it is possible for a postpartum woman to get pregnant even while breastfeeding. She stated that her doctor offered her an IUD so she can prevent getting pregnant

[17] IUD is an intrauterine device inserted into a woman's uterus to prevent pregnancy.

and be able to breastfeed her son for at least a year. He suggested in two years she can plan another pregnancy but to take care of her new-born first.

As I sat around listening to the latter woman's story and its similarity with my previous encounter, I recalled Rhoda Kanaaneh's (2002) ground-breaking study on reproduction among Palestinians in Israel. In her book, she examines Israel's biopolitical practices to increase the Jewish population and decrease the Palestinian population by 'containing Palestinians and their fertility' include but are not limited to 'citizenship and immigration laws to population policy, land distribution and zoning, residential planning, municipal budget allocations, settlements, educational curricula, and data collection' (ibid.: 253, 252-253). Furthermore, she situates Furthermore, Israel's racialized differences in health services causing higher infant mortality rates for Arabs than Jews (ibid.: 74).

However, according to Kanaaneh, one of the main determinants in Israel's influence on Palestinian population and reproduction is family planning services. She examines Israel's intervention into the reproductive decisions of Palestinians through family planning services arguing that these services are aimed Palestinians. Correspondingly, a recent article by Hawari (2020) states Israel's Ministry of Health's family planning strategies are strategically located in Palestinian cities and villages providing 'medical services for women during pregnancy and postpartum but also provide contraceptive and family advice'.[18]

Unfortunately, this is not unique to Israel, family planning strategies to limit Indigenous populations is located in other settler colonies. The United State's Department of Health, Education, and Welfare circulated a pamphlet promoting sterilization to Indian communities depicting a sad Native American couple with ten children and only one horse besides a picture of a happy Native American couple with only one child and ten horses titled '*Plan Your Family*' insinuating the more children, the less economic prosperity and joy you will have (Ralstin-Lewis, 2005: 78). This pamphlet is evocative of a family planning pamphlet issued by the Israeli Ministry of Health depicting a happy, modern and Middle-class Palestinian family reading to their one child (Kanaaneh, 2002: 79).

Thomas Volscho (2010) relates the encroachment on reproductive rights, particularly sterilization, is embedded in '[t]he racists hierarchy of "whites" on the top and people of color on the bottom maps on to an ordering of reproductive rights. In this ordering, European American women are least likely to have external authorities (e.g., the state, reproductive healthcare providers) constraining their reproductive abilities, while women of color are most likely to have such institutions influencing their reproductive lives' (ibid.: 19). Volscho goes on to explain that racist controlling images of Native American women and African Americans during slavery led healthcare providers to 'constrain, minimize, or completely eliminate the reproductive activities of women of color' (ibid.: 20). Kanaaneh (2002) similarly discussed this racialized hierarchy in the family planning strategies by the Israeli government to reduce the number of Palestinian Arabs as well as of non-European Jews.

This racist hierarchy is echoed by Stoler as a result of '[s]ex in the colonies had to do with sexual access and reproduction, class distinctions and racial demarcations, nationalism and European identity–in different measure and not all at the same time', therefore, '[e]thnographies of empire should attend both to changing sensibilities and to sex, to racialized

[18] The original article is in Arabic; translation of the text is my own.

regimes that were realized on a macro and micro scale' (Stoler, 2010: 78). Meanwhile, Bahati Kuumba (2001) positions this 'conscious manipulation of women's reproductive capacity' onto coloured women as a process of 'reproductive imperialism' (ibid.: 22).

Until this day, Western, developed countries use biopolitics and the inaccurate notion of the world's overpopulation to encourage infertile couples in developing countries to accept their infertility instead of undergoing treatments (Ombelet et al., 2008). India is a prime example, with the United States and Britain pressuring the state to lower its birth rate, claiming that overpopulation is the root cause of poverty (Hodges, 2008). Also, the international demand to lower population in Pakistan is played out through biopolitics, with the use of religion as the biopower attempting to manipulate and decrease fertility rates (Varley, 2012).

Medical and technological biopolitics plays a key role in enacting a racist hierarchy. Stoler (1995) points to Foucault's unpublished lectures revealing that in them Foucault's understanding of racism is 'more than an ad hoc response to crisis; it is a manifestation of preserved possibilities, the expression of an underlying discourse of permanent social war, nurtured by the bio-political technologies of "incessant purification." Racism does not merely arise in moments of crisis, in sporadic cleansings. It is internal to the bio-political state, woven into the weft of the social body, threaded through its fabric' (Stoler, 1995: 69). Similarly, Dario Padovan (2003) feared with the globalisation of reproductive technologies as '[h]igh-tech means of procreation may magnify racial inequalities… The racial disparity in the use of new reproductive technologies might well alter the demographic composition of several countries' (ibid.: 492). This, as examined in the literature review, is precisely what has occurred. The medical field inclusive of family planning strategies and assisted reproduction, have created a world in which reproduction is manipulated. This has led scholars to 'call for consolidating the link between reproductive rights and political determinants of [reproductive health]' when researching 'contexts of colonialism and with communities experiencing systematic discrimination' (Hamayel, Hammoudeh and Welchman, 2017: S93).

Additionally, Ralstin-Lewis (2005) argues the necessity to position the curtailment of Indigenous women's reproductive rights as a continued act of genocide. This type of genocide follows Foucault's positionality of 'killing' as not being 'simply murders' rather methods of decreasing population for the settler colony to pursue what Wolfe theorised as the logic of elimination. Furthermore, as previously mentioned, these are as Stoler positions it '[s]hattered possibilities to bear a child' (Stoler, 2016: 322) through biopolitical strategies and as such should be conceptualised as political infertility.

4.5. Political Infertility

Settler colonialism is a form of politics with an ultimate goal of eliminating the native population, which, once again, is a logic defined by Wolfe. It is an ongoing structure that permeates and influences everyday life of Indigenous peoples. The policies that are formulated to achieve this goal have tenacious presents in many sites and in less obvious ways. Reproduction, particularly infertility, embodies a pivotal entry point to understand the micro and macro levels of settler colonial practices and policies.

Infertility is an imperative motive towards native elimination through a 'natural' process. This process, I argue, is conceptualised as political infertility. It allows the settler colony to keep its hands clean by implementing a structure and policies that decrease the native population. Take for instance, the case of New Zealand, settler societies sought to decrease the Indigenous Maori

community. Governmental policies were implemented onto the Indigenous Maori communities to reduce fertility rates (Glover, 2008). It was later discovered there was a natural increase in infertility cases among the Maori women in 1881, which settlers deemed a bonus for their settler society, as the Maori population was 'dying out in a quick, easy way, and are being supplanted by a superior race' (Moon, 2016: 53 quoting Newman, 1881: 477). Compared to, the case of the Sand Creek massacre by the U.S. Army onto the Native population, Cheyenne and Arapaho, Colonel John Chivington 'charged his followers to not only kill Native adults but to mutilate their reproductive organs and to kill their children because "nits make lice."' (Smith, 2010: 48).

The term political infertility should not be confused with political fertility. The latter is a term coined by Courbage, and defined as the situation 'when the normal factors which induce a drop in fertility, notably urbanization, industrialization, and the level of instruction, cease to operate. The well-being of family and of children becomes a secondary issue as compared to the higher interests of the Nation' (Courbage, 2011: 148). Hansson (2012) further describes it as the unusual pattern of high fertility in comparison with other populations, deriving from a political motive to reproduce. It is a term closely in relation to the concepts discussed in part one, including the politicization of motherhood and reproductive norms. Likewise, during our discussion, Dr. Najjab located political fertility in the context of Palestine:

> Political powers are using women to be more fertile for the political, Palestinian-Israeli conflict, which is in my point of view unethical. In a way it is not fair for the women, because having high numbers of children affects women's health, affects family health and child health. Particularly if there is no spacing between children. Additionally, mortality and morbidity at birth is higher when the mother has a lot of children, because when women have more children there is more chance for abnormal pregnancy and abnormal children. Complications these women face include more bleeding, more stillbirths, as well as complications related to eclampsia, to diabetes, to obesity and so on.

Meanwhile, political infertility is a concept defined by Berk (2014) as the inability to birth a child due to physical and non-physical/tangible barriers caused by political policies. This type of infertility is described as attempting to reinforce 'traditional or hegemonic masculinities and gender identities' resulting from Israel's power to define Palestinian identities. Yet, through resistance and countermeasures by Palestinians, it also 'allows us to diagnose Israeli power and demonstrates that Palestinians are defining their identities' (Berk, 2014: 8). Furthermore, Berk argues the necessity to move away from the exploration of a number of similar themes in biomedical studies of Palestinians' health, a limitation which obscures 'the broader political and power contexts in their sequestration of biomedical illness' (Berk, 2014: 19).

Berk's 'infertility' is 'political (as opposed to biomedical)' meaning she discusses political infertility as the physical/non-physical barriers erected by the political atmosphere inclusive of imprisonment and borders that prevent the act of sexual intercourse, which in turn causes the inability to biologically reproduce (Berk, 2014: 6).Cognizant of Berk's findings, this research expands the definition of political infertility to include biomedical infertility. It defines political infertility as the inability to conceive children due to physical and/or non-physical barriers as well as a result of the political atmosphere on the economy, which influences if a couple will be able to undergo ARTs, and the health care system, particularly reproductive health, which influences reproductive in/abilities .

Reproductive health is defined by the United Nations as:

> A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

This includes 'the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth' (Cook, Dickens and Fathalla 2003: 12 quoting UN. 1995). Reproductive health is integral to fertility, the ability to conceive and give birth to children. Furthermore, I include reproductive health as a political aspect due to its intertwined nature with economics, mobility, quality and quantity of health services, and environmental impacts in the oPt. Accordingly, I argue Palestinian's reproductive health is inherently political and a determinant of the Zionist structure imposed in the oPt, which the following sections will expand on. The structure of Zionism shapes the possibilities for Palestinian couples to achieve or not achieve pregnancy with subsequent healthy childbirths.

As noted by the women in this research, childbearing is possible if a person's has the economic capabilities to spend on fertility treatments, has access to proper reproductive health care and/or the ability to move freely. Political infertility does not necessarily imply a direct and deliberate correlation to physiological infertility. However, it does propose politically-driven strategies – in this case settler colonial strategies – such as biopolitics, through the shaping and structuring of prospective fertility by means such as a failing healthcare system, crippling economic restrictions and lack of manoeuvrability. Also, included in the following discussions on infertile persons are involuntarily childless women, women who are not necessarily physiologically 'infertile' but rather are prevented from having children due to social and/or material reasons (Letherby, 2002b: 278).

The case study of Palestine is well-suited to provide an analysis of political infertility within a settler colonial setting. It provides as an example for tracing demographics and evolving biopolitical policies, particularly towards in/fertility, and potentially for understanding the state of infertility among Indigenous peoples. While, of course, not representative of other Indigenous populations, the Palestine case of political infertility nevertheless constitutes a critical and imperative example that could offer alternative perspectives and raise new questions relevant for other settler colonial contexts.

5. Terminology

5.1. Indigenous/Native

Indigeneity is an important concept which comes into play when utilising settler colonialism as a theory framework. Where there are settler societies, of necessity there are also Indigenous societies. However, there is a debate with regards to the utilisation of the word Indigenous, with an often-preferred term being Native.

The term Indigenous is posited as being Indigenous to the land; however, it has been argued that the utilisation of a framework of indigeneity in the context of the oPt may lead to scholars becoming trapped in the Zionist narrative by falling into a temporal approach of "we were here first". As such, this temporal analysis may seem problematic, given its mirroring the Zionist narrative.

Nonetheless, the position of this research is that Zionism is a settler colonial project. As such, I subscribe to the understanding that settler and Indigenous people co-define each other, with the ideology of indigeneity being a reaction to settler colonial incursion. As Morgensen (2011) states, '"[s]ettler" literally signifies the displacement of Indigenous peoples' (ibid.: 59). Accordingly, indigeneity 'connotes belonging and originariness and deeply felt processes of attachment and identification, and thus it distinguishes "natives" from others' (Merlan, 2009: 304).

The term Native is situated by Pappé (2018) as 'a more neutral, static term that defines location and attachment, almost an ecological statement, of a group or a society', whilst Indigenous connotes 'an evolving position of empowerment and resilience against the discrimination and oppression of the natives' (ibid.: 162). The study of the latter concept allows for 'research[ing] communities through an understanding of the communities' own agenda' (ibid.: 162).

There are benefits to regarding Palestine studies within Indigenous studies. De-centring the hegemonic viewpoints is where indignity and Indigenous studies come in, and not merely accounting for or incorporating the experiences of those who are subject to settler colonial projects and those who are members of Indigenous nations, but fundamentally rethinking the whole set of assumptions through which we have created knowledge about settler colonialism.

Additionally, Indigenous ways of knowing and being have the capacity of actually sharpening the lens we have of settler colonialism, so, if gender and sexuality tell us something new but also very important about the way that settler colonialism proceeds, learning from their perspective makes us recognise that looking from a position of domination does not allow us to do. With this being understood, this research positions Palestinians as Indigenous peoples, although the terms Indigenous and Natives will be used interchangeably throughout this research.

5.2. Settler Colonialism/Occupation

This section explains the utilisation of the term occupation, and characterising the Palestinian territories as occupied territories in conjunction with a settler colonial paradigm. Abed (2015) situates the occupation as:

> Israel's occupation of the West Bank and Gaza, if the fundamental tenets of Zionist doctrine are to be believed, represents not a prolonged foray into alien territory, but the extension of Jewish control over the remainder of the 'land of Israel'. This has the effect of redefining the nature of the condition that governs the lives of the Palestinian people in Palestine as it clearly goes beyond the notion of occupation. It is uprootedness and dispossession. Furthermore, the concept of dispossession in this context needs to be understood not only in the narrow sense of rendering the population landless, in itself a grave enough form of dispossession, but in the broader meaning of robbing the affected population of the material basis to live and prosper as a community and further to deny this population the right and means to redress the grievances that arise as a result of this usurpation. Given that Israel's occupation has also sought to deny, restrict or expropriate the Palestinian people's own culture and symbols of national identification, the concept of dispossession takes on an even larger meaning in the circumstances (ibid.: 8-9).

For this research, settler colonialism is the main conceptual framework applied; however, there are varying nuances and policies embedded in the Zionist settler colony creating separation and fragmentation among the Indigenous population. One such policy is the occupation of Gaza

and the West Bank as a manifestation of the Zionist settler colonial project (see, Veracini, 2019). This follows the ability of settler colonial practices to redraw boundaries that are not just physical but also mental, creating an understanding of 'them' and 'us' within the Indigenous population. For instance, the separation of Gaza and the West Bank, as well as the separation of Palestinians within the oPt and Palestinians within Israel, has caused such mental boundaries.

Secondly, within interviews the Zionist forces were referred to as '*quwat al ihtilal*' or '*al-ihtilal*' meaning 'the forces of the occupation' or 'the occupation'. Appropriately, the occupation is not just an academic, analytical unit, it is also the way the interviewees relate to the reality in which they live.

Furthermore, I am of the opinion, as are others (e.g. Abdo and Yuval-Davis, 1995), that the situation in the oPt is not merely an occupation which started in 1967. Rather, this occupation is part of the general settler colonial condition in Palestine that creates these economic and social problems. These problems in turn create other problems inclusive of infertility, which has yet to be highlighted by research up to now. Infertility has its bearings on settler colonialism, given settler colonialism's strong impulse to downsize the Indigenous population.

6. Conclusion

This particular study on female infertility in the oPt was undertaken for various reasons inclusive of the lack of research on the lives of infertile Palestinians, as well as the lack of research on infertility among Indigenous populations in settler colonial settings. However, the presented literature revealed infertility to be a topic with potential for development in understanding, defining and examining further factors associated with it. Particularly within a settler colonial setting wherein an Indigenous woman's body can occupy multiple spaces that are seemingly in contest, which is part of the process and the structure of settler colonialism. Settler colonialism created the categories of the Indigenous, occupied and colonised. It decides who lives and who dies. It structures all aspects of daily life. It forces the individual to live in multiple spaces, such as the women in this research who navigate womanhood, infertility, colonised subjecthood and Indigeneity. Settler colonialism makes us rethink the ways of not just knowing but actually being, that we can and are occupying multifarious positions, which may be reconciled easily. Thus, 'our bodies exist in a social context that shapes and forms them as we interact with others', and 'no thorough examination of occupation and resistance for Palestinian women could gloss over or ignore bodies' (Ryan, 2015: 52, 53).

Accordingly, it is imperative to not downscale women's lives to only their infertility as they are living with a multitude of circumstances in their lives besides infertility. Infertility does not curtail them from facing other worldly and biological problems. As a general aspect of infertility, infertility in the occupied Palestinian territories intersects with class, gender, and the complex interplay of private and public, making it impossible to speak of a singular 'infertile' experience. The mere attempt to write about a singular infertile experience, will cause injustice to the multitude of various experiences amid infertile females. Nonetheless, regarding what binds cases of infertility in Palestine together and differentiates them from general cases of infertility, the oPt bears the mark of Israel's settler colonialist agenda. Thus, these two themes of infertility and settler colonialism overlap and affect the daily lives of infertile Palestinian women in a distinctive way. This provides a dual struggle, of battling the settler colonialist regime on one hand and the typical forces facing infertile women worldwide on the other.

Furthermore, setting the research in the oPt provides a suitable context in which to examine the research aims. With the factors of demographic anxieties, high fertility rates and biopolitics, the oPt is a potentially insightful study area in which to consider the themes highlighted in the literature review, as well as issues such as the importance of children, the (in)ability to receive treatments, divorce and polygyny and the role of the extended family, as well as the influences of the settler colony.

In the literature review, infertility was observed as being intertwined within the political, societal and economical barriers that in turn provide a person with the in/ability to overcome their infertility, as well as being the causation of their infertile status. Infertility as a concept allows for a more critical perspective on everyday relations of biology with the political atmosphere which in turn make up the economic, social and healthcare systems. This chapter addresses the theory of settler colonialism as an ongoing structure defined by an inherently eliminatory process.

Within this structure are the formation of biopolitical practices, which presume who lives and who dies; the implementation of a gendered social structure as a means to subordinate the Indigenous population, which is brought into question by Native feminist scholars; and the permeation of daily Indigenous life on a social, economic and theoretical basis, creating the conceptualisation of notions such as reproduction. As such, a gendered analysis of settler colonial practices and their effects is crucial for understanding how settler colonialism is embedded in social, political, economic and cultural contexts. As a result of the utilisation of these theories and concepts, the dynamics of infertility among Palestinian women will be examined.

This thesis will discuss the different biopolitical policies and tactics Israel has put into effect that in turn directly (e.g. barriers and borders) and/or indirectly (e.g. a weak healthcare system and economy) affect Palestinians' fertility inabilities. This will be primarily presented in part two, which discusses in length biopolitical policies such as incarceration that leads to decreased fecundity in Palestinians, particularly males. It also discusses the impact occupation has on the health care system and the economy. Both of which determine the quality of reproductive health as well as one's inability or ability to overcome infertility.

Later in part three of this thesis, as settler colonial tactics trickle into everyday lives, I will discuss the effects of infertility on Palestinian women's everyday lives examining the social and psychological effects Zionism, through settler colonial tactics or pracxis has on the Palestinian population. I will also address the question of how, in the absence of childbearing, women find ways to reformulate their lives by utilising coping methods and dealing with uncertainty all while maintaining hope. For instance, due to the social, economic and political obligation for Palestinian women to bear children, infertile women bear the brunt of blame from their immediate family members and society for their inability to do so, which results in self-blame.

As you will locate throughout this thesis, the concept of political infertility frames the lives of Palestinian women's reproductive inabilities. It situates their abilities to travel and attend fertility clinics. It determines their reproductive health conditions. It sets the state of their economic status. It also influences societal and kinship notions, which in turn affect women who are unable to reproduce children. It is pivotal to understand that infertility in this thesis does not only refer to medical infertility but the inability to reproduce children due to other politically-influenced factors such as economic status.

PART TWO

SETTING THE CONTEXT: POLITICAL AND SOCIOECONOMIC FACTORS

CHAPTER V: POLITICAL INFERTILITY

Zionism as a settler colonial project conditions all aspects of the lives of the indigenous Palestinian population. Fundamental influences include prolonged occupation, restrictions and violence, which have a profound impact on political, economic and social conditions. Concurrently, infertile women are situated within this population. Infertile women, along with their infertility struggles, confront daily direct and structural violence perpetrated by the Zionist settler colonial project.

At the same time, infertile Palestinian women bear responsibility to find ways to overcome their infertility, manage the physiological aspects of fertility treatments and cope with the psychological distress caused by infertility. Therefore, the power of settler colonial interference and/or restrictions on reproduction is a concern manifesting itself beyond the physicality of space, discriminatory policies and mechanisms of control onto everyday life through biopolitical policies.

Infertility is only one characteristic of a Palestinian woman's everyday experience; therefore this study on infertile women's experience aims to go beyond the circumstantial and a brief view of what infertile women undergo. Rather, it is careful not to be overly normative. This part of the thesis aims to not only investigate how infertile women themselves understand and frame their everyday experiences with infertility, but also investigate how their medical state, as infertile indigenous women, is influenced by the settler colonial structure.

The concept for this chapter, political infertility, derives from findings collated during my field research. As I spoke to scholars and medical doctors on the subject of (in)fertility, they would frequently reference infertility as not only a physiological state but a state resulting from the political situation. I begin this chapter with Karima's narrative of her infertility journey, which is intertwined and encompassed within the lack of a proper healthcare system, economic inabilities and the political atmosphere (e.g. the presence of checkpoints around the West Bank). This extensive narrative highlights the thematic analyses throughout this research. Following Karima's narrative, a brief discussion on the term political infertility will be provided, and juxtaposed to the term political fertility.

This first chapter of part two provides the foundation for the subsequent two chapters (chapters six and seven), which discuss at greater length the influence of biopolitics on the Palestinian body through an analysis of the healthcare and economic sectors, which both in turn influence female infertility. In part two of the research, I propose to answer the research questions: does the Zionist settler colonial project control Palestinian reproductive (in)abilities, and if so in what ways? If so, how does this affect infertile Palestinian women? In order to answer these questions, I examine Zionist policies that undergird reproductive inabilities, focusing chiefly on female infertility with references to male infertility.

The analysis in part two is in accordance with the theory of Indigenous societies being considered by settler societies as inadequate to reproduce or raise children in (e.g. Landertinger, 2011) and indigenous presence being a threat to settler survival (e.g. Wolfe 2006; Veracini, 2011). As such, this chapter aims to provide a discursive analysis of the biopolitical methods

of Zionism that influence the reproductive inabilities and conceptual understanding of infertility of and by the Palestinians.

1. Karima: A Small Feather on the Surface of the Ocean

One evening in a refugee camp in Bethlehem, as I sipped on a cup of tea with my field informant Leila, she spotted one of her neighbours entering the refugee camp. Immediately she informed me, 'you have to meet Karima'. Leila hastily began calling Karima, who had just entered her apartment, and informed her about my research project, as well as asking if Karima had time to spare for an interview. Karima, a 49-year-old refugee, agreed and invited us over. We walked down three flights of steps, finding ourselves at the entrance of Karima's one-bedroom apartment. As I entered, Karima welcomed me with a hug and apologised for her appearance, explaining she had just returned from buying groceries and was feeling a bit weary. When I proposed coming back another day Karima refused, explaining 'people are always over asking me questions about my husband's situation, so I am used to it'. At this point, I was unaware of the meaning behind this comment; nonetheless, she guided me to her bedroom in order to provide a quieter atmosphere. There were approximately six women, including Leila, sitting in the living room conversing with one another.

As we entered the room, it became apparent to me what Karima meant by her "husband's situation". To the right of the entrance was a queen-sized bed with dark grey sheets, and to the left of the bed at the far end of the room was a hospital bed where her husband, Ahmad, lay. Karima faced me and in a reassuring manner stated, 'do not worry, he cannot understand us'. I would later come to the understanding that Ahmed is bedridden, incapable of moving any part of his body below his neck, as well as mentally unaware of his surroundings. Once in the room, Karima brought out two wooden chairs and placed them between her bed and her husband's hospital bed. When we sat, she immediately informed me that her current life stage was the 'most relaxing'. She characterised her life story as *'athab* [torment]. As she recalled her trials over conceiving a child, she frequently related back to her husband, discussing his mannerisms and/or his condition.

In 1991, at the age of 23, Karima married her husband, Ahmad, who was her maternal aunt's son and a year-and-a-half her senior. In the first two years of their marriage, Karima and Ahmad were unable to conceive a child. Initially, they did not inquire about their inability to conceive, perceiving it to be 'normal', although family members insisted they get examined by a doctor.

Subsequently, in 1993, they went in for their first appointment with a fertility specialist, only to discover that they both had medical complications resulting in their inability to conceive a child. Karima was diagnosed with ovarian cysts, as well as galactorrhea. She described her later 'problem' by telling me that 'anytime I see a child, I would make milk', blaming this on her *malhūf* [lovelorn] feeling for children after getting married. On the other hand, her husband's diagnosis was 'varicose veins, not in his legs, in his… [stutters and pauses] in the… [pauses] well, it is understood, the area that controls everything'. Karima was referring to her husband's diagnosis of varicoceles. She later revealed that he

> Also had a water sac [hydrocele], which he was supposed to get treatment for before he turned 20 so it would not affect him as he grew older. He had it for a long time, probably since he was a teenager, but no one knew, and I guess he did not look after himself. You know, men do not pay attention to these things and how they could affect them in the future. When it was around time for our wedding during the engagement period, he, he [begins stuttering] felt pain in the [pauses] what

> is it called, area [stutters again and leaves it unsaid]. So, he went to the doctor. It was this doctor who discovered the issue and told him that he had a problem. My husband told him, 'I am going to get married. What problems do I have?' The doctor replied, 'Not problems concerning marriage, problems that will need treatment to have children. So, nothing involving marriage acts, yet you will have to *ṭawl rūḥak*[19] for children.

Karima was aware of her husband's diagnosis of hydrocele prior to their marriage.

After their diagnoses, Ahmad had a varicocelectomy, 'an invasive genital surgery designed to remove varicose veins from the testicles' (Inhorn, 2012: 39). Karima underwent treatment for a while to remove the milk hormones, as well as her ovarian cysts. However, she and her husband had to stop their treatments due to financial reasons. She explained the cumulative costs of both treatments were too much to bear as they paid for their treatments. Moreover, due to the economic situation in the oPt resulting from the First Intifada, it was difficult for her husband to find work; Karima stated, 'my husband, *haram*,[20] would try to find work and do whatever job possible to save and pay for the treatments'.

With the end of the First Intifada came the formation of the Palestinian Authority. Karima was told the PA would provide free fertility treatments to infertile couples, if asked. As such, she sent a letter of request to the PA asking for permission to undergo free fertility treatments. She recalled,

> We received approval from Abu Ammar [Yasser Arafat]. This was before his death. However, at this time, due to the incidents, the approval was sent yet never reached us. It took a long time. When the approval finally arrived, the Second Intifada occurred. Now, as you would say, the situation became very bad financially.

Thereafter, her husband found another fertility doctor in Ramallah who was affiliated with Hadassah Medical Center [hereafter, Hadassah] in East Jerusalem.[21] She recalled visiting this doctor for two years: 'we would meet with him in his clinic for results and follow-up appointment but the exams and tests were conducted in Hadassah. We did all the exams and tests you could ever imagine'.

While conducting tests in Hadassah, the doctor provided Karima and her husband with hope, which she held onto and became optimistic once again. The doctor informed them if they underwent a six-month period of fertility treatments, they would be able to conduct an IVF treatment. Karima recalled the moment they received this information: 'we looked at each other and said "IVF, why not? It is good". The doctor gave us hope. We lived on this hope and continued walking our path. We began the treatment'.

---

[19] An Arabic phrase literally meaning 'lengthen your soul', connoting to have patience.
[20] An Arabic term meaning forbidden, but in this context it is used to mean someone to be pitied.
[21] There is a lengthy process West Bank ID holders have to undertake to be treated at hospitals in East Jerusalem. This process includes applying to Israel's Ministry of Health for travel permits to enter and be treated in hospitals within East Jerusalem, and, if accepted, these Palestinians are subjugated to checkpoints, which may deny or delay access. This permit system is a method Israel utilises to control the Palestinian population (e.g., Berda, 2017), and checkpoints are also means to control through the immobilisation of Palestinians (e.g., Peteet, 2017).

Nonetheless, this sliver of hope was shattered when she received an unexpected phone call from the hospital. The call was uninformative, only asking her to bring 'an adult figure from your husband's family, either his father or brother, to come to Hadassah and collect his test results'. At the time, her husband's father had passed away, and her mother-in-law as well as brother-in-law were in Amman, Jordan. She explained the situation to the hospital representative and further stated,

> 'He is my husband and we share everything together. Is there anything wrong? You can send the tests results to our [fertility] doctor, he works in the hospital with you and I can follow up with him and go to Ramallah to see what the issue is. My husband is currently at work and cannot leave to pick up the test results.' The lady replied, 'we have to see him in the hospital'. I became terrified. I figured that for fertility treatments they would not send after us in this way, especially because they asked for his father or brother.

Karima was feeling uneasy and decided to call her doctor, who confirmed her fears by informing her that they had found a complication with his skull. She recalled the incident that led to her husband's injury to his skull, as young child playing:

> When he was twelve years old he fell on a rock. He broke his skull and basically lived in the hospital for a while [laughs]. By the way, I did not know this story until after our marriage. After we were married, I would ask him what the hole in his skull was. He would tell me that he broke his head [skull]. We did not foresee it influencing our lives. There were doctors though, who informed us the injury was a factor causing my husband's infertility, but most doctors said no. The doctors confused us a lot. My husband's infertility is 90% deriving from the fact that his sperm die after a certain period of time. They only last a little while before dying. The ones that do not die are abnormal.

The couple were aware of the injury, yet were constantly reassured by doctors that it was not a reason for their inability to conceive children. Moreover, following his stay at the hospital as a young child, Ahmad was informed that the injuries would not affect his physiological and/or psychological state as he grew older. Nonetheless, after Karima retrieved the preliminary results from Hadassah, Ahmed underwent another examination of his skull and was made aware once again that it would not hinder his and his wife's goal of conceiving a child. They were, however, informed that he may suffer neurological complications in the future.

This occurred during 1999, as they were in their second year of treatment at Hadassah. It was at this moment when the doctor informed Karima and her husband that the fertility treatments were successful, and they would be able to undergo IVF treatment in their clinic of choosing. As they searched for a suitable clinic, a family friend informed them of a 'smart doctor in Haifa by the Baha'i Gardens near the sea'. The couple debated whether the journey from Bethlehem to Haifa would be worth it, as it is approximately 160 km from their home, would consist of two taxis (one with a Palestinian number plate and another with an Israeli one),[22] applying for permits to enter Israel, as well as passing at least one checkpoint. Another option was to conduct the treatments in clinics within the oPt; however, Karima reported being wary of the medical capabilities, as well as of the difficulty in holding a clinic legally accountable, if an error occurred, in the oPt. Therefore, after considering the advantages and disadvantages, they settled upon the clinic in Haifa, as their family friend had suggested.

[22] For more on settler colonial infrastructure in the West Bank, see Salamanca, 2014.

Karima describes the 'journey' to the clinic in Haifa as

> Torment. Yes, we were tormented. Each journey cost around 1,000 shekels between transportation, the doctor, treatments and injections. When we went to this doctor, we told him what occurred to us, how we were referred for IVF, and showed him our test results. We even gave him a list of every single medication we took from the beginning of our treatments. Even medication, like a pill of Acamol,[23] was listed. I used to save everything. I showed it all to the doctor. He looked at everything and took the results from us. The ones from Hadassah, Ramallah, even Nazareth. Every area, I had a folder. Hebron, I had a folder for our treatments there. The doctor told us he was going to give us treatments for three months, but every month he wanted to see us. We said okay, we are already in this struggle so let us just go for it. After the first trip, I did not want to continue, but my husband wanted to as a [psychological] relief for himself. Personally, I stopped wanting to go and come. It was exhausting and created a lot of psychological stress. The first trip was difficult and we took a car with people we knew, not public transportation [taxis], but we paid for the [travel] expenses. My brother-in-law went with us. We finished the first month of the treatment and returned to him [the doctor]. This was in the year 2000. Forget the expenses. I used to work before we got married and I had a car, you know when a girl is young and works a car is the first thing she buys. So, I had a car when I got married. But everything, everything I sold for the treatments. All that was left was this *dhiblah* [wedding band].

Karima revealed the clinic in Haifa is the final one she and her husband ever visited. She recalled how her husband, following the first visit to this particular clinic, was willing to end his search for treatment, claiming this to be his final attempt in seeking treatment and citing religious reasons for his decision:

> We did everything the doctor gave us. But that was it. My husband was finally convinced due to religious justifications. We did the work and put in the effort, as was our [religious] duty. Everything else is in the hands of God. He told the doctor, 'my last treatment is going to be with you. I am happy and what God wants to do is right. On us is the effort'. We did that.

As they continued their treatments and attending the fertility doctor's office, Karima found the situation becoming more financially, physiologically, and psychologically burdensome. She recalls,

> We took the treatment he offered us on our first visit and came back to him after a month, through all the hardship due to what was occurring [the Second Intifada]. During our third visit, the doctor provided us with test results, asserting 'we cannot continue, Ahmad needs surgery'. It was another surgery for his varicose veins, he had already undergone one yet the doctor said it had been a failed operation. This, of course, goes back to the government [PA] hospitals that we have. They created a problem for him. They did not remove the veins properly, causing him to start retaining water even more water [hydrocele worsening]. The doctor said 'we have to perform surgery for him now. Hopefully after it we can decide if we are going to do IVF'. You could say it was after approximately two months from our first visit. We asked him how much the surgery [which would take place in an Israeli hospital] costs. The doctor responded 'it is approximately, for the surgery itself, around 9,000 shekels'. The crucial part was that the same day we went home, gathered my gold and sold it. We made from it [the gold] around 5,000 shekels. We had to borrow from his family. It was costly. The taxi driver that took us and brought us back alone cost about 1,500 shekels. He [the taxi driver] has to have a yellow plate, they're expensive. Then the medication for me and him [Ahmad], of course. On that day alone we paid 13,000 shekels. In only one day. Between the surgery and transportation. It was a simple surgery that does not need much. It was an

[23] An over-the-counter pain medication.

> hour or even less, probably 45 minutes, costing us over 8,000 shekels He even went home under the effects of anaesthesia. We continued the [post-surgery] treatment at home.

The initial surgery to remove Ahmad's varicose veins was conducted in a governmental hospital operated by the Palestinian Ministry of Health. The surgery was not only unsuccessful, it exacerbated his hydrocele condition, resulting in the necessity to undergo a second operation.[24]

> The perpetual difficulty of traveling during the Second Intifada, the financial burden and continued setbacks led Karima to fall into a state of depression. [The money from] my husband's work, all he saved, was spent [on treatments]. We could barely even eat at home, just in the simplest, simplest, simplest way possible, only to continue our journey with the treatment. But we went home and we let things pass. A week after [the operation] he even started to begin working as normal. Also, he was not depressed. He has the soul of perseverance.

As Karima started to recall these few weeks, she remarked, 'now [laughs], I hope I do not forget anything'. To Karima, these days altered her way of life, explaining,

> We were supposed to go to our last appointment to see if we could do IVF and that was it. I even spoke to one of the fertility clinics in Nablus, and my husband had a friend who worked with him and told him, 'Ahmad, if you schedule a day, I will take you to the clinic'. Also, some of our family members told us they would go with us and even take us. We said '*InSha'Allah* [God willing] let us see what happens with us'. Now the day we had the appointment to go to Haifa, Al-Aqsa Intifada [the Second Intifada] started. The situation was very bad. No one could even go from here to there [points to the neighbour's house from the window]. There were attacks and banging sounds, everything. All we put into this [fertility treatments] went into the air. We did not go back [stutters], it [Second Intifada] lasted over six years. The first few years the situation was very bad, and my husband barely worked for us to spend on ourselves when it was bad. The situation only worsened.

Karima was taken aback by my curiosity in her trials during the Second Intifada. Perplexed, she asked 'don't you remember?' I informed her that I did not live in the oPt at the time of the Second Intifada, and had only read about the events that took place. She replied with a sigh of relief for me,

> Oh, good, you were not here. The situation got terrible. As I said, it was extremely difficult for a person to spend on his household, to eat and drink, *only* [emphasis in tone]. There were no opportunities to work. Ahmad could barely cover basic household spending'.

She discussed the difficulties they encountered, before returning to the subject of her fertility treatments:

> We did everything the doctor told us. All that was left was just determining when we were going to do IVF. Imagine. That's it, we reached the last stage before undergoing IVF. After about 15 years. We went to the end of the world, we did *jihad* [struggle], drained our bodies in the quest. All the expenses and our living situation filtered down to awfulness following the events [of the Second Intifada]. Should I lie to you and tell you during this period I maintained my strength? *'nhabaṭit* [I collapsed]. For example, imagine you reached the end of your doctoral degree, and all that was left

[24] Medical malpractice in hospitals within the oPt is common, yet few incidents are ever reported and legal action is rarely taken. For an understanding and comparison of the legal system in Palestine to the United States with regards to malpractice lawsuits, as well as an understanding of why legal action is rarely taken, see Fares, 2014.

> was to argue it [the thesis viva], you are on the stand getting ready, and someone comes to tell you – this is how I want to clarify my situation for you, but God forbid it happens to you – a person comes to tell you, the professor wants you to 'stop right here, do not argue or present. *That is it*. Do not argue it'. You did everything and struggled just to get to this part. This is the description of my case. Can you imagine that a person is optimistic and hopeful their whole life through the financial losses, the pain and suffering, and the yearning? Everything, everything needed from us was given, even a firm personality until the last moment. I vowed and told myself right after this stage [the first meeting with the doctor in Haifa], I do not want to do anything else. I just wanted this outcome, just this outcome. Either he [the doctor] tells me, 'have faith in God and do the IVF treatment', or he tells me 'there is no more hope'. As if [going back to comparing] you reached the end, you have argued your paper, and they are going to give you your results – hopefully yours will be one of the outstanding papers – so, you are waiting for the results but never receive them. Yet for me, I did not even have the chance to stand and wait for those results. That was it. Everything closed in my face.

Karima returned to describing the Second Intifada as an exhausting, financially burdensome and an 'emotionally destructive' time. From the year 2001 to 2003, Karima describes how her husband only had the opportunity to work 'simple jobs' due to the unsafe conditions, regulations and curfews forced on the Palestinians living within in the oPt in the Second Intifada. She refers to this time period as a 'terrible stage', during which her husband was cleaning the bathrooms in mosques as a last resort job. Moreover, she details one of her husband's jobs as 'risky and extremely dangerous'. She reported that Ahmad had a permit to work at a school in Jerusalem, a job he held for one year and two months. Due to the 'checkpoints, soldiers and gunshots', Ahmad would only go home to his wife once a week on a Thursday night, to stay for the weekend. However, even these simple, financially unstable, jobs, her husband was later unable to find due to the intensification of the Second Intifada.

During this time period, Karima and her husband did not visit any fertility doctors. As the year 2005 arrived, Karima's brother came to ask if her husband was working, because her brother had a part-time job to offer him at a local workshop. She responded to her brother, 'no, he stopped his work and he's sitting [unemployed]. But I think he has a problem.' When her brother inquired about Ahmad's 'problem', she recalled hesitantly explaining to him, 'his friends in Sur Baher [a neighbourhood in East Jerusalem] where he worked realised he had a problem. Ahmad told me he began to realise that at times he would just fall over, and at other times he would have sudden involuntary movements'. He interpreted her hesitance as a result of fear, deriving from two possible reasons: 1) her husband might become angry with her for discussing his inability to work properly, and 2) she was in a state of denial, wanting to believe that her husband and his friends were false. But once she spoke to her brother, 'what I hoped was a lie became true'. Following the discussion, 'within a month or two, I started to notice signs of his illness.'

Following this stage of Ahmad's illness, he started to show signs of dementia, as well as an increase in involuntary movements. Karima characterized their living situation as extremely difficult. Her husband became unable to perform daily tasks such as getting dressed, taking a shower and feeding himself. She explains,

> For years, only after eight days of being awake would I be able to sleep, and it would be only for two hours. It was only when he would fall into an unconscious state in defeat of his himself [due to energy loss]. Frequently during these short time periods, I would begin to scream, cry, and break down, all while not being able to get up. Despite all this, in my head, I would pray that God give me the strength just to take care of him. I would say, 'God give me strength for him, not for myself.

> I just want to live for him'. [Crying] It was due to this psychological stress and exhaustion that I went through a very terrible stage. The doctors would tell me 'if God loves you, Ahmad will reach a stage where he will stop moving. This is the best stage of his illness'. They also told me 'at this stage, his situation and your situation will stabilise'. He reached that stage. Yet, the stage before this [points to husband laying down on a hospital bed] was extremely difficult. I even forgot about children. I forgot about the exhaustion of [fertility] treatments. I forgot how much we ran after doctors for children. I forgot how life was. I forgot everything. Everything. The only thing in my mind was 'how can I deal with him? How am I going to get him dressed?'

According to Karima, health care insurance in the oPt does not provide home health aides to assist with her husband; there are private facilities, which are also not covered by governmental insurance only by more expensive private insurance. Therefore, Karima took it upon herself to be fully responsible for her husband, citing that she did not want her in-laws to be burdened with her husband. She also explained fearing they would begin to harbour animosity towards him. This 'stage' of involuntary movements and memory loss lasted six years. Karima recalls,

> *Min wijh al-ṣubḥ*[25] at 4 o'clock in the morning, he would run away from the house. Unaware of his surroundings. There is a checkpoint with armed soldiers up the street and that is where he would end up. Imagine yourself going to get a man from the checkpoint. You have drunk people coming from the hotels, reckless drivers at night, troublemakers, soldiers, all in the streets. I would repeatedly have to go get him from the checkpoint. Imagine a woman running after her husband in the night. If you are exposed to a bad person, you are going to be harmed. If you are exposed to the Jews [Israeli soldiers], you are going to be harmed… For twenty days I slept outside the house door. No, not where the metal door is, behind it. Outside, outside. Soldiers would pass by. Dogs would pass by. People in general would pass by. I am a female, where are my emotions in this situation? I had emotions, but they were all erased. *Khalas* [that is it], my mind, thoughts and energy were only for him.

Ahmad's running into the streets was a constant occurrence: 'he would open the door quickly and I would barely have time to get dressed before I saw him down by the streets'. Subsequently, Karima made sure she was always dressed and ready, stating

> Days passed where I would be wearing the same clothes. Day and night in the same clothes. I would not change or get undressed because I did not know what I would be exposed to. Trust me, I used to sleep like this, with clothing that was done up. I would wear a scarf or a hat on my head. I did not know what would happen to him.

While running away from the house, Ahmad would yell Karima's name in the streets. Given his loss of memory, Ahmad was only able to recall his wife's name but not his home, surroundings, or even how his wife looked. Karima recalled having to run after her husband and coddle him like a child, reassuring him, 'Ahmad, I am here. Ahmad, I am right here'. At times she would have to provide incentives for him to return with her home, saying such things as, 'come with me, there is ice cream in the freezer. Ice cream. Come on, let us go get some'. She reported there were occasions on which her husband would ask, 'are we married?' When Karima would reply 'yes', Ahmad would ask 'if we are married, where are our children?' As she recounted these occasions, she began to cry, and as I tried to comfort her she sighed a sigh of relief, explaining,

[25] An Arabic phrase literally meaning 'from the face of the morning', connoting very early.

> Presently, as I think about myself and his illness, I am convinced that my husband's faith was stronger than mine. He used to always say 'What God has written for us will happen. Maybe God does not want to feed us'. This was in the last phase of treatments, before the symptoms of his illness appeared. It was for a reason. Truly, God does not forbid a person from having children unless they will either come out mentally impaired, or they [the children] will torture them [the parents]. If we read the Quran and actually focus on it, we will know this is correct. They [children] will either torture us [parents], or will not be physically and/or mentally okay. Therefore, when the symptoms of his illness started to show, I said *alhamdulillah* [thank God]. It was at that moment I felt God confirmed this to me. How much we ran around and in the last moments before being able to do IVF, the path closed down on us literally! God has wisdom. God's wisdom is above everything. You see how my life is. God does not want to *'iblyny*[26] [grant me] children, or *'iṭ'amny* [feed me] children, so I am not tormented. Imagine having children and dealing with their father's situation. I went through circumstances and times where I would almost pass out while standing. I would not sleep at all. When I could, I would hide from him [husband] behind the couches, only afraid he might harm me with his sudden involuntary movements… It is something unbelievable. Unbelievable. Night and day movements, movements, movements. Imagine if we had children…

Towards the end of the conversation, Karima encapsulated her life in the following statement:

> This is my life story. From the beginning it was torture with the fertility treatments and wanting to have children. There was always pain, but there was still hope. Hope that I might have children. The real pain only came with his [Ahmad's] illness. I forgot everything. I completed removed the idea of children [from my mind]. I lived in tragedy. I had a hard life. But in my whole life – we are talking on the topic of children – all of it, all of it I now see as a small feather on the surface of the ocean in comparison to my life with my husband while he was ill.

When Karima finished her story, she wiped her tears, hugged me tightly and encouraged me to love endlessly, to not take life for granted, and to live life with a beautiful soul regardless of my physiological, financial and societal circumstances.

2. A Case of Political Infertility

How do we begin to analyse Karima's situation? Karima is one of the interviewees whose husband also suffers from infertility, causing her and her husband's quest for children to be a shared journey. They both think positively and are willing, particularly her husband, to go far and beyond what they thought themselves financially and geographically capable of, to conceive a child. However, my interest here is not only Karima's will to think positively throughout her journey, but also her journey as braided within the political circumstances, inclusive of physical barriers challenging movement, lack of proper healthcare to detect and prevent medical complications effectively, and economic deprivation inclusive of the necessity of her husband's labour migration. Throughout part two, the latter themes will be examined within a macro-perspective of political and socioeconomic factors in the oPt that cause, and/or hinder the ability to overcome, infertility.

She is one of the infertile women in my study whose life was expressed as being curtailed and politicised by the occupation. Consequently, Karima's story is an exemplar of political infertility. This is not to say her language of positivity is unimportant in the lives of infertile

[26] This term has a negative connotation.

persons; rather, I will be leaving the discussion of positivity to a wider discussion of coping methods in part three of this research.

Persons suffering from political infertility include women whose rights to reproductive health and fertility treatments are impinged upon. They have not been identified and included in this study arbitrarily; their infertility is the impact of a harsh premeditated political, social, and economical situation. Using the concept of settler colonialism, I argue that Zionist settler colonialism implements strategies, both easily identifiable and less evident, of political infertility.

Human insecurity and economic constraints are threats to health and do not have to be directly associated with violence (McNeely et al, 2014). Appropriately, in the oPt, the occupation has impacted the health and social wellbeing of Palestinians (Giacaman et al., 2004). Israel's military laws of occupation, fragmenting the land, dividing the Palestinian people, and of separating families, are the most powerful laws affecting Palestinian women's daily lives (Musleh, 2008). As such, Dr. Najjab frames the situation in the oPt as affecting infertility or being a means to infertility, explaining that

> Globally, people assume there is a peace agreement [i.e. the "peace process" following the 1993 Oslo Accord] but we have a lack of control over resources, water, borders, lots of restrictions in movement due to checkpoints and the wall. There is even lack of control over what the people use [i.e. herbicides and pesticides] on the vegetables and fruits, so the effect of them is unknown and may even led to infertility. There is an apartheid system, not only occupation, so, of course, the situation is bad. Moreover, tourism is not controlled by Palestinians. We lack an airport. It is difficult to export and import as everything must go through Israel. This is not to assume that the Palestinian population does not have problems related to social and political issues, yet Israel is the main problem and influences a lot. Palestinians, particularly the youth, have no hope in the future. These conditions cause stress and fear, all of which may cause infertility.

Although there is limited research on the effects of settler colonialism on infertility, research has been carried out on the factors affecting fertility. These may cause acquired infertility and/or prevent in/fertile persons from acquiring the necessary technology to become fertile. Appropriately, this part of the research seeks to set the context of Zionist settler colonialism and its manifestation on the formulation of infertility and prevention of overcoming infertility.

3. Political Incarceration

The foremost source of political infertility in the oPt derives from physical barriers of imprisonment. Since 1967, approximately 750,000 to 800,000 Palestinians have been imprisoned for political reasons, leaving only a small number of families which have not had at least one male family member imprisoned (McNeely et al., 2015: 224). In the post-Oslo era, in contradiction to international law, Israel transferred almost all Palestinian political prisoners from prisons in the OPT to Israeli prisons (Giacaman and Johnson, 2013: 59-60). As of March 2019, the total number of political prisoners incarcerated was 5450, of which 205 were child prisoners, 48 female prisoners, 540 servicing life sentences and 493 serving above 20 years (Addameer, 2019). In 2012, the average age of Palestinian male prisoners in Israeli jail cells was 46.9 years-old, with the average imprisonment time being 20.6 years (Wahbe, 2012).

These Palestinian political prisoners in Israeli jails are classified as security prisoners and are denied fundamental rights, including conjugal visits. Meanwhile, Israeli Jewish security prisoners are treated differently and are permitted conjugal visits (Vertommen, 2017a: 213). In

John Bongaarts' demographic model, among the factors that inhibit fertility is the component of 'spousal separation, which cause a reduction in the total fecundity rate' (Bongaarts, 1978: 119). Spousal separation has a tremendous impact on fertility levels, to the degree that Bongaart's study on fertility classified 'women whose husbands are absent for long periods as not currently married'.

This has led to an imperative issue among Palestinians: the phenomenon of long-term detention in prisons with the impossibility for the couples to have sexual intercourse is an element which favors infertility. Accordingly, male incarceration impacts reproduction as it removes them from women of reproductive age (Sykes and Pettit, 2010: 10). In this vein, incarcerated women are more affected, since they have a shorter window of reproductive capability. Consequently, the penal system is considered one of multiple institutions that 'alters the level and timing of fertility' (ibid.: 21).

Inclusive in spousal separation are factors of physical, psychological and health abuses within Israeli prison systems. Palestinian female prisoners undergo harsh treatment while incarcerated, including the utilisation by the Israeli Prison Service of *Isqat* [downfall], a term that 'refers to the use of the politics of sexuality', with Palestinian female prisoners sexually harassed and abused (Shalhoub-Kevorkian, 2009: 15). According to Addameer (2016), the Prisoners Support and Human Rights Association:

> The methods of torture and ill-treatment used against female Palestinian prisoners cause severe physical and mental suffering. Interrogation methods include prolonged isolation from the outside world, inhuman detention conditions, excessive use of blindfolds and handcuffs, sleep deprivation, denial of food and water for extended periods of time, denial of access to toilets, denial of access to showers or change of clothes for days or weeks, being forced into stress positions, yelling, insults and cursing, and sexual harassment. (ibid.: 2)

Furthermore, Palestinian prisoners face harsh health challenges and are subjected to systematic physical and psychological torture. The Palestinian Ministry of Health identified 'a range of legally-sanctioned physical and psychological torture techniques for interrogations, which have a range of negative repercussions on prisoners' health, including erectile dysfunction, infertility, strokes and permanent disabilities' (Awwad, 2016: 29). Political imprisonment for Palestinians is not only a 'traumatic event', but it is also a barrier between the imprisoned and their prospects of fertility (McNeely et al., 2015: 223). In addition, even after prisoners' release, one of the long-term effects of incarceration is a lower level of intimacy with a significant other (Comfort et al., 2005).

Political imprisonment affects not only the imprisoned but also their spouse. In an interview conducted with Noor, a 34-year-old female with infertility, she discusses her interaction with political incarceration as a causation for her infertility:

> Occasionally, after a few years into our marriage, I would feel stressed and feel the burden partially resulting from my infertility. However, at the onset of our marriage, I was rarely stressed. I longed for children, but was not burdened by my fertility trials. I was in a normal relationship. Even my uterus had no problems. I endured various fertility exams, and the results were positive. The doctors told me to have patience. My husband, who got tested every six months, apart from his time in jail of course, also received positive feedback on his fertility.
>
> But… [pauses] his time in jail. This is when I believe my infertility began. It was almost a year-and-a-half after our marriage when he was imprisoned. He stayed in prison for one-and-a-half years.

> When he was released, he was free for a year but was then imprisoned again for three years. He was imprisoned by the Israelis for *security reasons* [emphasis in her voice followed by an eye-roll]. During his imprisonment, I was ill frequently, very ill. I was easily susceptible to infections, which my doctor informed me was due to my weakened immune system. A lot of health issues occurred during these years.

Aside from psychological and physical torture and lower levels of intimacy among both prisoner and the prisoner's spouse, it was speculated in interviews I conducted with scholars on reproduction and fertility[27] that the food provided to male Palestinian prisoners in Israel was in fact a leading cause of male infertility. The food served is suspected to contain a chemical that if consumed on a long-term basis leads to lower sperm count and infertility. This was positioned by Dr. Edwan Barghouti, Director of Al-Hiba IVF Center, as a grave issue:

> In the oPt there has been an increase in male infertility, particularly in former prisoners. We have more than 7,000 Palestinian males imprisoned in Israel. More than one million Palestinian males have spent months or years in Israeli prisons. Typically, when they are released and come back home they are infertile, particularly suffering from low sperm count, which is a cause of male infertility. The reason for this phenomena is not determined or researched. There is no definite study regarding this issue. However, a large portion of our male-factor infertility patients are former [political] prisoners. They swear to God the food served to them has something in it that is meant to prevent them from being aggressive. We [the fertility clinic] assume chemicals in the food lower their testosterone levels to calm them [the prisoners], and over a period of continuous consumption this results in lower sperm count. leading to fertility issues.

The Palestinian population is becoming increasingly aware of the impacts of imprisonment on fertility and reproduction.[28] In an attempt to counter settler colonial policies, Dalal Ziben in 2012 gave birth to a baby, which was conceived through artificial insemination using her husband's sperm smuggled from Hadarim prison in Israel where he was serving 32 life sentences (Vertommen, 2017a). Following Dalal's case, the same fertility clinic in Nablus is continuing to aid in the smuggling of male prisoners' sperm in attempts to impregnate their respective wives, thus leading to the notion of 'babies from behind the bars' (Vertommen, 2017a).

Joshua Mitnick, a journalist reporting from Nablus, conducted an interview with this fertility clinic, the Razan Center, which identifies itself as the first fertility clinic to inseminate a wife of a Palestinian prisoner with smuggled sperm (Mitnick, 2016). In the article, Mitnick discusses the initial backlash from the Palestinian community, due to religious concerns and speculation that a prisoner's wife's pregnancy may be a result of infidelity. As such, the Razan Center has acquired approval from the Palestinian Authority's religious council, and instructs two representatives from each side of the family to be present during the treatment.

As fertility treatments are expensive, in some cases the Razan Center offers them free of charge for the wives of prisoners. Since the initial procedure, approximately 50 children have been conceived through this method. The women have mainly been in their mid-40s and have husbands who are serving anywhere from ten years to life sentences. However, the treatment

---

[27] Given the lack of data and the possibility of being considered "hearsay", all but one of the scholars preferred to be unnamed.

[28] There is an increasing amount of literature correlating incarceration with the prevention of human reproduction; in the case made by Oleson (2016), incarceration is a method of eugenics.

is not free to women in their mid-20s whose husbands will be realised within ten years. The Center stated the reason behind this free service is that if a political prisoner is released and his wife is over the mid-40s age range and without children, she will be too old to conceive, and 'the husband will marry another woman just to have a child' (Mitnick, 2016).

Berk evaluates the notion of "sperm smuggling" as obscure, given the lack of evidence regarding how the sperm is smuggled, in addition to the inconsistencies found in media articles covering the story (Berk, 2014). Nonetheless, Berk believes the legitimacy or method of "sperm smuggling" should not be the point of discussion. Rather, what matters is the capability of utilising 'in/fertility as a way to speak to power' and that it is 'a current iteration of Palestinian redefinition of identity and what it means to be a Palestinian' (Berk, 2014: 3, 61).

The physical barrier of imprisonment does not only affect prisoners' fertility prospects; it also affects the spouses of the imprisoned. This is seen in the above-mentioned instances of male prisoners being released to return to their wives who have reached an age where they are incapable of conceiving a child. Another is the stress on a prisoner's wife, regardless of the length of imprisonment.

Notable here is how a politically-erected physical barrier may lead to infertility. Even though there has been no prior research claiming this, it is pivotal in this instance, as well as throughout this research, to take seriously the claims made by the interviewees. My research does not validate any feelings as real or dismiss them as imagined; I seek to provide a definition and causation of infertility as determined by the interviewees themselves.

4. Conclusion

The political circumstances in the oPt have implications on whether and how treatment is accessible, as well as how women perceive their fertility being risked and their infertility caused. Particularly important circumstances to consider are the physical barriers challenging movement and conjugal relationships, the unavailability of access to proper healthcare in order to detect and prevent medical complications effectively, and economic deprivation preventing the ability to cross checkpoints and to seek treatments, and damaging reproductive health. These political circumstances are important, as they represent the causes of acquired infertility.

Political infertility, therefore, is a cause of acquired infertility. It is the inability to conceive children due to physical and/or non-physical barriers erected by the political regime, which in this case is a settler colonial regime with a doctrine of eliminating indigenous life. This elimination, through the barriers of political infertility, targets the reproductive system of indigenous peoples. As previously noted, political infertility does not necessarily imply a direct and deliberate correlation to physiological infertility. However, it does propose politically-driven strategies, particularly biopolitics, and structure prospective fertility through means such as a failing healthcare system, crippling the economy and reducing manoeuvrability.

As Karima's case illustrates, infertility is inextricably entangled with the political situation. Her and her husband's endeavours to conceive a child were affected by the occupation. From their childhood growing up in a refugee camp, Karima's husband did not receive the necessary healthcare to overcome his head injury, as well as his varicoceles. Karima's ovarian cysts and galactorrhea were not remedied completely due to financial constraints, imposed by the occupation affecting access to jobs and a stable wage, particularly during the years of the First and Second Intifadas. Moreover, even in accepting her infertility and trying to live her life

without children, Karima's life was forcibly imposed upon by her husband's worsening condition deriving from the lack of a proper healthcare system, which did not diagnose his head injury properly, and by the challenging circumstances she faces in her everyday life due to living under occupation.

Chapters six and seven will expand on two types of politically-driven strategies formulating the political and socioeconomic factors that affect and/or cause infertility inclusive of crippling the healthcare system and the economic sector. The healthcare system influences the development of, experience with, and treatment process of, infertility. Access to healthcare, in particular reproductive healthcare, is influenced by the political constraints inclusive of the occupation and the economy. Concurrently, the economy is influenced by the political circumstances of occupation and militarisation, which in turn affect the state of the healthcare system as well as women's access to it.

Chapter IV: HEALTHCARE, THE HEALTHCARE SYSTEM AND REPRODUCTIVE HEALTH

Would vaginal delivery at an Israeli army checkpoint be considered normal?
(Giacaman et al, 2008: 91)

According to Julio Frenk (2004), Mexican Minister of Health, a country's health conditions are dependent on its economic performance, which itself is intertwined with the performance of the health sector. Therefore, in order for a healthy society, there needs to be a strong economy accompanied by an adequate health sector, which provides people with the ability to stay healthy and thus work to allow the country to prosper economically (ibid.). In accordance with Frenk's understanding of economy and health as reciprocal, this chapter will discuss the healthcare sector in Palestine. Subsequently, chapter seven will discuss the economic sector. Presently, I will explore the link between healthcare, healthcare systems and reproductive health in relation with infertility globally, as well as with aspects specific to the case of the oPt.

Moreover, this chapter addresses the wider healthcare implications for infertile individuals through the understanding of the healthcare system, and linking it to reproductive health issues. The state of women's healthcare in correlation to infertility within the oPt remains under-researched. Nonetheless, research pertaining to settler colonialism in Australia and the oPt has located certain health conditions, which may lead to infertility (e.g. Chlyamdia trachomatis and PCOS), that are easily cured but left untreated due to a weakened healthcare system; infertile individuals living within areas that are deprived of sufficient healthcare benefits may therefore remain infertile. Lastly, I explore the consequences of the healthcare system for women's overall health, paying attention to reproductive health.

1. Rana: Maẓlūma

There we were, Leila and I, sitting down in a living room, as two teenage girls brought to us a range of fruits and Arabic coffee. Later I would be told by my field informant, 'they do not have the money to buy fruits. They rarely have any at home. All you saw upstairs was for us. They like to be hospitable even if it is difficult for them'. This hospitability was a recurring event I would encounter during every interview.

In that living room, we were accompanied by Rana, her two sisters and her sisters' children. As they spoke, Rana played with the hair of one of her niece's, braiding it into a fishtail braid, which Rana mentioned was 'her favourite type of braid'. The discussion topics ranged from the season's fruits and where to buy them, to Israeli checkpoints and the difficulty it took Rana to arrive at her parents' house in Bethlehem where we currently were.

Later, Rana guided me to a room at the far end of the house. It was a small, modest room with a drywall dividing it from the kitchen and adjacent living room. As such, even with the door closed, you could still hear the discussions going on in the living room. Inside the room, there was a sofa bed, which we both sat on. There were two windows, letting in a slight breeze despite the heat of the summer; however, the windows were on the main street which was loud and noisy. Rana decided to shut the windows in order for us to have some quiet.

Once the door was shut, the windows were closed and we were seated, Rana began:

> I was 23 years old when we got married. My husband, at the time, was 28 years old. We were only five years apart. Now, 14 years later, I am 37 and he is 42. We are still together, happily. But we have never had children. We visited multiple doctors, but they are all unsure why my husband and I are infertile. There is no specific reason or cause for our infertility. Or maybe they are unable to find the specific cause.

Rana and her husband have unexplained factors leading to their mutual inability to have children. The term "unexplained infertility" is 'applied to an infertile couple whose standard investigations are normal and whose infertility duration is over 2 years; therefore, the diagnosis of unexplained infertility is one of exclusion' (Isaksson and Tiitinen, 2004: 279).

> The first time I decided to visit a fertility specialist, it was six years into our marriage. I, of course, visited multiple clinics and doctors. I even went to Amman. They all provided me with the same results. In Amman, I visited a Romanian doctor. She was very sweet and caring, as well as smart. She is my sister's friend. She explained to me, 'in these circumstances, I recommend you undergo IVF and do not wait any longer'. She also added, 'we usually wait for one to two years, and if there are no reasons for infertility, as in after all the tests there is no specific cause of infertility identified, we recommend IVF'.

Born and raised in Bethlehem, Rana has a Palestinian-West Bank identity card,[29] but her husband who was born and raised in East Jerusalem has a Jerusalem residency permit.[30] Rana briefly discussed the extensive process of renewing her permit (not a residency permit) to live in East Jerusalem, stating:

> As of today, I have renewed my permit nine times. I have not received an Israeli I.D. and doubt I ever will. Also, I live close to the office where I renew my permit. They ask a lot of questions and have a long list of conditions for renewing my permit. They ask for bills such as water and electricity. I have to swear that I do not work [in Jerusalem]. We have paperwork from the lawyer stating that we live in Jerusalem. Our paperwork is always complete. They also ask about my husband's whole family to ensure they have no security issues, but there is nothing *alhamdulillah*. So, they renew my permit. Frequently, they cause hardships.

While she discussed her residency, she briefly joked about her infertility, saying 'they probably like the idea that I am infertile.' This simple joke reveals the entrenched idea Palestinians have of themselves being a threat to Israel's settler colonial end goal of native elimination.

As a means to fulfil this end goal, West Bank identity card holders living in East Jerusalem as Rana have to succumb to the discriminatory policies, which are within the categorisation of political infertility: unequal healthcare and socioeconomic opportunities. Rana does not have the same healthcare opportunities as her husband, other East Jerusalem residence card holders and Israeli citizens. These opportunities include access to Israeli fertility treatments. Therefore, all of her fertility treatments must be self-funded.

Accordingly, when cases of unexplained infertility are present, as Rana's doctor stated, IVF is the route most fertility experts suggest. However, due to its cost, infertile persons such as Rana usually prefer to undergo a range of fertility treatments before committing to IVF.

---

[29] For more on Palestinian identification cards and their impact on everyday life, see Abu-Zahra, 2008.
[30] Palestinians with East Jerusalem identifications are stateless citizens with limited rights. See Jefferis, 2012.

After my visit to the Romanian doctor, I started my journey of fertility treatments. I originally began with hormonal injections due to the cost but they did not work. This particular doctor could not provide me any other treatment besides the injections. Therefore, I was guided towards a fertility clinic in Ramallah, which has branches in other cities including Bethlehem. In the Ramallah branch, I underwent three cycles of artificial insemination. All of them were unsuccessful and did not result in pregnancy.

I then decided to undergo my first IVF cycle, which also took place in the Ramallah branch. The first time was unsuccessful. After three years, I underwent another IVF cycle but in their Bethlehem branch. The second time it was successful. I became pregnant and was very excited. Unfortunately, though I had a miscarriage after one month.

At this point in the interview, Rana began discussing her experience with the healthcare system in the oPt. She referred to the situations she has encountered such as 'doctors taking advantage of her infertility' as feeling *maẓlūma*.[31] She described three incidents during which she believes she was wrongly treated and had no power in the situation.

I will tell you about a situation. Once a doctor informed me, 'from the amount of hormones you have taken, you have a thick layer on your ovaries that is preventing the egg from being released naturally'. The doctor suggested an operation during which he would cut me open from my stomach area, have a look, and at the same time peel away this layer.

For the operation, there was an anaesthesiologist I did not feel comfortable with when he was briefly examining me. I felt his touches were not appropriate. I believed he was able to examine me from over my clothing, yet he did not. Naturally, I became nervous.

When the anaesthesiologist came to give me the anaesthetic in my right hand [i.e. to inject her in her hand], it did not work and my hand became swollen. I even had a problem after the operation because he tried to put it [the needle] in my bones, and my bones are very weak. He tried again in another place, giving it to me in my left wrist. He did not even say '*bismillah*' [in the name of God], or make me feel at ease.

Also, the anaesthesiologist put the EKG [electrocardiogram] stickers on my upper chest while I was conscious. Later, when I went home, I found the sticker residue in other areas. I became paranoid and thought, 'who moved them around?' Obviously, this was an operational room, and there was my primary doctor present as well as other staff members. The anaesthesiologist was not alone, but how did this happen? I became paranoid. I did not ask the doctor.

Of course, the EKG has to do with the heart machine. It is possible they had to move them or add more. I am just telling you how I think. Nonetheless, after a day or so, I called the doctor and told him my hand and bones hurt. He told me, 'during the surgery you were odd. The whole time you were tense. Your hands were tense'. I knew it was because I was not comfortable. This is just one reason causing it to be difficult for me, psychologically and physically, to undergo the same situations over.

Her distrust in the healthcare system is not unwarranted in her perspective. She further explained another incident:

Basically, it is hard for me to even *think* about undergoing fertility treatments. There are a lot of doctors that are good that I saw, do not get me wrong. Then there are doctors that wronged me. To

[31] Arabic term meaning oppressed and mistreated.

give you an idea, there was a doctor who informed me I have a condition in my blood, which is called antisperm antibodies.[32] I told him 'okay, what does this do?' He responded, 'it affects fertility and prospects of conceiving'. So, he prescribed cortisone for me for four months.

Prior to the medication, I had 200 over 100, yet the normal range is 0 to 90 over 100. These antisperm antibodies fight sperm when it enters the body. For me, I was going to undergo IVF, so I was unsure how that affected me, as sperm would not enter naturally and undergo this 'fighting' process. However, I decided to go along with the doctor's recommendation.

Four months later, I finished my prescription and, as he suggested, went in for a follow-up examination to see the results of the medicine on my condition. I had a blood test conducted. My test results showed an increase from 200 to 250 over 100 antisperm antibodies. The doctor looked at me perplexed, asking, 'I gave you this medicine?' I replied, 'yes, you gave it to me.' He asserted, 'that is impossible!' He denied ever giving me the prescription, and blamed me for taking it.

Imagine four months of taking cortisone. I spent money on buying the prescription. I even became bloated. Okay, I did not gain or bloat too much, but I was affected by the medicine. My husband became furious and wanted to hit the doctor. The doctor had the audacity to tell me, 'it is impossible that I prescribed this medicine to you, as it has nothing to do with conceiving.' To make the situation worse, the doctor is really well-known and reputable doctor.

Unfortunately, that is not all – no one, including the doctor, instructed me on how to stop taking cortisone. So, I just stopped it abruptly. Afterwards, I was told this was the incorrect way. Instead I was supposed to stop it incrementally, by taking at least two pills a day, morning and night. So, yeah… A lot of regrettable, sad occurrences happened to me. Maybe others experienced worse and were not affected. Yet, for me and my personality, I was affected by it a lot.

These incidents demonstrate Rana's lack of trust in healthcare professionals, the result of an accumulation of events.

Also, once, I did the coloured picture,[33] to see if my fallopian tubes were closed. My cousin did it after she got pregnant, and told me it is painful. And, truly, I was in a lot of pain, and there was no anaesthesia or painkiller given. From how much I was in pain, my legs began to shake, and the doctor would yell at me, 'you are not allowed to move!' All of these incidents and memories accumulated, making it difficult for me to cross this line into fertility treatments once again. [Laughs] Maybe I will need a psychologist to overcome this.

As she jokes about her needing psychotherapy to overcome her fears due to prior incidents, she discusses the position of infertile persons as weak, and the healthcare system's ability to take advantage of infertile persons and their situation.

Doctors take advantage of infertility. People are desperate for babies, and they know it. There are doctors whose conduct in their work is professional, yet they are a minority. For me, on more than one occasion I have felt *maẓlūma*.

---

[32] A study conducted in the northern part of the West Bank found a prevalence of antisperm antibodies in infertile couples, with the IVF procedure of intracytoplasmic sperm injection as possibly the only method to overcome antisperm antibodies (Yasin et al., 2016).

[33] Hysterosalpingography, a radiologic procedure of a woman's uterus and fallopian tubes using a contrast material, which is released after the insertion of a catheter into the cervix.

Subsequently to this discussion, she related these incidents as forming the rationale behind her decision to stop fertility treatments.

2. Healthcare and the Healthcare System

Rana's story is illuminating on multiple levels. First, Rana and her husband suffer from unexplained infertility, which was revealed only after their marriage and has no specific treatment. Second, Rana assumed her experiences with the healthcare system were unique. She was not aware of other infertile women and their experiences with fertility treatments. As such, she does not know of the high prevalence of infertile persons sharing the same distrust, unease and feelings of being *maẓlūma* as a result of fertility doctors taking advantage of their situations. Thirdly, Rana had not acquired legal justice for situations that have occurred to her, particularly the case of the doctor prescribing the wrong medication. Rana related this to her distrust in the legal system as well as the healthcare system.[34] Fourth, Rana has carried the burden of paying for her own fertility treatments although her Palestinian neighbours with Jerusalem residency permits or Israeli citizenship, do not have to pay for treatments.

Rana's story is interesting as it communicates a range of responses from women living in areas with an inadequate healthcare sector. Her story raises the questions, do women believe, respect and trust the healthcare sector? How does the healthcare sector view infertile women? Do they deem them desperate? How does the situation in the oPt affect the healthcare sector?

Due to the impingements on the healthcare sector, further discussed below, there are numerous accountability concerns towards fertility care providers. As Davis (2017) relates, women have weary experience with medical professionals and their medical power; Davis explains that women have 'felt medical professionals were in a position of authority over female patients and that they did not always use this power appropriately' (ibid.: 133).

These sentiments regarding the misuse of medical power and professionalism were reflected in Mariam's story as well as Rana's. Mariam, a 26-year-old female diagnosed with polycystic ovary syndrome (PCOS), recalled a similarly traumatising experience that occurred to her:

> I did not have an issue [with fertility] previously, and neither is my weight an issue [referring to a side-effect of PCOS]. A long time ago, I went to a private fertility doctor in Bethlehem. You can say this fertility doctor *'bda' fiyā* [got creative with me (sarcasm)]. He gave me injections, injections, and more injections. I know that when you take these injections, he [the doctor] should give you one last shot and that is it. Yet he did not follow this. I stayed with him for longer than a month, about three to four months. In the beginning he would see me, give me only one or two injections, but later towards the last month as a patient in his clinic I did not feel like myself at all.
>
> At the beginning of December, he prescribed me injections and only told me to take them without any directions on how. I began to take three injections a day for the duration of the month. Then came the New Year – actually right after Christmas, the injections finished and I was unsure what to do next. I called the doctor and asked, 'what did I take these injections for?' At the time and until now, I do not understand the procedure of fertility treatments. He responded to me, 'we are on

[34] The lack of a stable state in the oPt is part and parcel of manipulation and failure faced by Palestinians accessing the legal system. For more see Kelly, 2004.

holiday break'. I replied to him 'well, what do I do now that I have taken all of these injections for a month?' He did not reply. Every shot was about 70 shekels. You do the math.

Also, they [the contents of the injections] are all hormones and even more ingredients than that. I was put down psychologically, economically and in every way possible. Everything. In every way. There was no pregnancy, nothing. My stomach just began to bloat as if I was pregnant. In one month, I got bloated and began to look like a radish. My hormones became all mixed up, my period was not on time and became random. *'imily mushkilh mā 'lhā 'wal walā 'khir* [He created a problem for me that had no beginning or end]. I did not go back to him. He was very well-known. Everyone used to say his name and praise him, but there are a lot of problems with the way he runs his clinic. It was one of the only moments in my life that I felt taken advantage of. He is possibly the only person that, if I recall him and what he did, I do not wish any good for him.

She then discussed the fact that the process of taking the injections was not explained to her properly:

I am not a nurse to understand how to take the injections. I would go to the pharmacy and other places every day, just to have someone give me the injections. Imagine it yourself. At least I had a car to transport me from place to place. What if I did not have one? At the end I got sick and tired of going to different places and to different people, just for them to give me the shot. So I began to take it myself. I think I was taking it the wrong way, because it would hurt a lot.

As with Rana, Mariam's experiences caused her to be fearful and weary of fertility specialists in addition to fertility treatments.

I think the injections at the private clinic play a role in my difficulties with fertility. Also the ordeal I went through had a drastic influence on my psychology. Allah knows how I was at that time. How I used to run around for a doctor or a professional, just to give me a shot. Well, he messed me up mentally [crying]. He did not cause or play a part in my [physical] inability to conceive, but I personally feel and believe that he did, only for the reason that he messed with my psychology. After being a patient with him, I did not want to go see doctors. For him, when I visited, I felt like I was his slave, like I was no one. He would be willing to sit 30 minutes smoking cigarettes, with you and the other patients waiting in the clinic waiting room. And it was fine. You had an appointment at 8am, you wait. You would come even at 7 and still have to wait until 9, until he decided to take you in.

I left the private clinic on my own. That is it. I did not want to go back and see that doctor again. He even made me have a *'uqda nafsiya* [psychological problem]. My husband persuaded me to go to an herbalist in Al-Khader [a village near Bethlehem]. He said, 'you may get a better fertility treatment from her'. So I thought whatever, let me just go. She is an herbalist for everything, but most of her patients come to her with regards to their fertility issues. If it worked for them or not, I do not know.

I went and she would give me herbs and herbs and herbs. These are things for which you have to wait for a long time to see their results. I got fed up and tired of it. I did not get fed up because I was in a rush to get pregnant. I got fed up because *that is it*. Every day I would have to go so she can give me honey, medicine that smelt like goats [laughing], it was something Indian. I could not stand the smell of it and would get disgusted. I even threw up two or three times from it. Then I said no more, that is it.

However, she went on to compare her previous experience with the private clinic to her current experience at a public clinic, indicating that

> At least in this clinic, they provide us with the soft injections. Like, really *maSha'Allah* [as God has willed] to them. And the way they treat their patients is really good and makes you feel comfortable. Over there, no, he would give me the shot, and just tell me to go.

The perspectives these women provide is linked to the healthcare system within the oPt, which is weak, underfunded and lacks legal clarity. Understanding these stories requires an in-depth discussion on the healthcare sector within the oPt, a by-product of the Oslo Accords discussed further in chapter seven, and is essential to comprehending the inadequate quality of reproductive health and healthcare infertile women received.

The present state of Palestinian health and the healthcare system derives fundamentally from the country's complex political history (Abu-Zaineh et al., 2008: 2310). In 1994, under the auspices of the Palestinian Authority (PA),[35] the Palestinian Ministry of Health (PMOH) was established to 'provide comprehensive healthcare services to the Palestinian population and to promote an efficient and equitable utilization of healthcare resources' (Mataria et al., 2009: 1287). It was meant to be a period of reforming the weak and fragmented Palestinian healthcare system into an efficient system. The PMOH also attempted in 1994 to unify the West Bank and Gaza Strip's 'geographically isolated health systems' into one organisational structure; however, these attempts have been 'unable to erase 27 years of separation', which have created two *de facto* healthcare systems (Abu-Zaineh et al., 2004: 2310).

Notwithstanding this lack of ability to unify the two systems, each one compromises of varying healthcare providers. Rather than confront the 'complex and heterogeneous healthcare system', the PMOH decided to play the role of coordinator between the four main providers of healthcare services in the oPt:

> A "weak" governmental health care sector depending on the Israeli administration; a group of Palestinian non-governmental organizations (PNGOs) playing an essential role in primary health care delivery; United Nations for Works and Relief Agency (UNRWA) serving the Palestinian refugees of the 1948 war; and finally, a private sector only accessible to the most wealthy groups of the population (Mataria et al., 2004: 1287).

Simultaneously, Israel's policies have had a considerable impact on the inability of Palestinians in the West Bank to access urgent and preventative care: occupation and closures have led Palestinians to be denied or otherwise unable to receive health screenings or access to specialised care (Sousa and Hagopian, 2011). Consequently, the overall Palestinian healthcare system is highly fragmented, which may be a strategy of de-development in which there is deliberate and systematic destruction of the indigenous economy (ibid.: 521).

Further to this fragmentation, healthcare in the oPt is delivered in

> Three-tiered pyramidal levels, with primary healthcare at the bottom, secondary and tertiary care at the middle and top levels, respectively. Healthcare services at almost all three tiers are provided by four actors: the Ministry of health (MoH), a group of Palestinian non-governmental organizations (PNGOs), the United Nations Relief and Welfare Agency (UNRWA), and the private sector. In terms of delivery of care, 46.1% of total healthcare visits take place at MoH institutions (of which 67% made by households belonging to the lower half of income deciles), 21.4% at the Private

[35] An interim self-governing body resulting from the Oslo Peace Accords, see chapter seven.

> sector, while the remainder is shared between UNRWA and PNGOs in the ratio of 60:40, respectively (Abu-Zaineh et al., 2008: 2310).

The main insurance scheme in the oPt is the governmental health insurance (GHI). Although GHI is fairly affordable and easy to obtain, a large majority of the Palestinian population does not have health insurance and cannot afford healthcare services (Saca-Hazboun and Glennon, 2011: 284). Furthermore, the services of the GHI are slowly deteriorating, including a deficiency in essential drugs and supplies (Abu-Zaineh et al., p. 2310-2311). It is thus 'characterized by incoherency and inadequacy' (Baidoun, Salem and Omran, 2018: 3).

According to a 2016 report submitted by the Palestinian Ministry of Health to the World Health Organization, Palestine is

> struggling to deal with an Israeli occupation, arbitrary practices and repeated violations of international humanitarian law, and a dire financial crisis that is impeding the ability of the Palestinian Government to deliver healthcare services to its citizens. With limited resources available, the Palestinian Government is heavily reliant on aid and grants from abroad. The provision of support is often irregular or unpredictable, however, and is closely linked to political developments. The burdens and challenges faced by the Palestinian healthcare sector are therefore immense. The Palestinian healthcare sector remains in imminent danger of collapse, despite the considerable efforts that have been made to enhance its resilience. Ongoing attacks by Israeli occupation forces against Palestinian civilians and the repercussions of those attacks, including the thousands of persons left wounded and disabled in their wake, have exacerbated the burdens placed on the Palestinian healthcare sector and its capacity to meet the needs of citizens effectively. Furthermore, the devastating impact of the occupation on the Palestinian economy, coupled with rising unemployment and poverty rates has seriously undermined the overall health of the Palestinian population (Awwad, 2016: 51-52).

A subsequent 2018 report by the Director-General to the World Health Organisation reported continuing deteriorating health in the oPt as a result of 'exposure to violence [having] an immediate impact on health' (Director-General, 2018: 4). 'The legislative and physical division of the occupied Palestinian territory […] presents major difficulties for the cohesiveness of the health system and for access for staff, ambulances, patients and relatives' (ibid.: 5); the financial difficulties encountered by the PA to sustain its health services, as well as the population's difficulties in paying for uncovered healthcare, have led to 0.8% of the population becoming impoverished due to healthcare payments (ibid.); health services 'face chronic shortages of medical supplies' (ibid.: 6); acquiring referrals for healthcare services outside of the oPt, including the necessity of acquiring security permits through Israeli authorities, is difficult (ibid.: 7-8); and Palestinian prisoners in Israeli prisons report 'inadequate nutrition for prisoners, including those suffering from cancer or other severe conditions, and a lack of access to psychosocial support' (ibid.: 9). Additionally, a high level of attacks on health are recorded in the oPt. These attacks are defined by the WHO as 'any act of verbal or physical violence, threat of violence or other psychological violence, or obstruction that interferes with the availability, access and delivery of curative and/or preventive health services' as well as 'systematic denial and delay of patient access to health care outside the Gaza Strip or the West Bank' (ibid.).

The continuing deterioration of health, healthcare and access to healthcare facilities plays a key role in determining the wellbeing of Palestinians and their functioning capabilities, formulating

their human insecurities and in turn threatening their health and existence.[36] By 1992, the oPt was a site of high infant and childhood mortality rates due to 'malnutrition, infection, and lack of sanitation' resulting from Israeli policies (Young, 2003: 172).

Moreover, according to a WHO report in 2002, political conflict inherently threatens healthcare services (Sousa and Hagopian, 2011: 520). As such, in the oPt 'the entrenched conflict has altered social welfare and health care delivery systems in ways that pose challenges beyond those seen in other conflict or post-conflict situations' (Mataria et al., 2009: 93). These impingements on the Palestinian population are violations of human rights as health disparities derive from infrastructural or access issues, which are correlated to Israel's governmental policies (Rattani, Kaakour and Miller, 2017).

3. Reproductive Health

Israel engages in the biopolitical management of life through its daily engagement of deadly power and the right to kill (Shalhoub-Kevorkian, 2009: 119). In the mid-1980s, despite high birth rates, there was a decline in the Palestinian population, resulting from Israel's practices of 'war measures of mass arrests, imprisonments, explosions and splitting of Palestinian families' (Abdo and Yuval-Davis, 1995: 300). Two decades later after the 2008 attack on Gaza, Israeli soldiers designed t-shirts of a pregnant Palestinian women in the crosshairs of a gun, with the phrase "one shot, two kills" (Vertommen, 2017a: 210).

The continuance of military occupation and living in chronic conflict has impacted the psychological health of Palestinians (Mataria et al., 2009: 93). This has in turn hindered the reproductive and sexual health of Palestinians. Dr. Barghouti describes the situation of fertile, involuntary childless couples in the oPt in stark terms: 'the occupation does not allow for intimate relationships. How do you expect a couple to conceive a child when everyday they hear news about a family member, a friend or a neighbour being imprisoned or killed? You cannot be intimate in such a depressing environment'. This fear was termed as *khūfh* (fear) by Dr. Barghouti, which is similar to findings in literature relating infertility as a cause of war and warlike situations (e.g. Abu-Musa et al., 2008 and Maconochie, Doyle and Carson, 2004). *Khūfh* eludes to the biopolitical atmosphere resulting from the settler colonial project of elimination of the native, which in turn is leading to a lack of comfort and intimacy, causing fertile couples to be involuntarily childless.

Another biopolitical dimension includes the considerable impediments on movement within the oPt, leading to the inability of Palestinians to access urgent and preventative care, particularly the lack of protection and access to reproductive health (see, Hamayel, Hammoudeh and Welchman, 2017; see also, Long, 2006).[37] Israel uses health as an instrument of war, for example denying access to hospitals or refusing permits to expand healthcare facilities, which continues post-Oslo (Rubenberg, 2001: 168-169). For instance, after the start of the Second Intifada in September 2000, there was a period that coincided with repeated curfews and checkpoints, making it nearly impossible for doctors and nurses to reach healthcare centres to provide maternity care, causing women to seek services from locally available personnel who may not have been as well-qualified (Kitabayashi et al., 2017: 2161-

[36] For the effects of the political situation on the general health of Palestinians in the oPt, see Barber et al., 2014, and McNeely, 2014.
[37] For more on health in the oPt, see Sousa and Hagopian, 2011, and, Bosmans et al., 2008.

2168). Palestinian women also report suffering miscarriages as a result of exposure to toxic gas fired by Israeli soldiers (Rubenberg, 2001: 169).[38]

As such, Palestinian women are increasingly becoming 'more concerned with how and when they are going to get to the hospital', rather than being concerned with the medical aspect of the birth. Giacaman et al. pose the question, 'Would vaginal delivery at an Israeli army checkpoint be considered normal?' (Giacaman et al, 2008: 91). The lack of normality is demonstrated by the 2,500 cases per year of Palestinian women in labour being delayed in reaching the hospital due to delays and refusals of access, causing several women to give birth at Israeli checkpoints.[39] The Palestinian Ministry of Health (MOH) in 2004 documented 55 cases of women giving birth at checkpoints, resulting in 33 neonatal deaths (Giacaman et al., 2005: 135). Another source, the Human Rights Council, observed that between 2000 and 2006 there were 69 cases of Palestinian women giving birth at checkpoints, leading to four maternal deaths and 34 neonatal deaths (Wick, 2011: 539).

Evidently, healthcare for Palestinian women in the oPt needs to take into consideration 'physical, environmental, social, psychological and political influences' (Holt, 1996: 66; quoting Giacaman 1992). Ryan argues:

> Stopping and delaying women at checkpoints has a definitive link to Palestinian women's physical subjectification through the control of their reproduction. Such subjectification warrants great concern, as it represents attempts to control population growth by putting babies and the physical maternal body at risk of death or serious complication. (Ryan, 2015: 104-105)

An arguably 'unique characteristic' of the oPt is Israel's monitoring of the rates of pregnant women who have unsuccessfully attempted to reach health facilities, giving birth at army checkpoints (Mataria et al., 2009: 93). This monitoring is a tactic, as Kanaaneh (2002) describes, combined with the tactics of seizing land and controlling the reproduction of the Palestinian population as part of Israel's 'political arithmetic'. Comparatively, Paradies explains a similar situation among the indigenous population in Australia:

> Historically, non-Indigenous approaches to defining and understanding Indigeneity have focused on the need to surveil and control the socialization, mobility and biological reproduction of those with some descent from pre-colonial peoples of Australia. (Paradies, 2006: 355)

This brings us to the discussion of surveillance of reproductive rates. Inclusive in Israel's biopolitical strategies of controlling the Palestinian population, compartmentalising it and fragmenting it, there is also the strategy of surveiling it (Zureik, Lyon and Abu-Laban, 2010). Israel tracks the birth rates of Arabs and Jews not only within Israel (Kanaaneh, 2002: 39), but also within the oPt. This strategy of surveillance gained momentum principally after the Oslo agreement, which has been described as a 'population monitoring instrument in the hands of Israel' (Zureik, 2001: 218).

A method of Israel's surveillance of birth rates is the manipulation of knowledge. According to Giacaman et al. (2005), '[k]nowledge and control are potential tools in demographic strategy formulation, which are an integral part of the Palestine-Israel conflict' (ibid.: 133). In the pre-

---

[38] According to a report based on Bahrain by Physicians for Human Rights, toxic gas may lead to child miscarriages as well as birth defects and genetic mutations (Sollom and Atkinson, 2012: 38-39).
[39] For more on birthing in the oPt, see Wick, 2011.

Oslo era, the Israeli occupation authorities convinced the Palestinian population that a childbirth policy of hospital births would lower infant mortality, creating the illusion that home birth is 'associated with the image of the illiterate, barefoot *dayat*,[40] and hospital birth, on the other hand, was associated with modernization, medicalization, and progress'. This led to the gradual phasing out of the *dayat*, further accomplished by refusals to permit the licensing of new ones (ibid.: 129-139). This influence on the image of the "ideal" method of birth being hospital births, ensured accessibility to Palestinian birth rates.

With regards to infertility as a matter of reproductive health, the effects of Israel's military occupation are attributed to approximately one-third of Palestinians reporting low levels of wellbeing (Harsha et al., 2016: 1-7). Consequently, Palestinians are susceptible to mental stress, which influences hormonal imbalance triggering a reduction in fecundity (Issa et al., 2010: 2135-2136). Applicably, 'continuous stress and exposure permanently to toxins (tear gas) and to radiations emitted from Israeli checkpoints' are primary factors in the high percentage of male factor infertility in the oPt (Katwsa, 2013: 97-98). This is in line with Hansson's perspective of fecundity as a political factor, due to the biological aspects of politics in a conflict 'where the ability to reproduce is linked to teargas, imprisonments and Israeli food' (Hansson, 2012: 60-61).

Moreover, the lack of reproductive healthcare for indigenous communities has been connected to infertility. In Australia, PCOS rates among Aboriginal and Torres Strait Islander populations are three times higher than among the non-indigenous population; this and other factors 'can be addressed in both prevention and management through public health measures and appropriate clinical care' (Fertility Society of Australia, 2016). In the oPt, PCOS is under-researched, with one study finding the prevalence of PCOS as 'relatively high' (Musmar, Afaneh and Mo'alla, 2013).

Chlamydia trachomatis is 'the most common sexually transmitted bacterial organism'. It is typically asymptomatic, causing it to be easily undiagnosed and, therefore, untreated; however, '[u]ntreated chlamydia infection may ascend to the upper genital tract leading to severe reproductive complications like tubal factor infertility and ectopic pregnancy' (Dhawan et al., 2014: 253). A study in Gaza estimate 28.6% of infertile women have chlamydia trachomatis, which the authors argue is 'quite high and surprising' (El Qouqa et al., 2009: 340). Nonetheless, it is easily treatable if adequate healthcare is available.[41]

4. UNRWA and Infertility

At the offset of my field research, I was introduced to Dr. Ummayyah Khammash, previously UNRWA's Director of Health. Dr. Khammash introduced me to a plethora of issues relating to infertility among Palestinian refugees in UNRWA refugee camps. His particular knowledge base, of course, stemmed from his years of work at UNRWA. An understanding of the healthcare system provided by UNWRA is important, as it affects nearly 1.5 million refugees in Gaza and 1 million refugees in the West Bank (UNRWA, 2018) and is an agency that was created as the by-product of the 1948 Nakba, with a two-fold mandate:

[40] *Dayat* are indigenous birth attenders that were the principal providers of perinatal care in Palestine (Giacaman et al, 2005: 132).

[41] For more on the effects of chlamydia trachomatis, see Hajikhani et al., 2013, and Dhawan et al., 2014.

> to carry out, in collaboration with local governments, the direct relief and works programmes as recommended by the Economic Survey Mission and to consult with interested Near Eastern governments concerning measures to be taken in preparation for the cessation of international assistance for relief and works projects. (Bocco, 2010: 231)

This two-fold mandate includes providing health services for Palestinian refugees. However, this service has historically been severely hindered by the issues of funding as well as Israeli policies. UNRWA funding is 'guaranteed only by the voluntary contributions of donor countries', which carry political interests that have 'historically set limits to UNRWA's initiatives, activities, and autonomy' (Bocco, 2010: 233). UNRWA's largest donor country was the USA, donating over $360 million in 2017; in 2018, however, it reduced its funding to the Agency by 83%, followed by an announcement on August 31, 2018 stating it would terminate all of its financial support (Kitamaru et al., 2018: 2742). Although UNRWA subsequently attempted a global fundraising campaign, the Agency's deficit as of September 2018 is $68 million (ibid.).

This deficiency, coupled with Israel's policies of a blockade in Gaza and occupation in the West Bank including East Jerusalem exposing both regions to chronic violence, which jeopardizes the physical and mental wellbeing of Palestinian refugees in the oPt, has created a crisis situation for UNRWA's ability to provide adequate healthcare services (Kitamaru et al., 2018). This understanding of limited resources, donor countries' political interests, and the availability of health services, are traceable throughout the following conversation with Dr. Khammash.

Dr. Khammash began our discussion by telling me the biggest issue facing infertile women in the refugee camps is the healthcare system. This system, he argues, causes a combination of issues within all spheres of infertile persons' lives from social and economic to medical. He does acknowledge, though, that some domains and aspects of life for infertile women may be more critical and problematic than others, referring to the social implications of infertility.

Dr. Khammash continues his discussion on the medical domain relating to the insufficient reproductive healthcare provided by UNRWA, and its subsequent social and financial effects on infertile persons in the refugee camps:

> UNRWA does not support fertility treatments. Refugees have to pay for it out of pocket. Women who do not have children and cannot afford fertility treatment are severely impacted in their marriage and mental health. Of course, I believe they should have the ability and funding to undergo fertility, but it is not in my hands. It is due to the financial constraints within UNRWA. UNRWA does not even cover the cost for men to receive medically necessary operations in their testicles, which then leads to the loss of sperm caused by the blocking of the veins and/or obstruction of the veins. UNRWA perceives these operations as plastic surgery and unnecessary.

Dr. Khammash problematizes the circumstance of infertile persons by examining the issue of health, relating that infertility in the refugee camps has a multitude of causes. He argues that infertility among women is caused by multiple factors and is not only limited to physiological aspects from birth. He locates society and economy as possible causations of infertility. He portrays this through the comparison of two hypothetical situations, stating,

> Infertility in women is caused by multiple factors, not only one factor. A woman is affected by her or her family's lifestyle. For instance, stunting may cause infertility. Therefore, a well-fed woman who has a good nutritional diet will not be as affected as a woman who is not well-fed and has a

> bad nutritional based diet. Moreover, smoking, psychological problems and obesity are causes of infertility. As such, almost all societal and economic factors may contribute to and determine reproductive abilities. There is literature and research associating the health of a woman with her reproductive ability. This is not just a conclusion I have come to alone.

At this point in the conversation, Dr. Khammash discussed high Palestinian birth rates as a reason for the lack of research and discussion on infertility. Although there continues to be high birth rates within Gaza's refugee camps, there has been a recent decline in birth rates in West Bank refugee camps. He went on to criticize researchers and society for not reflecting on infertility and being solely focused on the fluctuating birth rates, because from his perspective 'infertility is high in Palestine, as well as fertility being high'. He argues people do not research and reflect the influence and influence of infertility on people's lives. He also finds that research on fertility in the oPt within the field of health and the social sciences disregard infertility. This lack of research discussing infertility in the oPt is problematic.

Dr. Khammash did acknowledge that this judgement of infertility and fertility both being high is more his own observation and understanding of trends, rather than being based on actual data, which to him is a further reason to research infertility. He explains, 'there are conversations occurring between doctors, even including Israeli doctors, discussing infertility within Palestinian communities as higher than infertility within Israeli communities'. This may be due to the lack of accessible ARTs; however, without further research it is difficult to explain or even locate the truth of these proposed measurements.

5. Conclusion

This chapter discussed the relationship between female infertility and the healthcare system in the oPt. It positioned infertility within wider reproductive health concerns, stemming from the fragmented, complex and heterogeneous healthcare systems in the oPt, which is a by-product of Israel's settler colonial policies. These systems have left infertile women in a dire state.

The political dimensions influencing the healthcare system produce considerable impediments on movement, the ability to access urgent and preventative care, and preventing access to reproductive healthcare. These impediments derive from biopolitical policies of controlling, monitoring and fragmenting the Palestinian population as a means to decrease biological reproduction.

The impediments to accessibility, and their experiences with the healthcare system, have left infertile women weary and unable to trust the healthcare system. In Rana's case, her experience and lack of legal remedy has led her to refuse fertility treatments and force herself to accept her childlessness. Mariam's distrust of the healthcare system has caused her to link her experiences with her infertility. The women, as further discussion will show, are not alone in their negative experiences with the healthcare system, the curtailment of their access to healthcare, and the inadequate outcomes due to the deteriorating healthcare system in the oPt.

Furthermore, the political dimension has also led to financial impediments on the healthcare system. The underfunding and political interests of donors, which prioritise achieving lower birth rates through family planning, is the leading cause of the non-existent fertility services within the multiple healthcare public schemes provided by UNRWA, the PA and PNGOs. These impediments are further exploited by Israeli policies, particularly the entrenched corruption of the Oslo Accords, which passed on the healthcare responsibilities to UNRWA,

the PA and PNGOs, which are directly related to the role of maintaining civil society in the post-Oslo period. The following chapter will explain in further detail the economic sector of the oPt as a by-product of settler colonialism.

CHAPTER VII: SOCIOECONOMICS OF INFERTILITY

In countries which lack effective social security systems, a situation is created in which elderly people are economically dependent on their children. As such, fertility is high in demand when children are of cost value, in comparison to being low in demand when children become a costly burden (Therborn, 2004). For instance, poverty-stricken families in Pakistan have a higher birth rate in order to generate more economic capacity to support themselves. Meanwhile, infertile women in countries that lack social security are deemed as an economic burden to their families, due to their inability to conceive the economically necessary offspring. This leads to weakened marital bonds, societal ostracism, and even physical and psychological abuse from their spouses, relatives and society (Mumtaz, Shahid and Levay, 2013).

As the political economist Sara Roy states, 'one cannot understand societal conditions without understanding the economic context from which they emerged' (Roy, 2004: 367). Consequently, economics plays a role in structuring opportunities in everyday life at the micro-political level, and shapes institutions including healthcare. This chapter discusses the influence of the economic sector in the oPt as playing a pivotal role in the conceptualisation of pro-natalism, as well as the in/ability to undergo ARTs due to the absence of health care insurances covering the cost of fertility treatments.

1. Yasmin: One Biological Child is Happiness

Once I arrived at Rana's house, her mother asked me if it was okay for a friend of hers, Yasmin, to come to speak to me. Yasmin, as they explained, was an infertile woman living alone in an apartment positioned on a very steep slope on the outskirts of Bethlehem. She heard about my research and wanted to discuss her situation with someone, in hope of bringing more attention to her situation. Yasmin later informed me that she was 'excited' to leave her house, as it had been a while since she last left. She explained how she did not have the financial means to take transport to Rana's family's house, but 'thankfully, I left my house and a taxi driver saw me and offered me a ride for the sake of God'.

I interviewed Yasmin in the same room I interviewed Rana. Once we sat down, Yasmin immediately began telling me her story, recalling

> My sister passed away in her late thirties, leaving behind her husband and three children. Her husband was 48 years old when his wife passed away. Her youngest was a girl, Leila, approximately four years old. Her eldest son, Omar, was around 20 years old. Her younger son, Yahya, was 13 years old. Yahya was really smart and my favourite.
>
> When his mother passed, Yahya had been imprisoned [by Israel] for almost one year. Throughout his imprisonment period, he was going between doctors and hospitals because the Israeli soldiers beat him up really badly, and his head was swollen. They pardoned him at the age of 13, but he went back to the resistance. He continued in the resistance and conducting acts [against Israeli forces]. So, they imprisoned him once again.
>
> The second time he was imprisoned, he was 15 years old and stayed until he was 21 years old. He was not indicted or have a court hearing. Every time he had to go to court, he would not stand up for the judge. His father told me that Yahya would say in court, 'I will not stand up for you' to the judge. Angrily, the judge would not continue the session, and have him sent back to jail. There was never a verdict or a ruling.

> After six years of being incarcerated, Yahya asked for me and his father to visit him together. He requested I marry his father to help him and raise his siblings. At the time, I was 30 years old and had never married. His father was 53 years old. Yahya expressed to me, 'I know you are still young, but I cannot entrust my father to anyone except you'. I agreed to marry his father with Yahya acting as my *maḥrm*.[42] Since then, everyone has called me *Im* Yahya [Yahya's mother].

As Yasmin explained, in Palestinian culture it was common for a woman to marry her deceased sister's husband in order to raise her nieces and nephews within the family, to prevent their fear of a potentially impolite and unkind new wife being given the task of raising family members. However, Yasmin reported that Yahya requested she marry his father primarily to take care of his father, rather than him and his siblings.

Yasmin explained that his request was not odd or unpredictable due to social customs, and she agreed. It was only the next day when she realised why Yahya had made his request.

> The day after our marriage, Yahya escaped from prison. He had planned to escape, but wanted his father to marry me before he fled. When he fled, he got far, but someone informed on his whereabouts. Yahya was a warrior and a resister. He is not like the Palestinian resisters nowadays. The Israelis found him fleeing, and assassinated him. They returned his dead body to prison and kept it for five years. They just left him after his death for five years! They claimed this was his sentence for having fled.
>
> After five years passed, it was time [for the Israelis] to give me and my husband his body. The Israeli officials told us that we could have his body only on one condition, that 'you do not allow anyone to attend his funeral'. They only wanted his close relatives. His father responded to them, 'I leave him for you. If I cannot make a proper funeral, I do not want his body'. In the end, at around half-past-nine in the evening, they gave us his body. The streets were filled with people, and everyone carried him. Yet even when they put him in the coffin, the Palestinian security officers would not allow us to see him. They took his body quickly and we all headed straight to the cemetery.

Yasmin expressed her and her husband's love for Yahya. Yahya's father even requested from Yasmin, 'when I pass away, bury me with my son'. Yasmin explains she did exactly that.

> I buried my husband, his father, in the same cemetery where the martyr Yahya was buried. Actually not only in the same cemetery, but next to him in the same grave. When the people opened the grave to place my husband there, they informed me '*Im* Yahya, your son is just as if he was sleeping'. Yahya was a man in all senses of the word. If he did not die, I know he would have been taking care of me now. He would not leave me.
>
> My husband passed away 41 days after returning from Hajj. He was 73 years old. We were married for 20 years. If he was still alive, it would be 26 years. In the last few days of my husband's life, my niece was going home, and the taxi driver told her *Abu* Yahya [Yahya's father] is not normal. That day at quarter-to-six in the afternoon, my husband found *salam* [peace]. He was sitting on my lap in the living room, telling me 'don't you dare cry. I do not want to hear you crying'.

[42] Meaning 'unmarriageable kin', though in this case Yasmin is referring to Yahya as being the witness to her marriage contract.

In Islam, when a woman's husband passes away, she has to complete an *'ida*.[43] Yasmin recalled her days during the *'ida*:

> Sometimes I used to go buy a couple of items, but come right back home and shut the door on myself. I barely ate and did not sleep. My weight was 59 kilos. My eyes when the *'ida* was over were small and black. I did not sleep, neither day nor night. I would be sitting, attempting to sleep, but I could not. I could not even eat, just drank water.

Her actions, as she explained, were due to her love towards her husband. She stated this love was mutual: 'My husband was affectionate towards me. He loved me. He was also very protective of me. He was good and generous to me'.

However, after his death Yasmin was left alone, regardless of the amount of times her husband implored his son Omar, 'if anything happens to me, take care of your aunt.' Omar, Yasmin remembers, would acquiesce to his father, 'but when he died, the son left and did not ask about me'. She describes Omar as a '52 year-old, unmarried man'.

One day, Yasmin reached out to Omar to ask him why he did not check up on her and make sure she was well, as she had no one living with her. Omar responded, 'it is your fault you did not have children'. Yasmin related how Omar 'always tells me "if only you had children…"'

Subsequent to her husband's death, Yasmin went to the bank to request they transfer Yahya's stipend money to her account, rather than to her husband's account. She explains:

> The bank informed me to go to the government municipality and ask. I went, asked, and reviewed the situation. In the end, the government told me, 'we cannot do anything, it has been transferred to his brother'.
>
> He told me it was my fault I did not have children. Can you believe it? He even took Yahya's stipend once his father died. He blamed me for not 'needing' it, stating, 'if you had a boy or girl I would have given you the stipend, but you do not have children and, therefore, do not need the money'. So, he thinks he can take the stipend.

At this point in the interview, Yasmin discussed her relationship with her husband's daughter: 'Even Leila I raised as my own, but she also *'tkhalt 'any* [gave up on me]. She is now married and lives in Jordan. She does not ask about me. She does not even try to call me at Ramadan or in the holidays.'

Subsequent to this discussion, Yasmin presents her situation after her husband's death as lonesome and lacking economic support.

> Now I am left to live alone, and only God knows how I live. I live like a childless widow with help only from people here and there. I am now 56 years old, live alone and suffer from multiple illnesses. I have low blood sugar, asthma and problems with my nerves. I recently got approved to be treated for my nerves. I never had children. God did not give me any even though I used to pray God would grant me a boy or girl to take care of me.

[43] Literally means 'to keep count', referring to the Islamic law of waiting a period of time in mourning after the death of one's husband.

In her comment, 'I live like a childless widow', Yasmin utilises the term 'like' because she regards her husband's children as her own who have abandoned her. She later discussed her inability to biologically have children due to age-related factors:

> My husband and I both had problems and could not have children. I was too old in age, and he got sick. My brother's daughter used to follow up with me, so she knows everything. I went to a very prominent doctor. I showed her all of our test results, and towards the end of our sessions the female doctor told me, 'do not tire yourself.' She explained there was no point in continuing because we would never be able to have children.

Resulting from her childlessness coupled with living within a state that does not provide social security, Yasmin is economically dependent on others, a situation her husband feared would occur.

> My husband used to always tell me, 'I do not know what is going to happen to you when I die'. Now here I am. Everyone knows my situation, how I am living. People pass by to see me in the holidays and events. At Eid, the neighbours who sacrifice an animal bring me some of its meat. They are my neighbours on the hillside where I live.
>
> At home, I did not even have a television. All day I would just be sitting there listening to the Qur'an. I lived two years without a television after my husband died. [In the end] People donated one to me. It is not an up-to-date television. It is a small, simple one, but that is okay. I entertain myself with it. I am always at home alone. No one comes to visit me.
>
> Even a refrigerator, I did not have one, but people also donated one. Thank God they did, because if I did not have one this Ramadan, I do not know what would have happened. Also, do you see this shirt I am wearing? I have had it for 30 years. It was originally a jacket, but I went to the seamstress and asked her to make it into a shirt because I do not like jackets.

Not only is she financially dependent, she is also physically dependent on others when she is sick. She explains an incident that occurred:

> Once at eleven in the evening, I vomited and my vomit clogged my air pipes, making it difficult for me to breathe. I have an asthma pump in the house because I usually get shortened breath. I ran outside to my neighbours; we usually have Israeli soldiers in the area at night, so it becomes scary to go out. People are frightened by late knocks on their door. Yet I ran to my neighbours and started knocking, he opened the door to find me on the ground. My face was like this purple shirt I am wearing. He asked me '*khalty,*[44] what is wrong with you?' He and his brother took me to the hospital's emergency section. Right away the doctors knew I had shortness of breath. My neighbour and his brother stayed with me in the emergency room until 12:30 at night.

Moreover, due to the location of her house being in Area C, the occupation is also a factor in her life and in her neighbours' lives.[45] Yasmin discussed her fear of the constant presence of Israeli soldiers as a reason why her neighbour's do not check up on her as often. She went on to recall a recent interaction with Israeli soldiers:

---

[44] Meaning 'my aunt', but also used when speaking to an elderly person or out of respect.

[45] The Oslo Accords designated the oPt into three areas: Area A is under civil and military control of the Palestinian Authority; Area B is under civil control of the Palestinian authority while military control is designated to Israeli authorities; and Area C is under civil and military control by Israeli authorities. Area C characterised a space of 'graduated incarceration' for Palestinians (Smith, 2011).

> Recently, soldiers just entered my house. When they came to me, I was alone. It was during the last year, in December. They are always in the neighbourhood every night. This time they came for a regular *taftīsh* [inspection]. They knocked the door and asked me if I was alone. I responded, 'yes, I live alone without anyone else'. They asked for my ID, which states I am a resident of Beit Jala, but where I have lived since my wedding is not Beit Jala. When they noticed this, they asked 'why are you in this neighbourhood?' I answered simply, 'it is my fate'.
>
> They searched the house, and when they were about to leave the captain saw Yahya's photo hanging on the wall. The captain looked at me and said 'is that Yahya?' I said 'yes, you are the ones who killed him'. The captain replied, 'no, not us'. I said 'then who?' He did not reply, but instead he asked me, 'how are you related to him?' I informed him, 'I am his father's wife and his aunt'. They then turned around and sat me on a chair for questioning. I told them, 'Yahya has been dead for decades. You see me here living alone, without a husband or children. What do you want from me?'
>
> One of the soldiers as he was opening the windows commented, 'you poor woman, how can you live in this house? It is all humidity.'

Yasmin discussed her vulnerability in these situations, and her inability to feel safe. She stated that she does not know what the soldiers will do or how they will react to a particular situation.

Later, she commented on the humidity issue brought up by the soldier, explaining to me:

> Yes, in fact it is humid. I leave my windows closed all the time. I do not have screens on my windows, so I get scared to open the window because I am on the ground floor and there are snakes and scorpions. Even with the cats outside, I still find a lot of snakes around my house.
>
> Just recently, like a few days ago, I opened the window to get some fresh air. All of a sudden I saw a scorpion trying to enter the house. A yellow one. I moved the chair beneath the window, threw the scorpion on the floor and hit it. I took my shoe and hit it. Imagine, if I did not notice it, it would have hidden between the couches.
>
> Honestly, people donated those couches to me. I used to sit on a plastic chair. I do not even have a bed. I sleep on a mattress and blankets on the floor. I do not even have a carpet. My brother's wife bought me a table and chairs. I really want to leave this country. Unfortunately, though, I do not even have the capability of going to Jordan.
>
> I went a week once without bread. My neighbour, who usually brings me food that his wife cooks, came by and I asked him after that week for a bag of bread. He asked 'What is wrong with you? Is everything okay?' I told him I just want a bag of bread. He sent his son with bread, yogurt and food his wife cooked. They are kind people.

Yasmin's economic situation leads to her inability to save money because she has minimal finances, all of which must go to food in order to survive. There is a lack of governmental assistance, not only in financial means but for other forms of assistance. For instance, Yasmin reports,

> There are even two dead cats in the water barrels. They fell inside and died because they could not get out. I have to drink from water bottles now because no one is willing to remove them. I called the governmental offices, even the fire-fighters, but no one responds to me. They take my number saying they will come by, but they never did. I cannot do my laundry in the washing machine anymore. Last time I washed my clothes, dirt was mixed with the water, damaging the washing machine.

At the end of the interview, Yasmin teared up and stated,

> I wish that I could live with dignity. That I do not have to live off people's kindness. When people bring me things and feel bad for me, it rattles my heart. They tell me, 'it is okay. We know of your situation. We know you do not have children'. The last Eid, one guy came with his wife to give me meat. I was really tired and uncomfortable [referring to her health]. He told me '*ya*[46] *khalty*, leave the door open in the daytime. When you feel uncomfortable, go outside so someone can be aware and pay attention to you'.
>
> I do not like anyone to get the wrong impression of me. I do not want people to think I am a burden to them. If so, they will have something against me. So, I keep living and not asking people for thing *alhamdulillah*. I only ask that God *mā yirmīnī*,[47] because who is going to take care of me? *Ya'nī* [48] I have no children, so no one is going to be aware of me. This [political] situation is scary for an elderly woman alone. If I had biological children, even just one, I would be happy. I would not have to worry about anything. I would not have to worry about myself and my future.

2. Socioeconomic Conditions in the oPt

Yasmin's story speaks to the importance of children in areas affected by military occupation coupled with settler colonial policies – not only Yasmin's desire to have children, but also the financial and emotional support provided by biological children. Yasmin chose to marry her deceased sister's husband out of love and affection for her nephew, as well as family expectations. However, after marriage, Yasmin discovered her and her husband's state of infertility. After their discovery, Yasmin's husband was concerned about leaving her alone without children. His worries were later actualised, as Yasmin not only described her life after her husband's passing as lonesome, but also full of economic uncertainty and vulnerability. Yasmin, along with many other infertile individuals in the oPt, suffers from the detrimental economic sector, the lack of social services and all the other impacts of the occupation.

Since 1948, the West Bank has undergone two transformations in its economy. With the creation of Israel in 1948, Palestinian society's political, social and economic structure was destroyed. The West Bank lost it markets and was impacted severely by economic factors, including the result of an influx of hundreds of thousands of refugees.

Subsequently, between the years of 1948 and 1967, the West Bank was integrated into the Jordanian economy, remaining 'relatively underdeveloped'. Then in 1967 with the Israeli occupation, the West Bank's 'economic relations were ruptured again and new links had to be made, mainly with the Israeli economy'. Israel pursued a deliberate policy of subordinating the economy in the oPt:

> Israeli planners, politicians and military leaders have undertaken efforts to de-develop the Palestinian economy through confiscating land and resources and undermining potential growth by rendering the Palestinian economy dependent on Israel. (Isaac, 2010: 19)

This was accomplished through two methods:

---

[46] Arabic interjection meaning 'oh'.
[47] Arabic phrase literally meaning 'does not throw me', referring to a person unable to move and needing constant assistance from people.
[48] Arabic interjection meaning 'that is to say'.

> Israel followed a dual policy of (a) absorption of Palestinian Arab labour into the Israeli economy and total control of trade and (b) undermining potential growth in the Palestinian economy by the expropriation of land, severe limits on access to water resources, the denial of an adequate banking system and restrictions on economic development by military orders (Mansour, 2015: 96-97).

As such, between 1967 and the establishment of the PA, 'the Israeli Civil Administration had full authority over Palestinian economic, political and institutional affairs' (Taghdisi-Rad, 2014: 15). Arguably, this also provided Israel the ability to control the development of Palestine's economy, ensuring its continuous de-development (Isaac, 2010: 19). Presently, the ongoing military occupation is obstructing economic and social development (Giacaman et al., 2011: 555), with prolonged occupation and Israel's strategies towards the oPt only reinforced by the provisions of the Oslo Accords which have resulted in structural, institutional and sectoral weaknesses (Taghdisi-Rad, 2014).

Consequently, since the Nakba, the Palestinian people have been and continue to be heavily dependent on international aid due to the trauma of successive wars, military occupation and life in refugee camps (Giacaman et al., 2011: 553). The post-Oslo period saw an influx in international aid, as well as international and non-governmental organisations attempting to assist in the formation of an efficient PA. Agencies and actors working with the PA are meant to implement and assist in the development of the Palestinian economy, but instead are arguably 'normalising the existing patterns of domination, rather than enhancing Palestinian capacity to develop independently' (Isaac, 2010: 20). International funding and aid is described as a 'form of soft colonialism' and predominantly governed by foreign donors, as well as bound by their respective country's political goals (Allen, 2013: 68).

This political and ideological allocation of aid without an understanding of the workings of aid in places of conflicts such as Palestine, has caused the economy to continue to suffer (Taghdisi-Rad, 2014). For instance, the fact that more than US $9 billion has been disbursed for the intention of Palestinian development and capacity-building since 1994, yet little development has actually occurred, points to de-development, economic deterioration and increasing poverty in recent years (Batniji et al, p. 1140-1141).

Frustration and lack of economic improvement led to the Second Intifada from 2000 to 2005. During this period, Israel initiated the destruction of many of the oPt's physical assets such as homes and businesses. Additionally, this period witnessed the construction of the "security" wall applying further pressure, fragmentation and isolation on the Palestinian population increasing economic loss (Roy, 2004: 367-382). Following the end of the Second Intifada, international donor funding was allocated to short-term emergency and institutional-building assistance, in the hope of preventing the collapse of the PA and a humanitarian crisis (Taghdisi-Rad, 2014: 10).

Accordingly, Meari argues that Oslo has been a means of transforming 'colonial relations of antagonism while preserving colonial conditions of domination' (Meari, 2015b: 82). Similarly, Farsakh argues that the Palestinian economy 'remains fragmented, dependent on Israel, and unviable', and describes the aid projects as entrenching the settler colonial project (Farsakh, 2016: 48).

Furthermore, it has been claimed that access to employment and resources is intentionally manipulated by Israel as a strategy (McNeely et al, 2014: 513). According to Dr. Najjab, it is

imperative when discussing the economy to take into consideration the participation of women in the workforce. She reports that:

> In the oPt, the women's participation in the workforce is 19%, which is very low and possibly the lowest in the Middle East and low on the global scale. This is the formal workforce. Women in the informal workforce, for instance women working with families, cleaning, etc., make up only 25%. So, approximately only one quarter of the female population is working and three quarters are not working.

This uneven positionality of high female unemployment leads to poverty and women's low status vis-à-vis men. She explains, 'wherever there is high female unemployment, women suffer first in various aspects, including lack of laws to support them'.

Due to high unemployment among men and women, labour migration by West Bank residents into Israel and Israel's illegal settlements within the oPt, has become a source of income (see Farsakh, 2005). Labour migration of Palestinians from the West Bank to Israel including East Jerusalem was discussed in interviews as a reason for the inability to conceive a child due to physical barriers and distance. Mariam described her and her husband's fertility concerns:

> We live now in Bethlehem but he works in [East] Jerusalem. He has a permit to enter [Jerusalem], but I do not. Because of this, my husband and I have a problem, which is the most prominent reason as to why we have not had children yet – he is not with me. He leaves for two to three weeks, and comes back for only a week. You know, the period of fertility [ovulation] is really only one day. The fertility period is ten days, but on only one of those days is the egg released. So now we have to be concerned with the days that he comes home. Will he come when I am in my fertility period, and especially the day the egg is released, or not? Will it be the beginning of the fertility stage or the end? Recently, he just came back. He will stay for a week and on the following Sunday he will go back to his work. Then he is gone again for three weeks.

She explains the reason behind this is that her husband has a work permit, but is not allowed to 'go and come as he likes' to and from Bethlehem.

3. Economics of Assisted Reproductive Technologies (ARTs)

I timidly looked down as we made our way through outdoor staircases down a hilltop, with nothing below us. As we reached the third floor apartment, a woman welcomed us into her home. The first room contained no furniture besides two plastic white chairs. The second room, where we sat, contained two fabric couches with matching loveseats, along with a table. The room was small, and there was barely space for one's legs. Above me perched two lovebirds in a green birdcage.

After I introduced myself, the woman who welcomed us into her house, Jenine, asked me to wait a minute. She looked over to the entrance of the room where two young girls who had just entered were standing and listening to us speak, telling them, 'you two know it is rude to listen in while women speak'. Framing it as 'women-speak' relates to the sexual aspect of biological reproduction as a sensitive discussion only for adult women. The girls apologised, moved away from the doorway and sat in the next room on the two chairs. The woman pointed to the room where the girls sat, stating 'those are my sister's children. They live downstairs but are always up here. Please continue'. So, I did.

Once I finished, Jenine quickly stated, 'you know, I got married at 17 years old. I have been married for eleven years but have never been pregnant. I want to undergo fertility treatments, but it does not work for me financially'. This would be the first of several times throughout our discussion that Jenine would discuss the topic of her and her husband's financial state.

She continued her discussion:

> I visited multiple doctors, but they all said that there is no specific reason for not reaching pregnancy. It is from Allah. I used to have an ovarian cyst, but thankfully I got treated and had it removed. However, even after its removal, I did not get pregnant. The removal was pointless. The doctor later told me 'you need to undergo IVF, there is no other solution'.
>
> If I found the money, I would undergo IVF treatment. My family continuously tells me 'do IVF, do IVF, do IVF'. I tell them, 'I live in a rented apartment; I cannot pay my rent, how can I pay for IVF?' His family, on the other hand, they do not ask or get involved in my problem. His family always helps us with regards to the rent, but they do not get involved with our fertility.

Jenine's sister, Roqaya, excused herself from the room to make Arabic coffee in the kitchen. Jenine revisited her and her husband's financial state:

> The financial state we are in does not allow us to undergo any fertility treatments. We were led down different routes and tried different ways to acquire money. We even went to Abu Mazen [PA President Mahmoud Abbas]. We went to everyone and reached all the places we could, but it did not work out for us. I even have a folder with the doctor's medical reports, stating we are in need of IVF, and it includes a letter discussing our financial status proving our inability to pay for the treatment. I sent the president letters five times, but it did not work out for us. I also went to the governmental building [Ministry of Health], but it did not work out for us. They did not help us. They claim to help and assist people to undergo fertility treatments, but it is an empty statement. They do not help.
>
> They used to help a long time ago during Arafat's time [previous PA President Yasser Arafat, in office from 1994 until his death in 2004], but not anymore. Now I am left to live in a rented apartment, and since marriage we have always been living here. I pay 100 Jordanian dinars [approximately US $140]. I pay for the water and electricity too. Electricity breaks us financially. I swear to God, the circumstances we are in does not help. If I had the monetary means, I would have done IVF a long time ago. I would have by now probably had two children.

Roqaya's daughter, Amani, walked in and served us Arabic coffee. One of the women stated that she would drink coffee only if someone would read her fortune from the coffee grounds (see, Jones-Gailani, 2017). A friend of Jenine who was sitting in the living room with us agreed to do so. The woman subsequently quickly drank her coffee, flipped the cup over the plate, and waited for the sludgy black grounds to dry. Jenine laughed and commented *al-dār dārkum* (this house is your house) before continuing her conversation with me.

> I just want to ask if there is anyone who can help, I wish they can. I have, as I told you, all the medical reports. I even went to a few clinics, one of them recently told me that I can pay them with checks, but where am I supposed to get checks from? My husband does not have checks, or even deals with checks.
>
> To be honest, I was going to tell my husband to take out a loan. It is my intention. However, we went to a sheikh and asked him, he said that a loan for IVF is *haram*. The sheikh is our neighbour; he lives two houses down. He said that if we take out the loan, 'God will cut off your livelihood, or God will not bless you with the child'.

Amani, Jenine's niece who had been standing at the room's entrance since serving the coffee, remarked, 'as if it is *haram* for you to have a child.' To this Leila agreed, saying 'I was going to say the same thing. What kind of sheikh is this? The sheikh that tells you it is *haram*, tell him "okay, put your hand in your pocket and give me money!"' Jenine replied, 'I accepted what he told me and leave my agency and hope to God.' However, Amani was not convinced, adding,

> If I were in your position and someone *ḥarmny* [made it forbidden] for me to have children, I would not accept it. Imagine going to everyone and begging them to give you money. This is what my aunt is left to do! No, I would take the loan and pay it off later.

Jenine looked at Amani and replied in a calm manner, 'what am I supposed to do? We went to the president and to everyone. The sheikh said it is *haram* and I do not want to enter into *haram*. Either way you should not be there eavesdropping, it is *'īb* [shameful]'. Amani left the room as the women flipped their coffees and started fortune telling.

Jenine as well as the other women interviewed live within a context of military occupation and substantial levels of poverty, particularly in refugee camps, in which participants often made requests of the researcher and showed themselves to be accustomed to being subjects of politically-related research. At times, interviewees did not fully understand my reasoning for interviewing them, and occasionally I would get women asking for monetary assistance, most frequently in my interviews with Yasmin and Jenine. During my interview with Jenine, she asked on more than one occasion if the recorder was on, in the hope that her discussion regarding her and her husband's economic situation would be related to others and she would, in turn, receive funding.

Although Jenine's conscious behaviour and desire to discuss her financial state may seem as if it would influence the interview, I found that instead it provoked discussion of the financial necessities, determination and desperation she has for conceiving children. Not only does she require additional financial support necessary in her case to conceive a child, she also fears losing her husband to polygyny and the inability to support herself in the future. As Bennett (2017) reports, the capability to prevent as well as treat infertility is conceded by fraught healthcare systems. Most people needing fertility treatments live in countries unable to provide it creating a myriad of inequalities in the burden of infertility as well as distinct experiences as such, '[e]conomic inequalities and uneven rates of development are deeply implicated in the key causes of preventable infertility, and also shape people's ability to seek solutions' (ibid.: 3).

Despite the ever-increasing presence of ARTs, the ability to acquire infertility treatments is heavily dependent on an individual's/couple's economics and healthcare access. The typologies of infertility and the creation of ARTs have formulated the conceptualisation of the economics of infertility. This concept is influenced primarily by the access to fertility treatments in developed and developing countries, and the economic disadvantages of not producing children.[49] Therefore, states that do not cover or subsidise ART procedures lead

[49] For more on economic access to fertility treatments, see Dyer and Patel, 2012, and Beckman and Harvey, 2005.

fertility treatment procedures to be only be acquirable by and to benefit a small, elite segment, with very little access for non-elite women.

The Palestinian Ministry of Health (MoH) previously financially supported infertility treatments while Yasser Arafat was president. Dr. Najjab discusses how the healthcare system and government considered (in)fertility as a political issue. She recalls, 'Arafat promoted the idea that Palestinian women should have a lot of children. He had the government pay money for fertility treatments, money that is not part of or from the insurance. If you were from the West Bank or Gaza, you were able to apply for funding'. However, the MoH discontinued doing so under its financial constraints, and heavy reliance on NGOs and donors which prioritise family planning over fertility treatments (Hansson, 2012: 51-52).

Given that true statehood and state institutions never emerged in the post-Oslo era, NGOs continue to play a crucial role in Palestinian society (Wick, 2011: 537). Donations and financial assistance have a grave influence on determining the type of health system emerging and its management through ensuring what they consider priorities, these including family planning programmes (Giacaman et al, 2005: 137).

Family planning in regions with ethnic conflict is a method of population control and is 'developed as part of a pattern supported by ideological underpinnings in healthcare. Thus family planning programs become implicated in genocide' (Rubinstein and Lane, 2002: 145). Further to this dimension, no NGO in the oPt provides funds for fertility services/treatments (Rubenberg, 2001: 176-177). This results from institutional actors refraining from introducing any national population policy due to political reasons and restraints (Memmi and Du Loû, 2015: 291).

Moreover, Rubenberg (2001) states:

> little attention has been paid to infertile couples within the context of family planning or in maternal or childcare clinics, although some such services exist, at significant cost, in the private, urban sector. The reason for such inattention resides, as discussed, in the family planning strategy of the World Bank and the NGOs it supports. It is notable, in this context, that no NGO provides funds for infertility services. (ibid.: 176-177)

Consequently, in the oPt, ART treatments are rarely covered by healthcare providers and may cost infertile individuals/couples between $3,000 USD to $6,000 USD for one treatment such as IVF. Due to the dire economic condition and lack of a proper healthcare system, couples who are infertile and seek treatment are often economically constrained and therefore incapable of paying for treatments. Coupled with this, it is almost always the woman who is blamed for the problem, and many Muslim men prefer to divorce a woman or marry another woman through polygyny, rather than submit to clinical procedures to ascertain their own reproductive capacity.

Thus, the most palpable economic disadvantage of infertility, is the requirement to pay for an ART procedure which has only a minimal guarantee of success. This payment may lead to the selling of land and/or homes for only one treatment, after which couples may still be left childless (WHO, 2010: 881-882). According to a nurse at a fertility clinic in Bethlehem:

> At this clinic we have a higher rate of infertility cases with male-factor causes […] After conducting the initial tests and screenings, the majority of the husbands that learn that the cause of their [the couple's] infertility is from their wife, will in turn divorce her or marry another wife. They [the

husbands] say, 'why should I spend the money on treatments? I might as well get married with it'. There needs to be a health system in place to protect these women from these economic constraints.

In one of my discussions with Dr. Barghouti, he stated that 'there are very good and technologically up-to-date fertility clinics in the oPt, with twelve clinics in the West Bank and eleven or twelve in Gaza', which he considered a sufficient amount for the population. The problem, he posed, occurs not with the amount of fertility clinics and/or available technology and expertise, but rather it is the financial constraints on the clinics as well as on infertile persons.

Dr. Barghouti reveals the health insurance sector within the oPt as a 'huge problem' for couples seeking fertility treatments, given that 'almost 99% of insurance companies do not cover treatments because it is expensive', and the ones that do cover treatments are private insurance companies. He explains:

> The Ministry of Health does not cover any treatment at all, no matter the case. Over ten years ago, during Arafat's time, he supported fertility treatments and ordered the Ministry of Health to cover IVF treatments, and a few other types of fertility treatments. But during the new leadership under Abbas, the Ministry of Health stopped providing funding for treatments from the first day.

Consequently:

> A lot of poor people suffer from the economic aspect of their infertility, not only the medical part. They do not have the money for the treatment, so they cannot have children, which is unacceptable. Unacceptable. In Israel, the government covers all fertility treatments until you have two children, even if you have ten IVF trials. In Palestine, there should be something to at least cover the first pregnancy. It is unacceptable not to have money and consequently not have children. It is a *ẓulm 'ikbīr* [great injustice].

As a means to overcome this injustice, Dr. Barghouti is attempting to locate funding for his patients and other infertile persons in the oPt. He reports that grants are hard to come by, because 'very few companies and organisations cover some or all of the expenses for treatments. They are considered *'stithnā'āt* [exceptions]'. As an exception, he does not rely on them as a source of support for couples who are financially unable to undergo ARTs. Another source of limited financial support, he explains, are people he describes as *fa'ālyn khīr* (good-doers) who call the clinic and ask if there is a couple in need of financial assistance, then offer to cover the cost of a couple's fertility treatments. Dr. Barghouti explains that it takes him a while to find a potential couple when such an offer arises, as he bases it on age, years a couple has been married, medical condition and income. When a potential couple is chosen, the *fa'ālyn khīr* pay for the treatment. Dr. Barghouti states that in comparison to the companies and organisations, 'there are a lot more cases of *fa'ālyn khīr*. However, this is not the solution to the problem'.

Nonetheless, he explains that even these instances of financial support are typically for 'personal gain'. When a person or organisation provides financial assistance, it is:

> Used as a political weapon, particularly by political organisation. They provide funds when they want to appeal to a larger demographic of people, and it usually coincides with election times.

In a discussion of politics, Dr. Barghouti argued that there is no such idea and ideation of 'political fertility' among his patients. He considers that:

> Seeking fertility treatment is a personal want. It is not political. In order to undergo IVF, a couple must pay at least $2,500. A lot of families cannot financially manage this cost. It is a large sum. They would not use this money for political purposes. They spend the money to have children and to feel normal by having a family.

Accordingly, it can be maintained that a person with infertility does not want to conceive for political purposes, which may differ from women who are fertile and have had at least one child. As such, naturally fertile couples may be viewed and may view their own fertility as a political weapon in the demographic struggle, whilst infertile couples are viewed as just desperate for children for personal reasons (see Hansson, 2012).

Furthermore, with regards to ARTs, the success rate for IVF is approximately 40%, at best not more than 50%. Therefore, at least half of the patients undergoing IVF will not conceive children, leading to feelings of frustration and depression. In Dr. Barghouti's experience:

> These feelings of frustration and depression are more prominent in women who have had three or more cycles. They have spent a lot of money and have taken a lot of hormonal injections. As such, without help from companies, organisations and most importantly the Ministry of Health, they will stop coming in for treatments, and possibly never have a child. This is the biggest problem in the oPt: patient do not continue treatment. The financial and economic status of most people within the oPt is low. Couples will collect all their money, sell everything, even their gold, to pay for their first IVF cycle and if it fails, they will be financially unable to do it again. However, we know that if they do it again they will have a much higher success rate.

As such, for women from economically lower or middle class brackets, that have used what little money they have to pay for an IVF treatment only to have the treatment end without conceiving a child, this is 'a big shock'. Dr. Barghouti found particularly difficulty in relating this result, describing it as 'the worst scenario we face in this practice'. He explains to each patient that undergoes a failed ART treatment the reasons why it failed, but some patients do not want to understand, while other patients do. In his experience:

> If they have money they will repeat it, and for this reason the patient wants to understand. Meanwhile, those who do not have money, they will not understand or do not want to understand, because their access to another IVF treatment is not an option. Even if you explain for an hour or two, they will be constantly crying. Truly this is the worst scenario.

Rana discusses her financial experience following the failure of her first IVF as 'it is expensive. Every IVF costs 10,000 shekels, which is all on me and my husband to pay. After the first cycle, my husband and I had to save money for the second cycle, which took three years.' Rana also explains the three-year period it took to save was a result of her husband not having a steady job due to the political situation. She described the difficulty he has finding work, let alone a job that provides a stable income. She identified the situation as 'uncomfortable in multiple ways', stating, 'I used to accept the [political and financial] situations we were in. Yet, the more I age, the harder it is for me to accept these situations.'

With regards to her job search, she mentioned her inability to work in East Jerusalem, as well as the necessity of constantly renewing her permit, as the reasons for not finding a job. It is important to note that in her explanation of finding work she briefly touches up on the effects of settler colonialism on familial relations and freedom of movement, stating:

> When I have to renew my residency permit. I sit two months just waiting for my permit. I cannot even visit my family. I even tried to work in Jerusalem. Honestly, I did not complete my education. Although I was really smart and did well, I left school as a type of rebellion during my younger years. When I left, I did not go back or continue. However, I had an opportunity to work in a village for orphaned children [in East Jerusalem] that did not require prior education or certification. But it did not work out because I am from the West Bank."

When asked if she would work in the West Bank, Rana replied, 'no, there is no way for me to work here. How can I go every day to the West Bank from Jerusalem? Only to get 1,000 shekels and have it all go to transportation. No, leave me at home. It is better financially.'

This emphasis on financial ability to seek and undergo fertility treatments is problematic, given the deteriorating economic sector in the oPt. Asmaa describes this financial burden of infertility within the oPt due to the occupation and lack of healthcare coverage:

> We pay for everything ourselves. Therefore, the only issue is sometimes it can be financially difficult. Especially with the [political] situation and living in Bethlehem with few job opportunities, it affects our economic standing, but *alhamdulillah*. My husband works hard and because of this we are able to continue going forward with treatments.

Not all infertile women are able to finance fertility treatments, and the few that are may not reach success, causing further financial and psychological difficulties. The lack of financial assistance from the government to acquire ARTs has caused Jenine to contemplate taking out a loan, even though this contradicts her religious beliefs. She has also recently been threatened by her husband to enter into a polygynous marriage. Whether he is able to do so or not is not the issue at hand; rather, it is the unstable position in which the crippled economy puts infertile women. Moreover, the lack of social services leads infertile, childless women helpless and reliant on their families and community, as Yasmin explained.

4. Conclusion

Whilst the childlessness and psychological distress of infertility are common to cases around the world, for Palestinian women, infertility is strongly dependent on the political situation. Settler colonial policies gravely affect the healthcare and economic sector. As discussed, there are numerous consequences of Israel's continuous occupation of the oPt on Palestinian society. It is inclusive of 'devastation of economic infrastructure, mass restrictions on employment and mobility, loss of lands, militarisation of daily life, widespread human rights violations and changes in cultural value systems' (McNeely et al, 2014: 496).

Accordingly, these consequences have reshaped all aspects of everyday life, including "infertility" and reproductive knowledge. It is, therefore, impossible to discuss or formulate a case of infertility in the oPt without discussing Israel's political, social and economic policies, as they define Palestinian health and determine healthcare practices, as well as manipulating access to employment and resources in the oPt. From this understanding derives the term "political infertility", as infertility resulting from and/or continuing, because of politically-driven strategies.

It is pivotal to understand the positionality of "infertility" as affecting Palestinian men and women; yet women, unfortunately, are more often the bearers of the political, social, economic and patriarchal negativity that spring from the condition. Infertile women in the oPt experience the 'inability to achieve adult status, the threat of divorce, and a lack of personal fulfilment'

(Rothenberg, 2004: 126). Israel subjugates Palestinian women to double patriarchal rule, with the susceptibility of violence in the public sphere 'through checkpoints, body searches, settler violence, and so forth', as well as in the private sphere, in which 'men and women have had to cope under conditions of tremendous anxiety and incertitude to ensure family survival' (Krebs and Olwan, 2012: 147).

At present, the reproduction-oriented knowledge of women must be a priority for feminist scholarship, and it needs to celebrated. A voice needs to be given to the diversity of non-reproductive women, and there is a need to counter the privileging of birth-mothers and the seeming 'naturalness' of motherhood (Malson and Swann, 2003). Additionally, women's reproductive health scholars need to understand and take into consideration all aspects of life, from the physical, environmental, social, psychological and political influences endured (Holt, 1996: 66). Achieving this, the paradigm of settler colonialism and the understanding of it as a comprehensive system, uncover the reality of the deeply embedded political structures that formulate medical, financial and social infertility in the oPt.

PART THREE

THE SOCIAL AND EMBODIED SELF

CHAPTER VIII: KINSHIP AND MARITAL IN/STABILITY

1. Introduction

Settler colonial policies significantly influence the reproductive in/abilities of indigenous people or, as previously termed, political infertility. Political infertility influences the cultural norms and social fabric of the community, inclusive of biological reproduction. In the oPt, Zionist policies of de-development, prolonged occupation, war and violence have permeated the reproductive culture of Palestinians, thus formulating a patriarchal and pro-natalist society. Palestinian women are influenced and, at times, pressured, into birthing children, with male children preferred. Consequently, the socio-cultural context of infertile persons, in this case infertile women, is influenced through the embedded structure of settler colonialism.

It is imperative to recognise that an overarching, homogenised 'Palestinian woman' is non-existent. Palestinian women differ in a plethora of ways. In this chapter, I take a closer look at the everyday lives of a handful of infertile Palestinian women. I seek to understand the similarities and differences in their everyday lives. In order to do so, a gendered intersectional analysis will be provided to investigate and describe what constitutes infertility locally, and, how individuals, couples and the wider community respond to infertility. By tracing the embeddedness of female infertility in everyday life within wider domestic and regional structures, I aim to later explore why women chose to live their lives as they told to me, and how these women negotiate and legitimise their choices.

As I take a closer look at the lives of these infertile women, whose narratives demonstrate several ways in which women's lives could deviate from the normative life course due to infertility in a patrilineal kinship system, which is the primary cultural and social system structuring Palestinian women's lives framing the concept of socially valued fertility; it becomes essential to briefly discuss the relevance of the concepts of kinship and marital in/stability. Kinship and marital histories dominated women's narratives, as family and marriage were the principal institutions, after the political setting, that affected the women's socioeconomic and social status. Therefore, the following sections will examine the conceptualisation and effects of kinship within Palestinian society on infertile persons.

Kinship as an adaptive strategy to political, social and economic changes will be conceptualised through a gender-oriented anthropological approach, as it 'attends to the biological as well as to the cultural, economic, moral and political dimensions of kin ties' (King-Irani, 1999: 322); similar studies on women's reproduction

> have enriched an understanding of the symbolic and interactive processes that produce and reproduce the structures and categories of everyday life while showing how and where changes and contradictions emerge by tracing these developments through the experiences, choices, and negotiations of individuals' interactions. […] these studies show the interrelationship of men's and women's worlds and lives, no less than the connections and interrelationships between the intimate domain of the household and the public domain of governance and resource distribution. (ibid.: 329)

Therefore, the following sections will discuss the conceptualisation of kinship as a by-product of the political and socioeconomic factors, which emerged as through Israel's settler colonial policies, in particular military occupation in the post-Oslo period. Meanwhile, infertility as related to marital in/stability will also be discussed, in/stability understood as 'when a woman left her marriage permanently (in the case of divorce) or temporarily, due to problems in the marital relationship or household. Inversely, marital stability is defined as an uninterrupted spell of marriage' (Hemmings, 2007: 152).

2. Lamis: Unlike the Rest

In a small, air-conditioned waiting room, as I waited for the director of the fertility clinic to arrive, I looked around at the artwork hung on the walls. Each painting was different to the next, but they all had one thing in common: they featured babies. One photo was an image of a sunflower, with the centre being a baby's face, and the petals being more babies. All of the babies were smiling. Another photo had sleeping babies as clouds, above a basket that contained a sleeping baby. In all the photos, the babies were either sleeping or smiling.

From the artwork, I looked down at my watch: it was 9:45 AM. An hour and fifteen minutes had passed since the appointment the doctor had provided me (8:30 AM). The receptionist spotted me looking at my watch and came over to me, saying 'sorry, the doctor is running a little late.' I said it was fine and asked when the office opens. She replied 'at 8 AM.' As I thanked her, I looked around the waiting room; all of the seats were occupied, and there were two men standing.

The people in the waiting room were of various age groups. Most of the patients arrived with someone else. The crowd consisted of two couples, a young girl and an elderly woman, two women alone, and two families (one was a couple along with an elderly man and woman, and the other a woman and three men ranging in age). There was not much chatter in the waiting room, as such the crying of one woman waiting to be seen were heard throughout the office.

After approximately 20 minutes, the doctor walked into the office. This was my first visit to this particular clinic, but not my last. It was also a recurring theme; the waiting room would slowly fill with patients arriving at 8 AM for appointments scheduled at 8:30 AM and onwards, waiting for the doctor who would arrive roughly around 10 AM. On two occasions, I witnessed an argument arise between patients and the receptionists, due to patients being frustrated for having an appointment booked before 9 AM, only to be seen by the doctor over an hour later.

In a hurried manner, the nurse, Mona, started to name patients, asking each one to wait in a different waiting room. As the waiting room emptied, Mona informed me the doctor was a little busy, but there was a woman who fit the criteria of infertility that I could interview. She guided me to a small room that barely fitted a hospital bed, a side table and a doctor's desk. Behind the desk was an unorganised glass file cabinet. On the wall behind the desk were framed news article clippings, diplomas and certificates. On the adjacent wall, above the bed, was another baby-esque photo.

Once I was seated, a woman entered the room and I introduced myself as well as my research. When she was made aware my research is on female infertility, the woman immediately stated:

> I am *biṣ'raḥa* [honestly] different from the rest of the patients. *Alhamdulillah* I do not have a problem. I came to the clinic for sex selection to have a boy, *inSha'Allah*. And because I am 40, it

is the last chance for me. This is the only reason. I do not have any problem. Everything is good but *inSha'Allah Allah yiṭ'mni*.[50]

Lamis, a forty-year-old pharmacist from Bethlehem who defines her reproductive abilities as 'normal', had been married for eight years, which according to her is not a long time, and described herself in the following way.

> I am happy and even content with my two daughters, and so is my husband. But, of course, he would be delighted to also have a boy. Because of this, I am undergoing sex selection, which I do not mind… As a pharmacist, I understand the choice I am making by taking the necessary medications and, luckily, I have not experienced any side effects. This may also be because I already have children, unlike other women in the clinic. I do not get as sad and depressed [as the other patients]. I am just trying and, if it works, perfect. If not, God chooses.

Subsequently she expanded on her reasoning for wanting a boy:

> I want a boy for myself and my husband. But firstly because my husband wants a boy, then myself. Honestly it did not bother me before, and I tried naturally to get pregnant, but I had two miscarriages. Therefore, I want to make the family larger, whether it is another brother or sister for my daughters. So, [I am here] just to have a third child. My husband wants a boy so we came to the clinic to do sex selection. But for me, as I said, I tried twice and had a miscarriage, so I just want to make the family bigger. Honestly, I just want more children.

3. Socially Valued Fertility

Lamis does not face the dilemma of infertility. She is one of three fertile women I interviewed at the fertility clinic; the other two women were attending the clinic due to their husband's infertility. Although my research focuses on female infertility, after much consideration I decided to include Lamis's story in this research. She, the only Christian woman I interviewed, discussed two essential themes resonating with the infertile women interviewed: the effects of fertility medications, and male-preference for a child. The former will be discussed further throughout part two, while the latter is an imperative theme crucial to comprehending the social, cultural and economic aspects infertile women face.

In chapter seven, I discussed how the lack of a welfare system creates a crucial need for couples to have 'enough' healthy children to support them when they are elderly and in poorer health (Yuval-Davis, 1997: 35). In general, in regions with weak institutions and political upheaval, high fertility rates are not only economically but are also politically beneficial, as a method of allocating resources in 'combat strength' (Janus, 2013: 493). The detrimental socio-economic structure of the oPt and the violence of the present has led couples to prefer having male children (Giacaman et al., 2008: 88-89). Meanwhile, the female gender is portrayed as 'weak and vulnerable' in Palestinian society (Kanaana, 1998: 133). In my conversations with infertile women, it was relatives, particularly in-laws, who played an important role in pushing for sons. Whilst Palestinian women are becoming financially independent and are supporting their elderly parents, this is still quite rare (Olmsted, 2005). Yuval-Davis (1997) notes that:

[50] Meaning 'feeds me', a metaphor to taste the feeling of having a child, in this case a boy.

> often there is a serious conflict between collective national and individual interests in terms of the number of children one has. When there are no welfare structures to look after the elderly and the ill, it is crucial for people to have enough healthy children to support them. (ibid.: 35)

Coupled with economic benefits, children additionally provide social benefits, which highlights the psychosocial importance of childbearing (see Suckow, 2008). Social infertility, as with political infertility, does not necessarily assume the same meaning or standards as medical infertility. There is no prevailing definition for social infertility. It may be that the 'individuals […] are biologically able to conceive a child but lack or do not want a fertile partner' (Gilbert and Majury, 2006: 287). It may also be applied to 'describe postmenopausal women, singles and same-sex couples who turn to fertility treatments and/or adoption for family building' (Boston Women's Health Book Collective and Norsigian, 2011: 475). These definitions outline social infertility as being a causation of primary or secondary infertility, due to biological and/or relationship-oriented reasons.

However, this section does not concern itself with these definitions of social infertility; rather it utilises Balen and Inhorn's (2002) formulation of social infertility as being in correlation to the societal notions of childbearing. This particular view of infertility is 'culturally variable', as being outlined by society's socially valued fertility. For instance, having no sons or less than the "normal" number of children in a particular culture, may be seen as a variety of infertility (ibid.: 13). This conceptualisation of social infertility is subject to the cultural understanding of socially valued fertility composed of a specific locality's preferred and required number of children, as well as the preferred gender of children.

Marriage in Arab Muslim societies is the 'official, legitimate means of regulating female sexuality and reproductive potential' (Peteet, 1991: 132). As such, pre-marital fertility is considered culturally taboo (Khawaja, 2003: 18). Women therefore enter marriage uninformed of their fecundity. Notwithstanding this, future childbearing is a consideration before marriage. Women are questioned about previous health problems by a prospective husband's family in fear that they (the women) might not be able to bear children (Rubenberg, 2001: 38). It should be noted, this exertion and overwhelming pressure on a woman to 'prove' she is capable of childbearing is not due to religion, as it is present in both Christian and Muslim communities (ibid.: 98).

Following marriage, a couple's fertility preference is shaped by their parents and/or the societies they grew up in (Janus, 2013: 501). Since 1948, with the destruction of the Palestinian community fabric, the family, principally the extended family, has become the 'basis for social and national identity' (Birenbaum-Carmeli and Inhorn, 2009: 27). Having a positive family and good social networks are of tremendous psychological value (Saca-Hazboun and Glennon, 2011: 284). Palestinian culture and, consequently, Palestinian society, pressure women to get married and bear children "on time", which is about two to three years after marriage (Katwsa, 2013: 2-3, see also Jarallah, 2008). This pressure is considered the social construction of reproduction, 'where the exercise of choice in reproductive intentions is constrained by women's broader contexts and the realities of their social worlds' (Giacaman et al, 2008: 84).

This was presented by Jenine's doctor who claimed it was *haram* (forbidden) for her to be childless. She relates:

> The doctor I went to recommended we do IVF. He informed me that because I am still young it would be successful. He gave me hope. He even said it was *haram* for me to stay like this. He said,

> ‘at least give birth to one child and it would be enough.’ That is what the doctor said, yet here we are. I am telling myself that in November [interview took place in August the following year], if God eases our situation, I will undergo IVF *inSha’Allah*.

The utilisation of the term *haram* reveals a brief glimpse into the attitude of Palestinians towards pregnancy, and having at least one child as a necessity.

Within Palestine’s socially constructed context of reproduction as socially valuable and necessary, the pro-natalist culture has debatably formulated an undeclared ‘reproductive contract’, detailing the Palestinian norm as conceiving four or more children, in which at least two should be sons, reflecting the *socially valued fertility* in Palestine (Memmi and Du Loû, 2015). If a couple does not fulfil their reproductive contract or give birth to at least one male child, this will not only cause conflict within the family and decrease their social standing, it will in turn undervalue their fertility and create an image of not yet completing the ‘norm’ of reproduction (ibid., 2015).

There are multiple factors emanating from the socially valued fertility in Palestinian society that affect infertile persons. The first, most dominant factor, is the physical and emotional effects related to and in association with societal influences, particularly on infertile women. Physical effects range from insomnia to palpitations, while emotional effects range from anxiety to the feeling of being incomplete (Hammoudeh et al., 2013). Societal pressures to conceive only intensify the pain of the infertile persons (Boston Women’s Health Book Collective and Norsigian, 2011: 474).

Palestinian women arguably define their quality of life and health as being attached to the quality of their family and the people surrounding them, thus having a collective rather than individual notion of quality of life (Spellings, 2014). Being secure in one’s husband’s household is related to the characteristics of the relationships that a woman has with her husband and in-laws. An important approach to having a good quality of life is to conceive a child, prompting happiness for the husband and in-laws, which in turn fulfils the wife’s happiness. Similar to Lamis, a son is desired for the family and the woman ‘*to feel complete*’ (Memmi and Du Loû, 2015: 282).

Women are not independent in their choice of pregnancy, as the husband is an actor in intentions of fertility. The extended family and community are also part of the fertility preference, and may have differing and competing preferences (Giacaman et al, 2008: 89). The second factor is the inability of a woman to be the decisive voice in determining whether or not to utilise contraceptives. If a woman gives birth to a male son, her husband uses this as a means to preserve his social power. Therefore, men who already have a son are three times more likely to allow the use of contraceptives. Meanwhile, women with no sons or only one son use contraceptives less frequently than women with no daughters or only one daughter (Memmi and Du Loû, 2015: 281).

The third factor is the continuing of reproductive measures to conceive a son, which is present even among educated Palestinian women. Coupled with not using contraceptives is the increasing usage of fertility treatments for sex selection (Memmi, 2012).

Social infertility and socially valued fertility cause a dilemma for women who only give birth to female children. In a subsequent interview, a fertility clinic staff member described her aunt’s reproductive history, stating,

> Ever since I can remember my aunt was pregnant and always holding a new baby. Unfortunately, and God forbid it [for me], she had twelve girls. Her in-laws were always furious and my mother told me that after the fifth girl, they did not even visit her after birth. Her husband, *haram* [unfortunately], has finally given into his hopeless fate.

The fourth is the utilization of women's bodies for political goals. The presence of a strong patriarchal culture that mandates large families and multiple sons, coupled with the Palestinian national movement's ideology of women as reproducers of the nation whose sole duty in the national struggle is to provide sons, has detrimental effects on women (Rubenberg, 2001: 166). Indigenous Palestinian women's bodies are, therefore, used to deploy bio-politics by indigenous leaders and their political perspectives (Shalhoub-Kevorkian, 2009). As one Palestinian women states, 'What a life … we women – our honour, our biological productivity – became the only weapon for men to *yitsalahou fiyu* [weaponize] themselves with … to protect themselves' (ibid.: 120).

Lastly, the conditioning of socially valued fertility, within women's understandings, have created a female hierarchy. Specifically, childbearing women (mothers) utilize this "norm" to ensure and deploy their authority on socially infertile women. As Díaz describes, 'women do not just passively reproduce motherhood but can also become active agents in the process of transforming and subverting it' (Díaz, 2016: 2). With this authority derived from motherhood, coupled with her age, a mother-in-law is customarily most concerned about an early pregnancy, reaching motherhood and birthing a son. When a woman does not reach pregnancy within twelve months of marriage, she may be met with her mother-in-law encouraging or even facilitating a quick divorce, and remarrying her son, so he does not form an attachment with his first 'infertile' wife and become reluctant to divorce her (Rubenberg, 2001: 94).

Arguably, concepts of social infertility, socially valued fertility and reproductive contract, are simplistic and Orientalise Arab culture, and as such they fantasise or generalise rather than reflecting lived experiences of Palestinian women. From the handful of interviews conducted, the attitudes theorised by these concepts seldom led to marital change (i.e. divorce or polygyny). There is only one case of divorce, which is presented in the interview of Sawsan, whose husband had fertility issues deriving from his sperm count, while she was unable to carry a pregnancy to birth. However, Sawsan explains her divorce is not related to her childlessness, however, it is arguable that the precursor for this divorce is childlessness. Her reasons include her husband's lack of financial assistance is correlated to the necessary ARTs. Another was the emotional disregard her ex-husband had towards her while she was undergoing the psychological and physical toll of ARTs. Later, she stipulates that if she had had a child, she would not have divorced her husband (unless he mistreated the child).

In all of these reasons, Sawsan's emotional and physical state of being an infertile woman with an apathetic husband is the core cause of her divorce, which all stem from her childlessness. Furthermore, she claims that if she got a divorce when she was younger she would have remarried, but after her experience and, particularly, her age, she might not. These reasons shed light on the taboo of being divorced due to infertility and the claim that every marriage must consist of a child, which will be touched upon in the following section during which Noor's discussion of her disinterest in getting a divorce is because she fears no man to want to marry a childless woman causing her prospective second marriage to be coupled with a psychological baggage derived from childlessness

Accordingly, these concepts do play a role in the interrelationship of infertile women with their husbands, in-laws, family and society. Whilst the picture is more complex and depended on the interviewee, I argue that an infertile woman's marital (in)stability is dependent on support provided by her respective family and her in-laws, coupled with, of course, her personal strength. The following narrative will demonstrate the effects of being infertile in a society that values fertility with a male child preference.

4. Infertility as a Woman's Issue

Before continuing the discussion on the influence of kinship on marital in/stability, it is imperative to discuss the viewpoint of infertility as a women's issue in the oPt rather than a man's. This creates severe challenges for women in infertile relationships whether they are the sole carriers of infertility or suffer from couples-infertility, which entails both partners have problems causing birth. Greil (2002) finds that despite situations where the male is the biologically infertile person, it is always the woman who is viewed as failing to become pregnant, making her body the locus of treatments and subject to medical gaze (see also Pashigian, 2002).

From Dr. Khammash's work and the cases he witnessed, he considers infertility as negatively impacting familial relationships of women in refugee camps. He explains, 'typically an infertile woman's husband will get remarried and decide whether he will divorce his wife or not. He usually does not, unless the infertile women insists, but that is rarely the case.' He further explains, 'men usually blame the woman for their inability to conceive children, regardless of whether she has the problem or not. Fingers are typically always pointed at the woman in a relationship, even though infertility may be caused by the male counterpart'.

This positionality was reiterated in the conversations I had with infertile women. In cases such as Karima's and Sawsan's, where infertility was from both the wife and husband, the women undertook the brunt of the responsibility when it comes to infertility and created an atmosphere of acceptability for men not be concerned about their own role. For instance, Sawsan situates:

> You know something, only after four years of marriage was I finally able to convince my husband to see a fertility doctor. He never wanted to go. I used to go alone and have tests conducted for myself. All of the results reported there was no problem with me getting pregnant. The doctor said my husband had to come in for testing. Finally, after four years, he agreed.

Within the first four years, Sawsan put the burden of childbearing on herself and seemingly might have continued to do so if it were not for her doctor requesting her husband undergo tests as well given her personal search for a treatment was unsuccessful.

After her husband agreed to visit a doctor, she was made aware her inability to conceive 'in a natural pregnancy, impossible to happen because of his sperm.' The only treatment option was IVF, which she describes as a woman's issue.

> In the end, IVF and treatments similar to IVF, what are they? They are all on the woman. It is a women's role [to take treatments]. For him, he would enter the bathroom – apologies for this – put the sperm in a cup and leave. In the end, all the syringes and the hormones would be left to me. This is IVF. These are fertility treatments.
>
> So, you see, the woman. This is exactly who fertility treatments are geared towards. Also, you should understand IVF as I do, because I read a lot about it. A doctor conducted research which

found that if a woman undergoes IVF, know that the problem is not from her. However, this society is *ibn ḥarām*.[51] They put all the blame on the woman, claiming it is her fault. No one believes it is a man's fault.

The larger problems for me were the hormones, the stress and everything I had to endure. On top of everything, did he even respect me? No. Did his family? No. My relationship with him was not good. It was worse than you could imagine.

Sawsan's statement was echoed by Mariam, who situates marital relations in the case of male infertility:

An infertile woman does not want her husband to hold anything over her if he pays. However, when it comes to male infertility, it becomes the husband's problem. He will not stay quiet, and is willing to pay any amount to overcome his fertility issues. Meanwhile, the wife stays quiet if her husband is infertile and spends the money on treatments. She will not argue or cause problems such as asking for a divorce. These are two polar opposites, and I have heard stories from both sides.

This compliments the conclusions of Inhorn (2012) that Arab women in the Middle East stay with their husbands who are infertile, in contrast to Arab men who are more likely to enter into polygyny or divorce when their wife is found to be infertile.

5. Noor: Marital Instability

As I approached the apartment building, I noticed two middle-aged men removing goods from their car and entering the building. They watched me as I went up two flights of stairs. Once I arrived on the second floor, there were two apartments, one with its door wide open and a woman standing by the doorway, and another with the door closed. As I wondered if this was the lady I spoke to over the phone, the other apartment door opened and a woman called out, 'over here *habibti*.' After we greeted each other, Noor commented on her lack of privacy:

Did you see the two men when you walked into the building? Did you also see the apartment next to mine with the door open and the woman standing by it? They are all my in-laws. They know of every move I make and anyone who comes to visit me. This whole building is owned by my father-in-law. The apartment across from me is for one of my husband's brothers. The lady in the doorway is his wife. They are all very nosey.

As I walked through her doorway, she went on to apologize for the men, making me feel slightly uncomfortable. Noor's apartment presented an informative insight into herself and her lifestyle. A room for receiving guests met you once you stepped into the apartment, a sign of wealth and the capability to have two living rooms, one for guests and one for family and friends. Noor wanted a 'relaxed' atmosphere for our conversation, taking me into the family living room, an open-concept living room and kitchen, which was just as well-put-together, but had a more modern and comfortable atmosphere to it. The whole apartment was very neat and tidy. The overall impression was that of a permanent residence in which she had spent years and always worked to ensure its cleanliness.

Her brother-in-law's daughter, of about seven years of age, was in the family living room. Noor had been tutoring her in math, and asked the little girl to take her books and go into one of the rooms at the far end of the apartment. Once I had settled, we properly introduced ourselves

[51] A curse literally meaning 'illegitimate son', in this case referring to the society being misogynist and patriarchal.

before someone knocked the door. It was a friend of myself, Leila and Noor's, Hala. We all sat down. Without two minutes passing, Noor got up, walked to the kitchen asking 'what would you all like to drink?'

She poured us mango juice in glass cups, serving them on a gold-coloured platter.

> My in-laws always involve themselves in every aspect of my life. It is difficult to do anything without them finding out. Less than two years ago, I decided to work in order to earn money for myself. I was an employee of a project within the emergency department of a United Nations Development Programme hospital.
>
> In this job I did not earn a lot of money. In a month, I made approximately 400 shekels [around US $100]. All my money, I saved. As my savings increased, I thought about what I wanted to do with the money. I wanted to spend it on something other than an IVF treatment, so I decided either go to Umrah [a religious visit to the holy Islamic city of Mecca in Saudi Arabia] or open a hair salon. Due to travel restrictions, Umrah was not an option. I settled on a salon.
>
> Opening a salon required approximately 20,000 shekels, of which I had saved one-fourth [5,000 shekels, approximately US $1,300]. The salon would be here, downstairs in this building. The building is owned by my father-in-law, so there we would not pay rent. My husband I agreed to share the expenses. The salon equipment I would pay for; meanwhile my husband would pay for constructing the inside of the store.
>
> Despite my determination, my in-laws found out about our plan and prevented us from beginning the process. Literally, they came to my apartment and stood right in front of my door. They instructed my husband, 'instead of opening a salon for her, go get married.' At the time and until now, they do not know the initial funding for the store was from my own savings. My husband quickly abandoned the plan to open a hair salon. He does not follow every instruction and command my in-laws tell him, but he tries not to disappoint them.

Noor hoped on many occasions to do what she thought befitted herself presently and in the future; however, her father-in-law, the male authority over his kinship network, overruled her decisions on more than one occasion.[52] As Noor recalled what would be one of her many arguments with her in-laws, particularly her father-in-law, she opened up about her infertility. Noor describes her infertility as a burden on her, her husband and their respective families.

> If I had a son, none of this would happen. On the contrary, if I had children, my mother-in-law and father-in-law would love me the most out of all their daughters-in-law. In the beginning of our marriage, they would stand with me, yell at their son, and were patient with me. I have been married for 18 years. My in-laws allowed me a few years of marriage without children, before bringing up the topic of polygyny and trying to get their son married [to a second wife]. If I were someone else, I do not think they would have been this patient.
>
> My husband is one of six children; he is the second oldest. My brother-in-law's children were three or four years old when we got married, and now they are men. My brother-in-law just built a house for his son because his son is going to get married. So, I value how my husband has stood by my side. It has been for a lifetime. I can say his family did not have nearly as much patience as my husband. He had a lot of patience. A lot of times he confronted his family and our problems [childlessness] for my sake. *Alhamdulillah* he always stood by me. He never deceived me. His

[52] As Noor and the other interviewees live within a patrilineal-kinship based society, authority is given to the eldest male. See Joseph, 1996.

> family, however, have not been as patient. They are very annoyed by the situation. They have a lot of… [pauses] I believe it is a pain for them. They want to see their son's son.
>
> They troubled me a lot about childbearing. His family advocated for him to get married again. They were not the only ones. My sister and my family too. I have two sisters who would comment about a co-wife, '*khalas, 'adi*' [that is it, it is normal]. They would also say 'leave yourself from him. Let him get married. Forget it.' Sometimes they would even tell me 'you have a problem, that is it, just let him get married. Stop tying yourself to him. You will never be relaxed.' I remember my friend used to comment, 'if God wills it, it will happen.' This friend provided me the strength and reassurance to me, God will grant what is beneficial.

Noor found herself alone in her disapproval of her husband taking up a co-wife. She begins to reflect on her early days of marriage, explaining how she arrived at her current marital state.

> Almost 18 years ago I married my husband. At the time, I was 18 years old my, husband was 26 years old. We loved each other, we still do. From the onset of our marriage, I wanted children. A few months passed but I did not get pregnant. I was afraid to go to a doctor. So, instead I went to a *sheikh* [religious figure in the Muslim community] who is known in our neighbourhood to treat fertility problems. Women I know claim to have been treated by him. On my first visit, he gave a drink. It was an unknown concoction he had made, I never asked from what. He advised me, 'drink this right away and have your husband conduct tests.' Immediately my husband was put under pressure. He was subjected to his first fertility test within a mere six months of our marriage.

Later, after a year-and-a-half of marriage, her husband was imprisoned. During his imprisonment,

> I had to earn money to get by without my husband. So, I found work. It was not really work, or a fixed job. I baked savoury goods for a nearby school, which I sold at their bake sales and during lunch time. After spending hours of kneading dough, adding various toppings and baking them, I would earn approximately 10 shekels a day [approximately US $2.50]. I worked long hours for little money. There was no other choice. I managed my money appropriately, leading me to be able to save some on the side. With my savings, I actually paid for my first IVF treatment.
>
> When my husband was finally released, an issue occurred with his income. For some reason, the PA was unable to release his pay checks. I think it had to do with reinstating him from his time in prison and putting his information in the system. He was and still is a member of the police force [in the Palestinian National Security Force (NSF)]. In order to make ends meet, he had to work extra jobs on the side. We lived a very simple life, relying on only the money from the side jobs.
>
> Once the issue was resolved, all of his accumulated income was provided to him in one check. I was stupid. It was my stupidity that caused me not to take the money for myself when the issue was resolved. It was my right to spend the money because I was patient with him and his situation. I did not ask for more than he could provide when money was tight. I even worked and tired myself. If anything, I could have used the money to fix my teeth. I was in excruciating pain due to my teeth. I could have or actually [in an angry and irritated tone] should have taken the money to fix my teeth.

During her discussion of not allowing herself to take the money from her husband's accumulated pay checks and spend it on herself, her voice became stern. She commented on being 'stupid at the time', with her failure to stand up for herself and take what she considered to be her right.

> Instead of taking the money, I told my husband to buy gold as an investment for the future. I said to him, 'you stood with me so I am going to stand with you.' In fact, we went to the jeweller the next day to buy gold. I did not purchase only with the amount of money we had, or even leave some extra money to save on the side. No, I bought gold worth more than what we had, creating a balance at the jeweller. We paid the balance in instalments. To me, this was the most considerate way to help him reach our goal [of having a child]. One simple action is capable of creating a positive change in a marriage.

Noor's decision to buy gold was considered by her a selfless act, through which she was giving back to her husband because he did not divorce her and always stood by her side through her infertility. She portrayed her action as 'the biggest way for me to help him and to be able to reach a goal for us.' Their mutual 'goal', as she describes it, was for her husband to conceive a child, whether it be from her or from an egg from another woman, and for her not to stand in the way of him doing so. As such, his path towards parenthood is a goal she aims for herself as well.

Noor conditions herself to believe the choices she makes are her own, and what she desires is her own choice rather than what her in-laws want and desire. Noor subconsciously abides by their desires, and in order to create a feeling of being in control, she positions her actions as preventing arguments that cause her 'headaches'.

Although hopeful, Noor considers her future as childless. She discussed her attempts at fertility treatments all of which she stated were unsuccessful. Following the failed treatments, it was at this moment that Noor decided, in order to ensure her husband has a son, she would succumb to him entering a polygynous relationship.

> Despite what occurred, I love to stand by my husband in every way possible. I want him to have children. I do not want to be the one who stands in his way. He is patient with me. He carried me and my burden [infertility] time after time after time. A lifetime has passed almost. Eighteen years! If he had children by now, they would have grown into adults.
>
> In my mind, I only had two choices: I undergo IVF again, or my husband gets married again. Financially, the money was not there for either choice. If the money my husband had was enough to cover an IVF treatment and also to get him married, he would without a doubt have me undergo fertility treatments. I know this without him even telling me. When the money is only capable of getting him married or IVF… [pauses] he *will* choose to get married.
>
> In the first ten years of my marriage, I experienced a constant emotional fear of polygyny. My original emotional fear derived from my mother-in-law and her relentless efforts to get him married again since around the third year of our marriage. My husband was not persuaded by her. As much as my in-laws spoke to him, he never accepted the idea until I accepted the idea.
>
> Initially, I was always scared of the idea of polygyny. However, when I reached the point in my life when I underwent IVF treatments twice without either causing pregnancy, I realised 'that is it for me.' Also, my perspective changed, leading me to think, 'my husband is getting older. He has to get married and have children.' For me, *khalas*, this is my *naseeb*. Either I accept this life and live with him having another wife, or he goes his way and I go mine.
>
> Believe it or not, we attempted to leave each other, but were unable to be apart. I could not leave him and he could not leave me. I told him, 'I am relaxed in my life with you. You love me and I love you.' Overall, I am relaxed and comfortable with this lifestyle. I thought, 'why not? Let me try having a co-wife.' I expressed my thoughts on the matter to my husband, informing him, 'if you

> want to get married, get married. I will stay here as a trial and see how life goes on.' I prayed for guidance from God and here I am. I am still with him.

Due to her inability to leave her husband, Noor decided to accept a co-wife. She recalled the details of their discussion:

> I explained to him, 'I am tired. I am tired from all the treatments.' I was having appointments and treatments after appointments and treatments, becoming physically tired. I am not obligated to constantly be tired. I told him, 'we have no children, and on top of that I just keep getting tired of this burden.' Through my persuasion, I was able to convince him to get married.
>
> Even though I agreed, from now until the future, between me and my God, I wish God provides me with children. I left everything in the hands of God. Yet, at the same time, I do not want to cut off my husband's *naseeb*. My husband is very good with me. His kindness. His love. It all makes me tell him, 'yes, it is okay to get married, have children and live.' He wants to have children and to raise them. So, I want that for him too.

Her growing dislike for fertility treatments and her love for her husband is her rationale for allowing him to enter into a polygynous relationship. Her husband accepted her permission, and got engaged to another woman.

> A little while after, he got engaged to a woman who he wanted and chose himself. She was 30 years old, previously married and divorced. People introduced him to her and he willingly got engaged. It is shocking but I swear it happens. There are girls willing and accepting of marrying a married man.
>
> During their engagement period, my husband paid for another cycle of IVF. I underwent the initial IVF procedures but this time, psychologically, I was not in the mindset. I was not stimulated. It was not enough for an IVF treatment. As I sat waiting for the doctor, I changed my mind, picked up my stuff and went home without continuing the treatment or going back.

Although she granted her husband permission to get engaged, she had hoped this IVF treatment would cause pregnancy, subsequently leading her husband to not enter into a polygynous relationship. However, she was unable to go through with the treatment physically as well as psychologically.

> After twelve years of marriage, my husband married a second wife. I was presented with a co-wife. This was about four years ago, in 2012. The co-wife lived with us in this house, my house.
>
> Once he got married, his family was relieved. They were more comfortable and happier. On the day of his wedding, my father-in-law yelled at me, 'you did not build the house or *'stathmarti* [make an investment] for us. You did not do anything with us. You never…' This led to a problem on the same day of the wedding.

The term her father-in-law used, which I translated into 'build the house', was *'amir al beit*. Noor explained, 'this was a way to say that I did not give birth to children leaving their son's house empty for the rest of his life.' After her explanation, one of the bystanders posed the question, 'all of this is because of childlessness?' Noor replied, 'Yes. If I had a son, none of this would have happened. As I said before, if I had children, my in-laws would have loved me the most out of all of their daughters-in-law.'

Noor further remarked that although her in-laws were happy their son got married, they aided him 'emotionally but not financially'.

> Personally, I tried to act as indifferent as possible. I even told my in-laws his [second] marriage is fine with me and does not make a difference in my life. However, my relationship with my in-laws never got better. Even after they got him married.

Noor hoped her in-laws would change the way they treated her after her husband's marriage, but her hopes were unattained. She explains that not only did she accept a co-wife in hopes of pleasing her husband and in-laws, she also hoped her husband would have a child from her co-wife. Noor's in-laws hoped their son's new wife, her co-wife, would birth a male child for their son. However, her husband divorced his second wife only a month after their marriage, without causing pregnancy.

> My husband did not last long with the other woman. He did not want her. He divorced her after only a month. But this is *naseeb*. The reasons for divorcing her within a month were because of very simple and minor issues. There were things she would do. Like… [pauses] I do not know.
>
> Incidents between her and I occurred. For instance, I would return home from work and find she had locked the door. I would assume she was sleeping and forgot to remove the key from the door. Once, I told her 'just take out the key from the lock so when I come, I can open the door on my own.' Our doors cannot be opened if a key is inserted from the inside. She never listened. Every time I would come home, her key would be in the lock. I would knock and knock, as she took her time to answer.

Although Noor hoped polygyny would be a supportive institution, providing her husband the son he desired and her relief from being pressured to conceive, it was also the source of jealousy and conflict towards her co-wife, which are feelings that have been found to emerge in other polygynous relationships where one co-wife is infertile (Tabi, Doster and Cheney, 2010). Moreover, as the co-wives shared an apartment, there was tension on a daily basis.

> When my sister-in-law has arguments with her husband, she fakes fainting and being extremely tired. Right away her husband reconciles with her. That day my sister-in-law calls my husband, 'come quickly and see your [second] wife, she fainted!' My husband went quickly from his workplace to the house, asking why and how she fainted. My sister-in-law told him, 'she was unable to stand on her legs; they seem to have been paralysed.'
>
> I am not aware of the exact details of what occurred exactly, but in the end it was proven she faked the incident. My husband said 'I do not need a headache and these endless acts.' He sent her to her family's house. This was the main issue. She was mimicking the acts of my sister-in-law. My husband told his family and I, 'I am nauseated by her and dislike her, so let her *hel 'ani* [go away from me].' He added that she 'extended her tongue.'[53]
>
> My husband swore he suddenly realised traits about her he did not like. He stated, 'I do not want her. That is all.' People started gossiping, claiming it was because of his first wife, myself, that he wanted to divorce her. He told everyone it was not because of me, rather he did not want her. He would say, 'I sat with her, stayed with her, but the girl, no! There is no relationship.' It was over. He did not *want* her. He divorced her after only a month of marriage.

[53] Meaning that she spoke back to him.

Noor was against her husband getting a divorce, but her attempts to convince him failed and her in-laws sided with their son rather than her. She begged him to reconcile with his second wife, at least until she was pregnant. In her attempts to obtain her husband's fatherhood, she was in fact reinforcing the notion of women as vessels for pregnancy, paradoxical to her position as a woman on the verge of divorce due to her inability to become pregnant. She did not acknowledge this positionality, as she recalled:

> I attempted to reason with my husband not to divorce her. Regardless of how hard I tried, he was not convinced. He just kept repeating 'I do not want her.' I even told him 'at least for the children, do not leave her.' He would not accept anything. He did not want her. Because of his decision, we lost a lot of money. We even had to sell our car to pay for the divorce.
>
> My in-laws also claimed my co-wife was at fault. They would say, '*Allah la iroudha* [may God not return her]. The last thing we need is a crazy person.' They were convinced in aiding my husband emotionally to get a divorce. For me, I was the opposite of everyone. I wanted my husband to stay married.
>
> My in-laws paved the way for him to leave her. If my in-laws stood against my husband even a little, telling him 'you are not allowed to divorce her', my husband would not have divorced her. Presently, my in-laws regret their decision, making comments such as 'if only she stayed with him, if only, if only …' They now realise he could have at least stayed married and had a child before divorcing her.

Hala interrupted Noor by commenting, 'what would lead a husband to leave his wife after only one month if his main reason for marriage was a child?' Hala insinuated a physical dimension to the marital displeasure, specifically sexual displeasure. Noor replied, 'your guess is as good as mine', yet did not expand on this point. She was in agreement with this statement, but refused to expand on the subject. Noor then continued,

> After the divorce, I underwent another IVF treatment, but it did not lead to a pregnancy. This failing treatment hurt me physically and emotionally. All I could recall was my husband's marriage to my now ex-co-wife. During his marriage, God made me relaxed. I tried life with him married again, and it was the opposite of what I feared. Life surprisingly became more comfortable. Those ideas and fears, how can I get pregnant? What can I do to get pregnant? They were gone.
>
> I also always felt *thanb* [guilt] as though I was preventing him from having children. When another woman came along, I felt relieved. Here was a woman to get pregnant and bring him children. He lived his life and I will live mine like I want to, without the burden of conceiving children.

Noor suggested her husband is currently seeking to get married once again. This time she wants to help him find the most 'suitable candidate'.

> Within this past year, my husband has been thinking about getting married again. He wants children, therefore he is determined to get married again. This time, on the other hand, he made the decision to not get married to just any woman. He wants to think about suitable candidates. He wants to find someone he likes. He also expressed wanting a *fahmana* [understanding] girl. He argues his ex-wife was not educated or *fahmana*. In fact, I agree. If a person truly understands marriage, they would know not to just marry anyone.
>
> I tried to help by looking for suitable brides. If I saw a girl who I believed was worthy, I would ask about her and introduce myself to her. People within the neighbourhood and my friends helped introduce me to women. Recently, a friend introduced me to a pharmacist. She seemed perfect compared to me, since I only finished *tawjihi* [high school], never studying in college.

Soon after hearing about her, I went to the pharmacy where she works, but she was not there. I asked one of her co-workers for her number, but he informed me it was against company policy to give out workers' phone numbers. Therefore, I gave him my number, asking him to have her call me. I was determined to meet her. The following day she called and we spoke. I introduced her to the idea of becoming my co-wife… [pauses] She refused! She told me, 'I cannot marry someone who is already married.'

A few weeks later, I met another girl, a PhD student, who accepted the idea of becoming my co-wife. She is my niece's friend. She was really respectful, and even told me 'you are beautiful.' I liked her a lot. However, she had one issue. She was overweight. My husband would not accept her. He has an *'ougda* [paranoia] about fat girls, because he considers me fat, and I never became pregnant. He believes fertility has to do with weight. As such, he wants someone skinny. There is nothing I could do to convince my husband to marry someone otherwise. The next time we met up again I apologised informing her, 'frankly, your body does not suit my husband. He and his family continuously say that I am overweight. and that is why I am unable to have children. So, if they saw you, they would get angry with me. I do not need the headache and problems.'

Noor informs us her husband is not only seeking an educated, young woman, but also a woman with a particular physique. Noor herself was a petite woman, weighing not more than 140 pounds.

Throughout her search for a potential co-wife, her in-laws were not aware of her actions. When they became aware, they were infuriated.

My friend introduced me to another girl a little over a month ago. When I spoke to her, she was against the idea of marrying a married man. I used to find the best girls for him. The whole time, though, his family did not know. It was later revealed the girl I last spoke to was a family friend of my in-laws [and she told them]. I was unaware.

As the days passed, my in-laws confronted me. They had spoken about it amongst themselves for a week, and only confronted me after discussing it. They were against the idea of me asking for this girl's hand in marriage [for her husband]. My brother-in-law came to me, yelling 'I told you not to speak about this topic with anyone!' I informed him I met a girl who I liked and decided to ask her.

My in-laws had the audacity to change my words and the conversation I had with the last girl. They speculated that I had told her, 'I love my husband and he loves me, but he wants a girl just to have children with.' The real issue is they are scared I would tell people I was the one who got my husband married. All of my in-laws started to confront me, 'we are his family. We are going to get him married. We will find a wife for our son'. They would not end the problem. They were constantly yelling at me.

I gave up, telling them, 'peace be with you, do as you wish. Get him engaged, get him married, do whatever you want with him.' I want to relax my mind. Let them get him married and do what they want. With regards to me finding him a wife, I am not concerned. Let him and his family find someone.

My in-laws still do not know that I am the one getting him married, *because* I am the one who is agreeing to his marriage. Without my consent, it is impossible for my husband to agree to a marriage. The least I would do if he gets married without my consent, is that I will divorce him. As such, it is impossible for him to accept this. Impossible, impossible for him to allow me to leave; even just the thought is impossible for him to imagine.

Noor claims she felt indifferent towards her in-laws finding him a wife without her assistance. She did have one essential condition, which, however, was declined by her father-in-law.

> This all happened within the past two months. Personally, since he wants to get married again, I am going to let him get married again. I do not have an issue with him getting remarried, not at all. *Khalas*, this is what God has written for us. I now have a conviction this is so. I have to accept my fate. There is only one condition, each woman lives in a separate house. This way I am relaxed and so is she.
>
> I had the intention of splitting our apartment into two, if he gets married. All I need is one bedroom. I would build a wall between the guest room and the living room. I would just close this section of the house off and put a door from here. That will create two small apartments. She will have her own bedroom, living room, bathroom and entrance. We will even be able to build a kitchen for her. I would have the remainder of the apartment. Her section, if divided like this, will actually be bigger than mine.
>
> My father-in-law, as usual, stood in my way. He refused arguing, 'impossible. It is impossible for you to divide the house like this. I will not allow it.' My in-laws wanted the living room, the whole kitchen, the guest room and the bedroom for the new bride. The only part of the apartment left for me would be the two bedrooms at the end.
>
> I refused this. Why should I be thrown in the back, just because I cannot have children? The situation escalated greatly, to the extent that I had to bring my brothers into it. I informed my brothers I would not accept living in one house with a co-wife again. I told them it is my right to have at least three rooms I can turn into a kitchen, living room and bedroom. My brothers, however, did not want the argument to escalate, telling me, 'it is okay. There is no problem [with her in-laws' favoured arrangement].'
>
> My eldest brother called me imploring, '*khalas*, either you accept this division of the house or you get a divorce.' I asked if this was his solution to the issue. My brother told me 'Yes, that is it. Let the man have children. He was patient long enough.' I acted as though I was convinced, but personally and truly, I was not convinced. I just stayed quiet.

Considering the patriarchal and pro-natalist influences in the oPt's society, Noor's brother defended her husbands' and her in-laws' position of Noor having to accept polygyny and the division of the house as her father-in-law desires, given her husband has been 'patient long enough'. Noor did not disobey her brother's statements; rather, she pretended to agree with him, regardless of her lack of reassurance or happiness.

> My husband later told me, 'I promise you I will get you a house better than your house. Just wait a little until I am able to breathe.' If my husband promises me something, he does not go against his promise. So, I said okay, and was convinced to divide the house as my in-laws wanted. I refuse for some lady to be better than me, but my husband's support and constantly standing beside me is what made me feel at peace and comforted.

The desire to have her own apartment with its own entrance, relieves Noor of prospective problems with her future co-wife. Having her own apartment also allows for the establishing of territory, if the future co-wife were to have children. However, Noor conceded her request for the sake of her husband, although she was still not content. She positions her husband as being under stress, and believes it a necessity to be considerate of his position as he has always been supportive of her and stood by her throughout her fertility struggles.

Her main concern now is to ensure her husband is stress-free and has children. In her perspective, this will lead to her own stress-free state, and she will be content.

> Once my husband takes a second wife, he will be relaxed, and a co-wife will allow me to be relaxed. Before my husband entered into a polygynous marriage, I was always concerned about polygyny and having a co-wife. Yet once he went through with it, it was like this big looming fear of mine disappeared. I never imagined how calming having a co-wife could be. I experimented with my feelings when he got married and yes, in fact, I was relaxed, relaxed, relaxed! I lived one month with a co-wife. Every day I was relaxed.

It is important to note Noor's wording and perception of 'relaxation' in relation to her husband's polygamy even though she notes all the trouble her and her co-wife had. This may seem as blatant contradiction, however, with regard to childbearing, Noor was relieved of the pressure to conceive. Therefore, polygamy became a coping method from infertility albeit not an ideal method, which will be further discussed in chapter nine.

> Personally, I do not ask or indulge myself in people's gossip. There are always people on the side-lines. I do not bother myself with them. People talk a lot or a little, either way they talk, so I do not care. They never allow a person to relax. For this reason, I was relaxed with the perspective that 'here is a woman. If he gets her pregnant, perfect.' I am not running away from this, but psychologically and physically, time is up for me. It is not working out for me to get pregnant, so why should I continue to tire myself?

Noor is awaiting the day her husband marries a second wife so that she could be relieved of the stress and pressure to conceive children. However, their financial situation is creating a delay in her ability to enter into a 'relaxed' state.

> Financially, a wedding would not cost much. We have the house already. The gold will amount to about 3,000 Jordanian dinars [approximately US $4,200]. I do not think my husband's family will buy less than 3,000 Jordanian dinars-worth of gold. Clothes will be another 1,000 Jordanian dinars [approximately US $1,400]. Everything else is ready. Even the bedroom is present. The bedroom for the first wife. I do not know if she will accept it or not, but it will not be costly, add another 1,000 Jordanian dinars. Roughly, 6,000 Jordanian dinars [approximately US $8,400] will get him married.
>
> Notably, my husband will not have to save all of the money himself. He will find his father and his brothers to help him. If he is able to save some money, they will complete the cost. If my husband had the money, he would have been married for over a year now. The only thing stopping him from marriage is his financial state.

Following her breakdown of the cost of a wedding, Noor briefly discusses wanting her husband to provide her with a fertility treatment prior to getting married, as she hopes to become pregnant, which she argued would render obsolete her husband's intentions of getting married again. Through this statement, Noor contradicts her repeated positionality that she has given up on the desire to have a biological child yet she feels pressured to provide her husband the option and ability of having a child, particularly a son, by any means – through her or a co-wife conceiving a child.

> My husband told me, 'if I had the money, I would pay for your fertility treatment, rather than get married.' It costs 10,000 shekels. Occasionally, I need a lot of syringes, of which I am able to get a portion financially covered by the PA, making it less expensive for me. The PA assists, given my husband is a soldier.

> If I knew he had money and did not give it to me for fertility treatments, I would go crazy if he gets married instead. I know he needs someone to assist him. We are trying to raise money and stand on our feet to be able to undergo IVF, and to be able to get him married. I know… I have not one percent doubt that, if he had money, he would let me undergo IVF every day.

Noor discussing her ability to undergo IVF with the money, prior to utilising it for a wedding, is an example of her framing him as constantly standing by her side. She also explored other situations:

> My husband stands with me all the time. When the last argument over the topic of me choosing a wife for him occurred, he could have easily divorced me and told me go home. He would be perceived as a man who had a lot of patience, the ideal husband standing by his wife who was unable to get pregnant for sixteen years. Instead he opposed his brothers and his whole family.
>
> Additionally, after his brother argued with me, my husband made my brother-in-law feel insignificant and put him in his place. Everyone came back and apologised to me. My brother-in-law even came to me, apologising 'you are my sister. *Inti 'ala rasi.*[54] I put you over my household, wife and children.' Everyone knows how good I am with them. I never *qasart* [fell short] with anyone. At the end, I know his family just want to see my husband's children. My brother-in-laws have children who are about to get married.

Noor further related her husband did not want to get married again. He would instead rather her have children.

> My husband would complain to me 'why should I get married? I do not want to get married. You just get pregnant and that is it.' He is not asking if I have a boy or a girl. He just wants me to get pregnant. Even yesterday, I asked him 'do you want to get married or for me to get pregnant? Honestly.' My husband bluntly told me 'I want you to get pregnant. I do not wish to get married to anyone over you. But I just want children.' My husband told me he does not want a wife to spoil him. He just wants a son to call him '*baba*' [daddy]. That is all he wants. *InSha'Allah*, Allah will feed us or grant him a child. I just want God to give him a child.

Subsequently, she revisited the subject of separating from her husband and her conditions for entering another marriage.

> Nonetheless, if the situation occurs in which I leave him, I would get remarried. It is not wrong for me to get married again. I am still young and my life is still ahead of me. I do not have any objections to getting remarried. However, I would not allow myself to get married because I cannot have children. I would not accept it.
>
> If the chance occurred and there was nothing stopping me from getting married, in my mind I would constantly be thinking 'I cannot have children. Why would I get married? Why should I put myself in the same position and have to undergo the same scrutiny and possibility of fertility treatments?' No, I will live my life, work and build myself from the beginning to continue my life.
>
> If, God forbid, my husband dies, I would never ever get married or even think about it. If it was in the past, today or in the future, I would not allow myself to think about marriage. If we split and I had a good marriage opportunity, I would get married. Although the preferable option for me is not

[54] Literally meaning 'you are on my head', meaning 'I respect/will do anything for you'.

> to get a divorce and not marry a different man. I cannot have children. Why should I bother myself? Regardless of these thoughts, the main point is I love my husband. I cannot leave him.

Noor continues to express contradictory views. In this case, she contradicts her views on marriage after divorce. This is due to her current infertile marriage and perspectives of society; Noor is of the mindset that a woman only gets married to have children. Noor feared divorce, due to the lack of options open to her after a divorce. Noor's options include returning to her parents or getting remarried; however, she felt no man would want to marry an infertile woman. She is not confident in the possibility of entering into another marriage, due only to her infertile state.

Towards the end of our discussion, someone knocked on the door. It was her sister-in-law wanting to enter Noor's apartment. Noor asked her to wait a little while, as she shut the door and returned to us in the living room. She quickly commented her final thoughts, before having to return to her sister-in-law. She concluded the conversation with a statement contrasting with her previous articulations:

> *Ya rab* [oh God], stand with me. No one in this house believes I am in favour of my husband getting married again. I am telling you, the other day my brother-in-law and I had an argument about marriage. I told him 'I do not care', to which he replied, 'these are just words, but when reality sets in you will say something different.' I responded to him, 'I am accepting my husband getting married, not because of you or anyone, but because of God and my husband, of course.' My God, as big as the problem is, He will make it easier for me.
>
> But to be honest, having a co-wife is painful. I was in pain. In pain. If I said I was not in pain and depressed, I would be lying. When my husband first got married again, I was here at night and it was really uncomfortable. I started to make *duaa* [prayer] to God, as He is the only one who stands by me. I am not, and was not, accepting of my husband's marriage. It is not in my hands, or in my willpower to stop. Regardless, the problem is with me. Whether I like it or not, I have to accept it.

Her final comments reflect her inability to wholeheartedly cope with her husband entering into a polygynous marriage. Noor continuously stated that her husband is always by her side, presumably as a coping method, imagining him assisting her; but her final statement of God being the only one by her and understanding her, illuminated her inner feelings of loneliness. Attached to loneliness is pain, which she articulated throughout her discussion, that there was very little she could do in her situation aside from being nice to the first co-wife, and being ready to be nice as well as welcoming to her prospective co-wife. When Noor weighs the two choices of not allowing her husband to take up a second wife or to allow him, she chooses the latter. It prevents her from becoming divorced, as well as providing her the ability to position herself as the obedient wife who is accepting of her husband's wants and needs. All the while, her choice necessitates being loving towards the co-wife, and not jealous or angry towards her. Accepting a co-wife is also her method of accepting her infertility, which is also discussed in the following chapter as a coping method to infertility.

6. 'Amir Al Beit

Noor's words illustrate the doubtful self, overshadowed by the imposing notions of kinship and reproduction set out by society and enforced by in-laws and family members. In her concluding remarks, she expressed experiencing pain from the wound of infertility that lay at the heart of her marital relationship, yet she goes on loving and supporting her husband through minor, everyday gestures from household chores to considerable gestures such as finding him a

suitable wife. Despite Noor's light-hearted tone throughout our conversation, her words shone light on conversations with other infertile women who perceive infertility as a debilitating state of being leading to the loss of marriage stability.

Noor's experience with infertility and her personal life revolved around two predominant concepts: *'amir al beit*, and polygyny. This section will discuss the former, while the subsequent section will discuss the latter. This section will also provide a brief profile on the importance of bearing male children in Palestinian society, with the aim of setting the context for the discussion of the various aspects of infertile Palestinian women's lives in the sections that follow.

Arab 'familialism' is an 'ancient adaptive response to insecurity; group cohesion is as important for survival under state oppression as it is for survival in the absence of the state' (Peteet, 1991: 176, quoting Sayigh 1981: 267). Arab societies stress the importance of family and kinship, as they are interwoven in society, identity and connectivity (Joseph, 2005). However, these perceptions of family and kinship in the Middle East are responded to differently in the context of the oPt resulting from the understanding of the intimate workings of daily life in the specific context of settler colonialism. Preceding discussions have touched upon the influence of settler colonialism on the elimination of the native, and its ability to permeate daily life (see part 1), as well as on the economy and health care including reproductive in/abilities (see part 2). This current discussion touches upon Zionism's influence on societal institutions, which strengthen patriarchy in Palestinian society (Taraki, 1997: 16-19).

Mataria et al. (2006) explain, 'in Palestine, the absence of social security benefits and safety nets translate into a de facto arrangement where older people by necessity must rely on family financial resources, as well as, social assistance and support for survival' (Mataria et al., 2006: 324). This is made especially prescient 'due to the impossibility of travel conditions, especially for the elderly, often requiring travel on dirt paths and walking substantial distances (siege and closures) under the fear of being stopped or shot at with tear gas, sound bombs, rubber bullets, and even sometimes, live ones' (ibid.: 324). This fear is similar to that undergone by Karima during her trials, as she would try to retrieve her husband from the streets and encounter soldiers.

Consequently, patriarchy is strengthened (Taraki, 1997: 16-19) and family is considered the 'central institution' (Baxter, 2007: 746) ensuring survival (Peteet, 1991: 171). Family is a significant social organisation system that is greatly valued. 'Family' is compromised of the extended family (*aila*) and the clan (*hammula*) (Saca-Hazboun and Glennon, 2011: 283). The *aila* consists of blood relatives, including the women who are brought in through marriage; meanwhile, the *hammula* includes all the individuals descending from the same great-grandparent (ibid.: 283).

As a patrilocal community, women relocate to their husband's place of residence after marriage (patrilocal relocation or patrilocal marital residence) and, essentially, to a new patriline (new *aila*) which is also the principal unit controlling domestic economy. Sons are crucial in fortifying a woman's position in her in-law's family. Having a son allows a woman to contribute to the sustenance of the patriline. A son is the future head of the household, with hopes to be loyal, concerned and assistive towards his parents.

From this understanding derives the concept of *'amir al beit*, literally meaning 'build the house', and referring to the reproduction of male kin who continue the household. The Palestinian family unit is characterized as extended, patrilineal and patrilocal. Therefore, when a woman gets married, she moves out of her parent's house and into her husband's neighbourhood. A male, however, does not leave his household, and instead brings a wife into his parent's house/neighbourhood, thus, 'building the house' through maintaining its occupancy and continuing the patriline. Male children in a patriarchal society, as Noor illustrates in the following statement, provide honour, economic benefits, and the ability to preserve the family name.

> I desire children for my husband. For our future, for when we get older. A man needs children in his old age. When he cannot work and has no income, he will be able to rely on his son to provide him an income and take care of him. Forget the financial reasons, how about in the case of an illness? Living in a country that does not provide good healthcare and social security, we need to think about these potential circumstances. These are the reasons behind my conviction that a son is a necessity. A son is a *sanad* [support]. A son is something big to the family.
>
> My husband, however, desires a son to carry his name. He does not anticipate future financial or physical issues and the benefit of children if and when these issues arise as I do. For him, it is more psychological and social. Generally, people want children to carry their names. This is not the case for me. I have a conviction that God with His wisdom has not granted me children. Of course, I want a child, especially I want to have and feel one growing inside me, but this is what God has written.

Children are considered a resource, not only in a monetary sense, for a couple and the extended family. Noor hoped to have children to take care of her and her husband, yet a child other than a biological child was considered as eventually becoming disloyal, as she described her nephew-in-law in the future lacking empathy and regard. Noor also discussed all the help her in-laws receive from their sons, daughters, and daughters-in-law. By comparison, she located herself as reliant only on herself when she grows older, as she does not have a son, a daughter-in-law or even a daughter to assist her. Inclusively, children help the extended family, as Noor's in-laws send their children to help her around her house when she is lonely and provide her joy.

Her statements epitomise the concept of *'amir al beit*, a longstanding cultural concept. Granqvist's research conducted in Artas, a Palestinian village near Bethlehem during the early to mid-twentieth century, quotes an interview with a Palestinian man who explains, 'He who has sons born to him does not die. The house is built up. Ahmad Jedallah left only four daughters. The house is ruined' (Granqvist, 1947: 29). A house without sons, regardless of the number of daughters, is described as 'ruined' and not 'built up'. *'Amir al beit* thus demonstrates the cultural necessity of childbearing for purposes of preserving kinship connectivity, particularly lineage, and having a male son to become head of the household. In my field research, I first came across it when Jenine stated 'It is natural for a house to be built with children. There is not one person who does not want children.' Subsequently, I started to recognise the women discussing aspects of the phrase *'amir al beit* as in Noor's case.

Concepts of kinship are adaptive and transform in response to a crisis (Peteet, 1991). Since the First Intifada, 'national identities' in the oPt have become more intertwined with 'kinship identities' (Abdo and Yuval-Davis, 1995: 318). Kinship identity is integral to Palestinians, as their lives are construed on the primary basis of their kinship connectivity, 'the people and groups to whom they are related by blood' (Rubenberg, 2001: 14). Kinship connectivity

arguably 'shapes individual identity and the management of everyday social relations through a group of precepts that both define identity and legitimize personal connections' (ibid.: 14).

Kinship connectivity in patriarchal societies is observed as 'patriarchal connectivity', which is defined as 'the privileging of males and seniors and the mobilization of kinship structures, morality, and idioms to legitimate and institutionalize gendered and aged domination' (Joseph, 1999: 12). However, the patriarchal figures are not the 'prime movers or causes' of the intertwined nature of connectivity and patriarchy; rather individuals, including women, are 'active participant[s], both caused and causative of the relations of inequality in patriarchal systems' (ibid.: 14). Thus, '[c]onnectivity exists independently of patriarchy and probably occurs in most cultures (or subcultures) in which individuation, autonomy, and separation are not valued or supported' (ibid.: 14).

Rubenberg (2001) describes kinship connectivity in Palestine as a social form:

> Palestinians construe their lives primarily in terms of the people and groups to whom they are related by blood – that is, paternal agnates (although maternal blood relations are often important too). In this social world, kinship connectivity shapes individual identity and the management of everyday social relations through a group of precepts that both define identity and legitimize personal connections. (ibid.: 14)

As Palestinian women live within a patrilineal and pro-natalist society, motherhood and reproduction are means to console power relations within the social construction (Díaz, 2016: 1). Therefore, in infertile relationships the inability to conceive a child, let alone a male child, causes problems within the couple's marriage and within their families. Consequently, this basic unit of the family may either become hostile, helpful or indifferent to the situations infertile women are subject to, particularly deriving from the inability to conceive a child.

Concurrently, Palestinian women are not independent in their choices of reproduction. Husbands are actors in the intentions of fertility, as are the extended family and community. This produces differing preferences of fertility between the wife and the actors involved (Giacaman et al., 2008: 89). Palestinian women's reproductive behaviour is, therefore, socially constructed, limiting their reproductive choices due to the constraints of their 'broader contexts and the realities of their social worlds', constructing pregnancy as not a biological event but rather a social one (ibid.: 84, 91). Infertility, therefore, is commonly discussed as a social and political concern (Hansson et al., 2013). Childbearing is not taken as a private matter, and family as well as friends weigh in on the issue.

As the extended patrilocal family contains political and economic advantages, it is socio-economically beneficial for individuals to follow through with their demands of childbearing (Abou-Tabickh, 2010: 190). Having a good relationship with one's extended patrilocal family is incentivised due to the political and economic advantages they provide (ibid.: 190). It is pivotal for a husband, as well as his wife, to have good relations with the patrilocal family, for the reason that in Palestinian society until the present, there is the concept that 'a man standing alone is weak but brothers, united and working in harmony, cannot be overcome' (Granqvist, 1935: 142); this is portrayed in Noor's husband's relationship with his brothers.

This returns us to the concept of *'amir al beit* and the position of male children as continuing the blood kin, but also maintaining financial networks for the future and ensuring continuous residency in the house once the couple passes away. Shadia, an infertile woman in her late

twenties, conveyed to me that her family members (mother and brothers) rather than only her in-laws, accuse her of not helping her husband '*e'amir al beit*', the action of building the house. Shadia reported that her family often discuss her necessity to have male offspring to help her husband financially, as her family and her husband's family believe that her husband is providing her the monetary funds necessary to conduct IVF treatments. Shadia stated that her family is not aware of the loans she takes out to pay for the treatments, and instead she informs them that her husband pays for the treatments. Shadia put herself in financial debt to pursue fertility treatment, in the hope she would get pregnant. Financial debt as well as psychological distress is assumed to be preferred to polygyny or divorce.

7. Polygyny

During my initial reading of literature on female infertility around the world and on marriages in the Middle East, I repeatedly came across the notion of *polygyny*. I initially refrained from putting it into my initial literature review for fear of Orientalising Palestinian society, and portraying a view of the Middle East as 'backward'. Nevertheless, in more than half of the interviews with infertile Palestinian women, the topic of polygyny emerged. It was very much present, particularly in the case of Noor. The subject of polygyny among infertile Palestinian women goes beyond merely the husband taking up a second wife. My findings locate infertile persons entering or discussing the possible entrance into a polygynous marriage as not an impulsive reaction, but rather a reaction to the necessity to fulfil the social requirement of a husband to achieve fatherhood. Polygyny for the women interviewed was discussed in various ways: as a means of coping; as a threat to her by her husband and/or in-laws; or as a joke in passing. This section explores infertile women's experiences with polygyny, including whether and/or how polygyny occurred in response to infertility, as well as what effect it had on infertile women.

Polygyny is a type of polygamous relationship defined as 'the *sanctioned* marriage or union of one man to many women' (Al-Krenawi, 2014: 3). It is the most socially acceptable type of polygamy found in the oPt, as it is rooted in Palestinian culture and Islam given its acceptability by *sharia*[55] and the PA's personal status law. According to *sharia*, a man is allowed to have up to four wives, 'providing that he has the economic and health requirements to care for each, and that each is treated equally' (Al-Krenawi, Slonim-Nevo and Graham, 2006:174). Therefore, it is permissible in Islam, but the husband must provide love and economic support equally between his wives. Nonetheless, polygyny is discouraged by the Qur'an within the verses that do allow it (Hamadeh, 1999: 144), given a man in a polygynous relationship 'runs the risk of coming into conflict with his religious duties' (Granqvist, 1935: 200).

Personal status law in the oPt legalises and allows a husband to enter into a polygynous marriage. There have been concerted efforts to make it illegal for men to pursue polygyny; however, the political, legal and social settings have made it difficult. In 2005, a reform was to be considered, yet due to the election of Hamas that year and the subsequent rivalry between Hamas and Fatah, the Palestinian Legislative Committee did not have the chance to review the proposed reform. The inability to change the personal status laws and to make polygyny illegal is due to the stateless nature of the oPt, the recent Islamization of the region, Israel's occupation and its destructive measures on the socioeconomic fabric of society. The absence of the Palestinian Legislative Council 'has created a vacuum in any authoritative regulation of

[55] Islamic law.

Palestinian affairs, a vacuum that has been filled by customary law' (Naser-Najjab, 2015: 1091), and the internal fighting of the Palestinian Authority.

There is no accurate data on the prevalence of polygyny in the oPt (Welchman, 2007: 77). Although permitted by Islam and the law, polygyny in the oPt does not have widespread social acceptance (Naser-Najjab, 2015). Factors motivating men to enter polygynous marriages include media influence, the necessity to secure masculinity due to it being assumed as crippled by the occupation (ibid.), and to obey religious duties (Al-Krenawi, 2014). It is also advocated as a tool to counter Israel by raising the population count (Kanaaneh, 2002: 62).

Meanwhile, factors contributing to the agreement of women accepting a co-wife (or becoming a co-wife) are extensive. Primarily, the social and political atmosphere has prompted women to be dependent on men, producing 'an insupportable sense of entrapment and powerlessness' (Naser-Najjab, 2015: 1097). Secondly, gender and reproductive norms have discouraged women from seeking divorce. For Arab women, divorce is associated with shame and a decrease in socioeconomic status (Al-Krenawi, 2014: 61). Furthermore, divorce has 'a level of social shame equal to that attached to polygamy'; however, divorce is subjected to 'much stricter scrutiny by the community than […] polygamy' (Naser-Najjab, 2015: 1097).

Therefore, polygyny is more acceptable to women than divorce. Men prefer to enter into a polygynous marriage than divorce their infertile wives, in order to maintain family ties and relationships (Shahd, 2003: 22). With regards to infertility, infertile women fear they have to agree with a polygynous marriage rather than face divorce, as the 'only recourse in the case of divorce is to become a second or third wife herself for maintenance purposes' (Al-Krenawi, 2014: 62). Noor spoke about the condition of being a divorced infertile woman trying to get remarried as pointless, on the basis that men marry for children, which infertile women are incapable of bearing. Her account reflects a reason for infertile women to stay in unstable/unsatisfactory marriages, out of fear they will never remarry an unmarried man.

In a pro-natalist society, a woman's self-worth is linked to the amount of children she bears (Al-Krenawi, 2010: 83-84; see Snyder, 1999). Therefore, infertile women, such as Noor and Rana, conceive allowing their husbands to take up a second marriage as a selfless and worthy act. Furthermore, an infertile wife may 'urge' her husband to take a second wife, for 'purely egotistical reasons to strengthen her own position in the house', thinking of the second wife as 'merely a tool and a means by which the first wife guards her own interests' (Granqvist, 1935: 212, 213). As reflected in Noor's account, she persuaded her husband into a polygynous marriage in the hope that her in-laws would treat her better (they did not) and, subsequently, when her husband decided to get a divorce, Noor pleaded with her husband to have a child with her co-wife before divorcing her.

In addition, polygyny is utilised as a method of relieving one's self of having to undergo the emotional, psychological and physical hardships of not being childbearing when diagnosed with infertility and feeling reluctance to undergo further treatments. One of the interviewees, Rana, prompted the discussion of polygyny with her husband, informing him she would be willing to accept a co-wife if he wished. She initiated the conversation, disclosing to me:

> My in-laws never put pressure on my husband and me to do anything. A lot of people ask if they [the in-laws] want him to enter into a polygynous relationship, but no. They never raised the issue of a second marriage, and neither has my husband. Actually, it was me who brought it up and offered. *Yes*, I told my husband to marry a second wife.

> The topic of polygyny was brought up by myself two years ago, after the last IVF treatment I had. I do not want to be selfish, which is the main reason I brought it up. The second reason is, maybe God does not want him to have children with me. The third reason is that I cannot leave him. I heard of situations when a couple cannot have children together, but once they leave each other and each one gets married to other people, they have children. For me, this option is not possible. I do not favour leaving him.
>
> I actually spoke to my husband twice about it and *khalas*, not once after. The first time I raised this issue with him, I told him 'what do you think about getting married again? Maybe God does not want you to have children with me. I have no objections to this idea of you getting married.' He refused the idea and told me no. The second time he also refused, and asked me to never discuss this subject.

According to Rana, this was not an easy discussion to have; however, it was one she felt religiously and morally obligated to have. It also aided her ability to cope with her condition, as well as ease her conscience.

> A second wife. It is not an easy topic to speak about. From a religious perspective, I do not want to *athlemo* [wrong him]. Now, I am 37 and still have the opportunity of getting pregnant, but soon I will not. As for him, he has had diabetes for six years. With his condition, he has the prospect of having a child. Soon though, he also might not be able to. This is how I understand the situation. That is why I brought up the topic. In the future, neither he can blame me, nor can I blame myself.

As Rana, Noor also argued that polygyny was 'for God and my husband': she wishes to do right by her husband, as she interprets it is what God would want. In addition, Noor and Rana provided their husbands with permission to enter into a polygynous marriage as a result of their undergoing multiple failed IVF treatments, prompting their objection to fertility treatments and pressure to have children. This was not necessarily always the case, however. For instance, Mariam states,

> Oh, if my husband got married to a second wife… [pauses] I cannot even imagine it. I swear *baq'ud 'alīh* [I will sit on him]. Unfortunately, infertile women just give in to the pressure and the reality of the situation, and allow their husbands to get married to a second wife.

She argued that the 'reality' of infertility should 'not be held against anyone'. Regardless of a couple's marriage stability or lack thereof, Mariam believes polygyny will always taunt infertile women as being considered as an option or outcome by their spouse and/or family members. Mariam reported that

> My husband brings up the topic as joke, not seriously like other men. He, in general, says it as a joke. Even when we were engaged he would joke about it. Now though, if he brings up the topic in front of me even as a joke, I tell him 'you do it and see what happens.'
>
> I act as if I am joking as well, but in my head I am thinking 'well, will he really get married? Is it because of the [lack of] children?' An infertile woman constantly thinks like this. But, oh well, life will go on and a person has to live. I always tell him, 'this is your destiny, you like it or you do not, you are stuck with me.'

The topic of polygamy is one Mariam frequently encountered, not only in her marriage but in the marriages of her family members and friends who are also experiencing infertility,

> IVF is a financial burden. I have witnessed its affect on my husband's cousin, who is also infertile. Her husband takes out loans to pay for treatments. I feel sad. This is her fourth or fifth time undergoing IVF, and it is unsuccessful. The last time she was depressed and felt really down.
>
> Her husband recently began to say he wanted to marry another woman on top of her. Due to this, she started to think a lot, and stress out. Even as she underwent her last IVF, she only lasted a week, and it did not work for her. She told me her mind was constantly thinking, 'if this IVF does not work, he is going to get married. He is going to marry another woman.' Therefore, for her, I believe it [the failure of IVF] became psychological.
>
> With the case of my husband's cousin, the problem is mainly from her, although he does have a small issue with his sperm count. Her husband is a good man, but unfortunately she has a mother-in-law and a father-in-law that from the second year of her marriage have told their son he has to get married to a second wife. They continuously, literally 24 hours a day, would tell him, 'we want to get you married again. We want to get you married.' To the degree that he even started to agree with them, and put conditions [to his wife], saying 'I love you and I want you. But if I get married, I want you to stay with me and around me.'

This dubious position of lacking the capability to produce a patriline, is a grave threat infertile women face. Sawsan also discusses the issue of age in relation to divorce,

> If I got a divorce a while ago [i.e. when she was younger], I would have, of course, remarried. At this moment, I am not thinking about marriage. I cannot leave a psychological shock to enter another psychological shock. I cannot see myself with another human being after all I have been through. To undergo treatments again, it is overwhelming. Also, if the first time was a failure, the second time will also be a failure.

Sawsan acknowledges her inability to have children in a pronatalist society will be the basis for a 'failed' marriage.

As a result of infertile women anticipating a failed marriage, polygyny is a constant possibility for infertile woman. Simultaneously, polygyny for infertile women presents a means to contribute to a husband's kinship, relieve the self of future regret over a husband's childlessness, to relieve the self of childbearing, and to find power in a powerless situation. It is a strategy used by infertile women as a means of patriarchal bargaining (Kandiyoti, 1988), a term coined by Kandiyoti who observed that

> women strategize within a set of concrete constraints that reveal and define the blueprint of […] the patriarchal bargain of any given society, which may exhibit variations according to class, caste, and ethnicity. These patriarchal bargains exert a powerful influence on the shaping of women's gendered subjectivity and determine the nature of gender ideology in different contexts. (ibid.: 275)

Patriarchal bargaining pertains to women agreeing to conform to the patriarchal system in exchange for benefits. Throughout the interviews, patriarchal bargains were discussed in attempts to maintain a marital relationship, to conceive a child with the current spouse and to prevent divorce, whether it be through persuading a husband to financially support fertility treatments, to join the wife in fertility treatments, to accept a second wife, or to be a part of a childless marital relationship.

For Noor, her insecurity and her uncertain future as infertile and childless within a society that does not provide social services, played a role in her attempts at patriarchal bargaining through her acceptance of a first co-wife and accepting the prospect of a second co-wife. To further her

bargaining in the prospective polygynous marriage, Noor attempts to resolve and transform her situation further by dividing her current apartment, which her husband initially accepted, but was resisted by her father-in-law who had the last say in the subject, causing her husband to also back out of his agreement on separating the house.

Coupled with these aspects, polygyny comes with its own baggage, causing women in polygamous relationships to undergo psychological disorders including depression, anxiety and disinterest in life, through contemplating and/or attempting suicide and suffering psychosomatic illnesses (Naser-Najjab, 2015). Noor's marriage lasted for 16 years before her husband entered into a polygynous relationship. Although Noor tried to maintain emotional stoicism during the interview, towards the end she revealed the pain she was in. She felt powerless in her situation. The only way she felt able to control it was to accept a co-wife. Noor, although in pain, found relief through this acceptance.

As Shadia describes,

> Every time I am around and my mother-in-law passes by my husband, she tells him loudly to make sure I can hear her, 'we are going to get you married. We are going to get you married.' They do not even talk to me. They only want me to accept him getting married a second time. I am constantly thinking 'he wants to get married. He is going to get married to a second wife.' Every time I undergo IVF it is unsuccessful. I have become broken. Then I go home to my husband's family, who only add to my problems. They are very aggressive and attack me verbally.

This psychological toll has led to Shadia becoming frightened by even the sense of her in-laws around her. However, unlike Shadia, Jenine was not provoked by the threats of polygyny from her husband and in-laws, due to a reason that may have been an instrumental factor in the continuation of their monogamous childless marriages: a husband being unable to financially support entering into a polygynous marriage. As Jenine expresses,

> Just four days ago my husband brought up to me the subject of polygyny, saying he wants children. We got into a huge fight. His family said they are going to help him get married. I told them, 'if you have [money], get him married' But they do not have, so they cannot get him married […] In the past my in-laws never got involved, only recently have they started to get involved. In the past, my mother-in-law never took me to doctors or anything. She would only say 'may Allah feed you' [grant you children]. That is it. If they had the financial ability, they would get him married. But [reassuring herself] they do not have the money, and will not be able to. My father-in-law passed away, may God rest his soul, and their financial state is not good at all.

Subsequent to Jenine's statement, her sister entered into the conversation, claiming, 'If the in-laws had money to get him married, she would take it to do fertility treatments.' To this her other sister stated, 'yeah, then if it did not work, he can get married [again].' However, due to Jenine's husband's financial incapacity, he is unable to marry a second wife, nor provide his wife fertility treatments.

8. Adoption

Women interviewed felt obligated, at times, to pursue all possible paths to achieve the goal of being a parent, inclusive of ARTs and polygyny. Adoption, however, was an unacceptable path to pursue for the women interviewed. It was not given as a solution to overcoming infertility and reproduction in any of the interviews. The underlining reason behind this refusal was that

an adopted child would not be part of the blood kinship and, as such, would be deprived of kinship connectivity.

Social negativity is present towards infertile persons adopting children. Karima recalled that her neighbour also suffered from infertility.

> There was a friend of mine who was actually my neighbour. She used to live right across from my window here [points to bedroom window], but she left. She understood me. We both struggled with conceiving children. She moved out of her apartment because of her in-laws. They darkened her life. We got married around the same time and became good friends. My kitchen door is right across from where her house entrance was. We would open the doors, sit outside and drink coffee together. One day she had enough, divorced her husband and left the refugee camp. When she left, she adopted [a child]. She did not care any more about society and getting remarried.

Karima was happy for her friend and her ability to overcome societal negativities towards infertility, divorce and adoption. However, Karima claimed that adoption was not an option she would accept:

> My mother-in-law, after about five years of my husband and I undergoing fertility treatments, suggested adoption. She said to us, 'why don't you relieve yourselves of all of this pain, exhaustion and expenses by adopting?' Hussein told her 'mom, no. What God does not *'iṭ'amny* [feed me], I will not go longing for. I will continue looking for a treatment.'

Karima acknowledged the rarity of a mother-in-law proposing adoption, as, according to her, the proposition is normally polygyny. Karima claims that this rare occurrence was due to love: 'my mother-in-law's love for us was the same. She even would be on my side more [than on her son's side]. A second marriage was never an option.' Karima indicated her gratefulness towards her mother-in-law for standing by her side.

However, Karima's mother-in-law's perspective is a unique case. In my conversation with Dr. Khammash, he related that 'if the woman wants children and she is not the one with the issue, the refugee camp makes it unacceptable to adopt, and it is socially difficult to divorce and get remarried'. This difficulty to adopt is iterated by Noor, who personally had a strong stance against adoption. Noor repeatedly provided her husband's perspective, and the necessity of him having a biological son. She claimed her husband never considered adoption, as it is 'not the same, it is something else', by comparison to the concept of blood kinship. She explains:

> Some people suggested I adopt a child; however, adoption is never an option for me. An adopted child is not the same as my husband's own son. Completely different. My husband never even thought about it. He would never even adopt one of his brothers' sons, let alone a stranger's. He would never. He has this belief that a biological son is unique. On a daily basis, my in-laws' children are here in our house. We practically raised them. Yet, my husband will always state comments such as 'no, this is not *my* son.'
>
> When the days pass and a person gets older, he or she barely has the ability to control or be respected by their own son. How about if it were my husband's brother's son, or even a stranger's? There is a saying, 'even your son might not listen to you, so do not expect others to'.
>
> Today, I am capable of telling my brother-in-law's son what to do. I can ask him to get me something, or take something from me. Tomorrow, he is going to get married, and after he does it is possible he will not even say the word *salam* to me. His wife might deny him by suggesting, 'she is not your mother'. This is only one of the reasons I have a strong stance against adoption.

> Women have an innate desire to love and care for children. We love to be surrounded by children. For me to fulfil this innate desire, I have my in-laws' children. I feel as though they are mine. I change them. I bathe them. I tutor them. They mess up the house for me, moving things around. When I am home bored, I call them. They come to me. They love me. We are always together. They are always with me.
>
> Even at times when my husband is at work late, they come and sleep next to me. I feel as though I am their mother. I fulfil these motherly desires. All of this care and love, I am satisfied through my in-laws' children. As much as I would love to have children, God did not grant me any, so this is good enough for me. It is better than nothing.
>
> So, the idea of adoption is completely out of my head. Maybe if someone tells us there is an orphan child from a massacre, or somewhere like Syria, okay. I would accept to adopt one. Even one of the orphans in Gaza. Maybe if I had children, I would be more accepting of adoption.

She continues her discussion of adoption, by explaining people's perspectives on adoption.

> Forget my husband or I, can you even imagine how much gossip I would have to hear from people? Just imagine what my husband would say. Or, my in-laws, oh they would talk a lot about me. A whole lot. They would give me a headache, claiming I did such and such, only because I adopted. People gossip a lot, and for me to bring a child no one knows into the family would be hell.
>
> Almost ten years ago, I babysat my best friend's daughter while she was at work. I took care of her in my house. I fed her, tutored her, put her to sleep and played games with her. I enjoyed her company a lot. My in-laws, on the other hand, were not happy with this arrangement. They told me to 'stop bringing people's children into your house'. Until this day, they start arguments with me if I babysit anyone's child who is not part of our immediate family. I try not to satisfy them by providing them a reason to talk about me. Arguments are not what I want. So, I stopped babysitting children who are not part of my immediate family. The important thing is I do what I want.

Although she is concerned the society she lives in will not accept adoption, the biological ties to a child are of more importance. Based on the notion of *'amir al beit*, blood kinship, as well as due to the lack of social security furthering the necessity to have children who are capable of helping with old age. She stated the core of the issue with adoption is 'my husband wants a boy to carry his name.' This corresponds with the culture within Arab societies of wanting to birth a male child 'to continue the family name' (Al-Krenawi, 2014: 46). In Islamic law, adopted children must keep the last name of their birth parents.[56]

9. Karima: Crazy in Love

As with the case of adoption, Karima's in-laws' perspectives towards her and her husband's childless state is very unique. Her and her husband's quest for fertility, which was curtailed by the political situation and abruptly ended due to her husband's neurological condition, portrays an infertile couple's ability to thrive and have marital stability without children as the determining factor towards happiness and stability. Karima, who has been married for 26 years, jokingly commented, 'it does not show on me, right? If it does, it is because I am sick today and look a little older.' As she slowly stopped laughing, she returned to the subject of her marriage. 'My mother-in-law, I used to love, love, love her. She passed away a while ago, I still cry over her loss.' Her voice begins to shake and her eyes begin to swell with tears, 'Oh,

[56] On adoption in the Middle East, see Mattson, 2005.

how long it has been since her death, and I still cry for her.' With her swollen eyes and a smile on her face, she expresses her feelings towards her mother-in-law:

> *SubhanAllah* [Glory be to Allah], the amount of love I received from my mother-in-law and husband. It was overwhelming and beautiful, *alhamdulillah*. Although she passed away, she is still in my soul. By the way, she is my mother's sister. My aunt. But I do not love her because she is my aunt. I love her because she is my mother. I feel as if she is my second mother.

She explained that her love for her husband derives from her love for her mother-in-law:

> You know your love for your mother, when you miss her and long to see her so much that you begin to cry? This is my relationship with my aunt. She was very, very, very beautiful. *Allah yirḥamha* [God have mercy on her]. In all sincerity, she does not leave my mind. My love for her son arises from my love for her. *Alhamdulillah*. Look, there is nothing here [waves to her husband attempting to get his attention]. I am living in what is considered an exhausting state, but I am happy. I am exhausted. I have problems, for example, in my back. Yet, I would still carry him, even though I would cry from the pain.
>
> Despite being tired and crying, I still do everything for him. Your faith in God and love towards your spouse is more sufficient for you than the whole world. It is sufficient to take you away from the problems of the world. If you have faith and love a person, that is enough, *Alhamdulillah*. But I do believe my love for him has only grown because of my mother-in-law. I know she would never leave me or want me to leave my husband. So, I stay with him and take care of him. I love him and I love her.

She recalls events that led her to love her mother-in-law:

> You can imagine a person does not hide a secret from her mother. This is how I was with my mother-in-law. My secrets were shared with my aunt. Imagine. He would go to work, *haram*, he used to be very tired. Remember, I told you he stayed a year and two months at a job in which he would be gone for a week. Before he would arrive, he would order cake and food for us, just so that day everything was ready. Imagine.
>
> When he would come home, he would tell me to call my mother-in-law to come and eat with us. He used to love her and so did I. What would she respond? I would tell her '*Khalti* [my aunt], Hussein is here, come eat with us.' She would respond, 'live your lives. He has been gone for a week. After you two eat I will come down.' I would tell her, 'do not eat, but come at least.' She would say 'okay, I'm coming,' then she would just say hello to her son and leave. Now when she entered, Hussein would always kiss her hands and tell her to also eat with us. She would tell us, 'I will eat later. I will heat up the leftover food.' She would refuse, telling me 'Hussein has been gone for almost four or five days. You spend time with him.'
>
> Before he would arrive for the weekend, she would tell me to get a facial and do my hair. Every Thursday, the day he would return, she would tell me to go to the facial lady who was right by our house. She would constantly ask if I had been yet or if I dyed my hair. She loves, like a mother, for her daughter to look good. I would tell her 'yes, I did my hair.' She would ask to see how it came out.
>
> As I was saying, she would not stay for dinner and would always leave to come back later. We would sometimes wait for her until quite late, but she would always comment, 'you got all dressed up and did your hair for what? So I can be here?' I felt she supports me to look good for my husband, and gives me a chance to be alone [with him]. She is not the type of mother-in-law to just sit so you are not alone. No, no, no.

> She would even ask what I am going to wear. Once she went out and came back all happy. 'I saw this lingerie set I liked for you. Tomorrow is Thursday and Hussein is coming home. Let's go to the store.' She rarely leaves to the *sūq* [market], she only went to have a change of scenery. While walking around she saw it on the mannequin and thought of me.

Her mother-in-law's actions could be interpreted as quite controlling behaviour although Karima projects it as positive and motherly. Karima interprets her mother-in-law's actions as contented by ensuring her son's and Karima's marriage was filled with alone time and sexual gratification. She cared for their happiness and did not want to impose, which may be contrary to the perceived norm of a mother-in-law and daughter-in-law relationship, in Palestine and elsewhere.

The rest of her in-laws, as portrayed by Karima, were also loving and caring: 'his family and my family are one. We are all cousins, aunts and uncles. There were no situations of his family versus my family; rather both were one and always supportive as well as aided us.'

As she discussed her relationship with her in-laws, her sister-in-law walked in to check up on Karima and her husband. Karima introduces us: 'this is my oldest sister-in-law, I love her.' Her sister-in-law asked how Karima was doing. She asked her what happened at Karima's doctor's appointment, and if she was feeling better. Once they completed their brief chat, her sister-in-law said goodbye to Hussein and left the room.

Karima informed me she tries not to show her emotions, particularly sadness, to her in-laws, explaining,

> With all that has occurred, I am still living in terrible circumstance. Two days ago, due to the amount of pain I had, I started to cry. However, I called my sisters-in-law and asked them to come over. I made them coffee and sweets. Even while I was crying, I continued making the sweets. I did not cry in front of them. Only in the kitchen. When I was pouring their coffee, I told them 'I entrust Hussein to you.' He is *maskyn* [a poor fellow]. I do not know what will happen to him in the future, if I pass away.

She insisted that her love for her husband has made people think she is deranged:

> Every day I give him a shower, once or twice. I always put cologne on him. I like to make him smell good. People come and ask me, 'what is wrong with you?' Seriously, when I am tired and cry it is only because I cannot do anything for him. I cannot do anything. I do not cry for myself. Hussein is my life. I like to give him a shower, put perfume on him. I even lotion and moisturise his hands and feet. That is it, I am used to it. I like to do it. I like for him to have the nicest of smells. People tell me, 'you are crazy.'

10. Conclusion

Socially and financially, children are assumed to play a pivotal role in marital stability and in one's future. Childless marriages often incited contempt from those around them, leaving women in a socially ambiguous position. Even if they were loved by their husbands, childless women often encountered wider disapproval. Being secure in a husband's household was pertinent to the characteristics of the relation a woman had with her husband and in-laws. Infertility, arguably, contributes to encouraging women to stay in unsatisfying marriages. Potential developments occurred in infertile marriages which caused marital instability. This research identifies two results: the husband gaining a co-wife (polygyny) and divorce.

However, spousal support was at times adequate enough to ensure infertile women stayed well; at other times though, it was insufficient, particularly because in their visions of the future, women would not expect their husbands to remain as committed towards them maritally and financially. They would also fear the lack of social support in these instances. However, women's narratives suggested this was not always the case.

Infertile women in stable marriages showed an alternative basis for why marriage existed, apart from having children. For instance, Karima's case stood out because although she was in a stressful situation due to her husband's illness, she was less distressed about her infertility compared to other women interviewed. Twenty-six years without pregnancy would have been viewed very gravely by most people, but Karima laughed and smiled throughout the interview, and did not accord great significance to infertility in shaping her life. She even found infertility to be the least of her problems, comparing it to 'a small feather on the face of the ocean'.

In spite of her positive attitude, Karima acknowledged certain aspects of her life had been affected by infertility, namely her prolonged treatment-seeking and selling of possessions to access better treatment in the past. She stressed that infertility had not affected her marriage, but either she was presenting a stoical face, or she was genuinely less anxious about her situation. Several aspects of her story suggest the latter interpretation is plausible. Firstly, her husband's family was supportive of her and did not judge her for her infertility. Secondly, Karima believed her husband to be partially responsible for their infertility, which relieved her of the full burden of blame that most of the interviewed women carried. Thirdly, Karima continued to be able to fulfil her motherly instincts in her childless marriage due to the presence of her in-laws' children, who fulfilled some of the functions of having her own children, such as companionship and helping around the house. She found them to be like her 'own children'. Finally, Karima's husband's condition overshadowed their infertile marriage, causing infertility to be a secondary issue. Moreover, her husband's love for her created a bond for Karima she would not be able to remove herself from, regardless of his neurological disorder let alone their childlessness.

Evidently, the strength of a couple's relationship greatly affects their ability to withstand challenges such as infertility. Although structural, economic, and other social factors were important in shaping people's lives, the degree of love and commitment within marriage was also a provisional factor in marital dynamics, though it was difficult to quantify. Women rarely wanted, or were able, to express their feelings on the matter, beyond frequently citing the importance of 'love' and 'support'.

In spite of people commonly remarking that men marry a second wife in cases of infertility, and older relatives frequently recommending that their sons do just that, it was and is not always easy for men to enter into polygynous relationships. As Granqvist states,

> the woman represents a far too high value for it not to be a man's interest to esteem and take care of her; one can after all not so easily get a new wife. Even the women themselves would resent bad treatment from their husband and not permit it. If she has a father or a brother she will never submit to the whims of a despotic man. (Granqvist, 1935: 169)

Multiple aspects of Palestinian marital culture with its patrilocal context illustrate that married women should strive to achieve motherhood. This chapter discussed the social context and conceptualisation of kinship and patriline that shape infertile women's lives. Children, particularly sons, are highly valued. Moreover, children are thought to fortify marriages and

one's future. The following chapter will discuss the ways in which these concepts and contexts have affected women's daily experiences.

CHAPTER IX: INFERTILITY AND THE EVERYDAY

1. Introduction

Infertility impinges on the realm of the everyday, formulating itself into a consequential issue that threatens to hinder marital stability and psychological well-being in the oPt, a pro-natalist and patriarchal society in which childbearing builds the family unit, continues the patriline and secures provision for the elderly. This impingement has been complemented by the rise in distribution of ARTs normalizing and making it expected for infertile couples to undergo treatment; the politicization of reproduction as portrayed in demographic politics between Israelis and Palestinians; and, in the case of the oPt, settler colonialism, which curtails the political, social, cultural and personal aspects of their everyday lives.

This chapter examines the impact infertility has had on the embodied self of Palestinian women in their daily lives. The embodied self, as described by Clarke, Martin-Mathews and Mathews (2006), is the relationship between the body and the self. With the case of infertility, the embodied self reflects the 'relationship between an infertile person's sense of self and the perception of the female body as a dysfunctional machine' (ibid.: 96). This conceptualization of embodied self will be utilised to aid in understanding the methods with which the women interviewed construct their 'dysfunctional' body with respect to their identity, personhood and social status. The following sections will examine their beliefs and experiences, and the coping strategies of their embodied selves.

2. Treatment-Seeking

On my second visit to a public fertility clinic, I was introduced to a young woman named Asmaa who was accompanied by her husband, Yousef. After being seen by the clinic's female doctor, Asmaa granted me permission to sit in on her consultation with the nurse. As we walked into one of the patient rooms the nurse explained, 'Asmaa has primary infertility as a result of polycystic ovary syndrome, small eggs and other unexplained factors.[57] Today I will be teaching her how to take her injectable medication.'

In the room, Yousef and I stood by the closed doors as the nurse taught Asmaa how to prepare as well as take the injections. The nurse removed a few items from a brown bag, displaying them on the table as she began informing Asmaa about the contents.

> These vials contain sterilized water and these are the powders of medicine. You will need to mix one vial with one portion of powder. In order to mix, you will use the larger syringe to extract the powder and then the water from the vial. It will mix right away. You then put the mixed contents in this smaller, yellow syringe. You must take the shot below your abdomen, in an area with fat, not muscle. You can take it in a muscle [if a medical professional is delivering the injection], but since you take it at home alone, keep it below the skin in a fatty area of your abdomen.

As the nurse separated one vial and a pack of powder, Asmaa commented in a low, nervous tone, 'my sister-in-law will actually be the one giving me the shots.' The nurse replied, 'okay, good, your sister-in-law may choose where to give you the shot.' Once the syringe was ready, the nurse clarified,

---

[57] For more on unexplained factors of infertility, see Isaksson and Tiitinen, 2004.

> You have two more powder solutions for Tuesday and Wednesday. For today, Monday, I will give you the shot. You also have two vials of sterilized water, and two extra vials just in case. The water is sterilized and is specific for mixing the powdered medicine. So, do not use any other type of water.

The nurse returned the remaining contents into the brown bag and handed it to Asmaa, who then gave the bag to her husband to hold. Asmaa at this point seemed extremely nervous and frightened by the injection. The nurse walked over to Asmaa in her nervous and fearful state. The nurse asked Asmaa to raise her shirt from the left side, so she may take the injection. As she did so, Asmaa looked at her husband, who tries to help and comfort her by holding her hand. Up to this point in the session, Yousef had only spoken one word, '*salam*' to the nurse. He also seemed tense and nervous.

With the tip of the syringe on Asmaa's abdominal area, the nurse began to speak to her as a means of distraction. She began to insert the syringe: 'Remember, you can insert the syringe anywhere near the abdominal area. *Yalla* [let's begin], *bismillah* [in the name of God]. It does not hurt; it does not hurt.' Holding the syringe in place, in Asmaa's abdomen, the nurse continues to comfort her, 'did it hurt? It did not hurt, right? If I gave it to a little child, he would not be hurt by it. Now I will release the medicine and then pull the syringe out.'

After removing the syringe, the nurse comments,

> *Salamtik*, [hope you feel better] we finished. Now you are going to go straight home. Once you get home, right away put the medicine in the fridge. You have enough for tomorrow and the day after. Now again, you take one powder and one vial of water in the morning or, at least, preferably in the morning, okay? Thursday will be your follow-up appointment.

Asmaa looked at me and commented, 'we finished early, I guess we have time for any questions you have.' Following this, the nurse moved us to another room for us to have some privacy.

Witnessing Asmaa's injections was my first first-hand experience of the process of fertility treatments. It helped better shape my understanding of medical fertility tretaments, which were brought up in conversation on multiple occasions with particular reference to the hormonal injections that are meant to cause pregnancy, which Asmaa was taking, as well as the fear and pain of the injections themselves.

However, the women interviewed sought treatment through traditional medicine, hospital medicine, and in one instance, a sheikh (religious authority). Different treatments were sought due to two main reasons: the first is financial and the second is word of mouth. Traditional medicine and approaching a sheikh are the cheaper treatment options. Meanwhile, if a couple found one route was successful for another couple struggling to conceive, they would pursue that path.

Regardless of which treatment was chosen, several components were involved in this process: finding an appropriate figure to carry out the diagnosis and treatment, found mainly through word of mouth, then securing the financial cost and finally undergoing the treatment, if financial abilities allowed. Women sought fertility treatment citing conceiving a child as their final goal, or gave up their hope in treatments but not in conceiving a child. This section seeks to understand the fertility treatments women undergo, how they perceive them and how they construct their identities in relation to them.

2.1. Medical, herbal and religious

There is a power and status associated with medical science that encourages women to seek medical assistance for their social problems (Letherby, 2002b: 285). With the increased dissemination and globalisation of ARTs, infertility has become a medical problem, causing infertile persons to be pressured into and feel stressed over the utilisation of treatments to overcome infertility (Dykstra and Hagestad, 2007: 1525).

In Palestinian society, assisted conception or fertility treatments are perceived as methods of fulfilling hopes and desires of childbearing yet are also faced with criticisms and fears that these hopes and desires will be taken advantage of by the medical field. Nevertheless, as Kanaaneh writes, 'the control permitted by modern reproductive techniques is widely perceived as a means to escape marginality, negotiate identity, and attain progress' (Kanaaneh, 2002: 228).

The average timeframe for the women attending fertility treatments and/or seeking a doctor's advice regarding their inability to reproduce, was rarely within a year's timeframe of marriage. This is mainly influenced by the social and personal necessity to reproduce a child and obtain the status of motherhood. The average timeframe for visitation to a fertility specialist was two to three years after marriage. Although several of the women visited due to familial pressure within this timeframe, there is often some recognition by society and in-laws of a woman's or couple's independence, and resistance by women to immediately visiting a specialist.

Infertile women undergoing medical fertility treatments are conceptualised by Johnson and Fledderjohann (2012) as *medicalised embodiments of infertility* referring to their distinct psychosocial response to their infertile state in comparison to women who have not experienced fertility treatments. This is in part due to medical treatment being reported by women as one of the most stressful and invasive experiences (Cousineau and Domar, 2007) causing women who undergo unsuccessful medical treatment to be in a place of existential chaos (McCarthy, 2008). When discussing medical treatment, the principal treatment interviewees underwent is IVF, which is centred on the female body, causing physical and emotional exhaustion that arguably requires support groups and consideration by health care professions (Kaliarnta, Nihlén-Fahlquist and Roeser, 2011). However, support groups and emotional considerations were unfortunately not present in the lives of the women interviewed thus leaving them to cope with almost solely alone with their medicalised embodied selves.

With regard to the interviewees, all but two infertile women underwent medical fertility treatments (Jenine and Yasmin). For the rest of the interviewees, the desire to become a biological mother through medical fertility treatments was also accompanied by great hardship and pain by other interviewees. The interviewees efforts of undergoing a successful medical fertility treatment were not met and they remain childless.

Mariam told me the hardest parts about undergoing fertility treatments for her:

> I have had two previous IVF treatments. There are two parts to this process that are the hardest. The first is taking all of the shots and undergoing the procedure without knowing if it will be successful or not. The second is when you get the results of the treatments and they state it was unsuccessful. It hurts psychologically. So, it is not only physically but emotionally and psychologically hard.

Following this, Sawsan provided me with a more in-depth discussion of a variety of processes used in fertility treatments. 'I am a *daktora*, *habibti*, ask me anything!' These were the first words Sawsan, a petite, 35-year-old woman, uttered to me. As I entered her living room, I found Leila and Sawsan's best friend. The living room was also her bedroom; as such, her best friend sat on the bed along with Leila. Sawsan retrieved two foldable chairs and a foldable side table from the kitchen for us to sit on, placing them across from the bed. When asked if she would like privacy or for us to return at a more convenient time, she replied, recalling her close friendship with not only her best friend but also Leila, 'are you kidding? These two know all about my life.' Sawsan lives alone, renting her own studio-styled apartment. She divorced her ex-husband and moved out of his house but did not return to live with her parents/family, which is considered to be a bold move in Palestinian society.

Sawsan went to the kitchen to boil water in preparation for making Arabic coffee, as she described her story in a loud tone allowing me to hear her properly.

> I went to more than one doctor. I visited both private doctors and public clinics. I also conducted some research. I will send it to you. It is on the reasons behind the failures of IVF [laughs]. I am a teacher so I like to understand everything. I do not like to be a *ghabya* [ignorant person]. It is a problem, though, when you understand everything. By the end of my treatments, the doctor told me "that is it, you need to come and work here." I research everything about myself. Anytime people in my clinic see me they always say, '*keefik ya daktora* [how are you, doctor]?' After all of my treatments and research, I became a doctor.

Sawsan's embodied self is represented through her knowledge and remembrance of the exact dates associated with her infertility and subsequent fertility treatments along with the treatments failure at reaching pregnancy. This self-awareness is portrayed in her statements:

> I got married. I was 22 years old. During my marriage, I had seven IVF treatments. Twice I got pregnant. The first time, I had a miscarriage at three months. In this pregnancy, I had three embryos. One of the embryos was stronger than the other two. During the first trimester of my first pregnancy, my hormone level was at 22. Every 15 days I had to go in to test my hormone level because it was increasing. The doctors believe the two weaker embryos killed the third stronger embryo to survive. The doctors attempted to remove them or do something to prevent this, but the embryos were young, approximately two months and five days old. The doctors feared conducting any procedure. I got married in 2004, this occurred in 2008. After almost four years of marriage. Wait, wait… [thinks out loud] oh yes, it was the 26th of August 2008.

Most women I interviewed briefly recalled the years and possibly the months of their fertility treatment; therefore, when Sawsan recalled the exact dates, I was slightly taken aback in a positive way. She noticed my reaction and stated,

> *habibti*, I am a history teacher. I remember all the dates. Even my third IVF, took place in 2011, wait… [pauses] the 24th of January, the day before Hosni Mubarak [the ex-President of Egypt, overthrown during the Arab Spring protests] fell.

After she mentioned this, everyone in the room started to laugh. Her best friend commented, 'you do not remember anything else, except Hosni Mubarak.' Sawsan responded, 'I do not forget. Also, my sister told me "Hosni fell, but *inSha'Allah* your pregnancy will not fall." And I stayed pregnant. However, the pregnancy lasted for only 20 days before I had a miscarriage.'

Sawsan was the only woman I spoke to who had used the method of freezing her eggs for IVF treatments. This may be explained by the high financial cost of freezing eggs and her having a stable job providing the resources necessary to pay for this process (see Waldby, 2015).

It is pivotal to note not all infertile women undergo conventional fertility treatments provided by the medical field. There are other various ways by which treatment is sought. Herbal treatments were frequently cited as a non-medical method used to treat infertility. However, in the cases cited, these treatments proved ineffective. Karima situates her experience of using herbal treatment for eight months as an insufficient timeframe due to 'natural treatments need time'. Moreover, herbal treatments not only require time but are also costly. She recalled when her husband, Ahmad, insisted that during the First Intifada,[58] when his financial state was in near disarray and they were forced to stop the medical treatments, they would try natural treatments and remedies.

> We repeatedly tried new natural remedies and mixes prescribed for us from Nazareth by way of an Arab doctor [referring to an herbalist]. They conducted an exam to test our hormones, where they took a hair follicle from the head, like this [points to her scalp], and from the root of the hair they conducted the exam. From the results of this exam, they would send us prescriptions. We also conducted exams here in our home. But we never went to Nazareth. There was one individual who would go to them and return. He was our middleman, brought us the medicine and gave them the tests. I cannot remember his name, but what I do remember is it was very expensive. They were pills and mixes, but through an Arab doctor, so natural treatments or what are called Arab treatments. The cost was very high and would reach almost 1,000 shekels a month just for the middleman. It was expensive. It was very, very, very expensive. At the end, we decided we would start going ourselves, but the incidents occurred. You know at the beginning of the 1990s, there were incidents that would occur and they would last a long time [referring to the First Intifada] we had to stop the treatments. When the incidents worsened, my husband stopped working even small jobs because of travel restrictions and curfews.

Karima and her husband later came to the conclusion that one herbal treatment is less costly than one IVF treatment, however, was not as effective and required more than one herbal treatment for results. Coupled with this conclusion, Karima recalled a medical doctor's perspective on herbal treatments:

> I had a folder with all of my test results and treatments. We took these results and treatments to show the doctor in Bethlehem, who told us '*kul hād ḥaky faḍy*'.[59] He was specifically referring to the herbal treatments. This was after spending around 15,000 shekels. We were humans living in the simplest of ways just to pay for treatments. I do not know if doctors like to attack, or talk bad about one another, I swear I do not know. The point is, this doctor told us we had to undergo more tests to see if our conditions were treatable or not.

Karima expressed her dislike for the doctor, stating 'he was very inconsiderate about our financial and emotional state'. After their consultation, Karima refused to visit this particular doctor again.

Similarly to the doctor's perspective on herbal treatments as pointless, Noor felt the same way and distrusted herbalists due to the following encounter:

---

[58] The First Intifada started in 1987 and ended in 1993.

[59] An Arabic phrase literally meaning 'this is all empty talk', connoting uselessness.

> To be frank, I think there is deception in that area. For example, a friend of mine referred me to an herbalist claiming to specialise in fertility treatments. The herbalist was a female, and when we first met, she explained my specific treatment would cost 500 shekels [approximately US $130]. I paid her only 300 shekels [approximately US $80], informing her once the treatment was complete, I will pay the rest as well as return for further treatments.
>
> During the first session, she conducted an ultrasound of my uterus. The on-screen image displayed spots on my uterus. It seemed as if the screen was dirty or the signal was weak. However, I refrained from commenting. I took the treatment she provided, which was a blend of herbs, as recommended for two weeks.
>
> When I returned for my second session, the herbalist conducted a second ultrasound of my uterus. The on-screen image display was clear. No spots appeared on my uterus. The herbalist informed me that this was the result of the treatment. At this point I was thinking to myself, is this lady mocking me? Does she assume I am ignorant?
>
> Typically, herbal medicine requires six months to at least a year for results to become apparent. For this herbalist to tell me within the span of two weeks that there have been drastic results, there must be something wrong. I told her, 'forget it, I do not want your treatments.' I never went back or completed the payment.
>
> The thought she might have done something to the screen to make it seem as if there were spots that suddenly cleared up, led me to not trust her. If she told me, 'look, there are a few spots left but some of them are gone,' I would be okay with that result. It is more realistic. Yet, for all of it to be gone within two weeks, impossible! The leftover herbal blend, I threw out.

Noor's followed up with her previously infertile friend that reached pregnancy as a result of the herbal mix. Her friend revealed to her that she had taken the mix for a six-month period. Noor claimed she taken aback by her friend's comment explaining to me, 'why should I put all this money for herbs? I could have undergone not one, but two IVF treatments. The lady had the money and ability to spend on a six-month period of use. *Me*, I am not financially able.' This understanding links back to the financial burden of fertility treatments. A main concern for the women interviewed (except Sawsan) was the financial cost of treatment regardless of it being a medical and/or herbal treatment.

Another method to overcoming infertility were through religion. The only interview who went attempted this method was Noor, who went to a sheikh first before a doctor to resolve her fertility complications later resorting to medical and herbal treatments. However, Noor did not expand on her experience with the sheikh and simply stated she went to one. Rana, on the other hand, preferred utilising religion in comparison to medical treatments, though, she revealed scepticism about religious authorities and their presumed powers to remove *ḥasd*:[60]

> People frequently suggest I go to a sheikh. They suggest I may have *ḥasd* put on me by other women. However, I did not feel comfortable with this idea. I read Qur'an over myself. I pray. I even read specific chapters over myself meant to cause or aid in pregnancy. I read Qur'an over water and drink it. Yet to go and see someone face-to-face, I refused this idea. I do not trust them.

Her distrust, she explained derived from the belief that religious figures exploiting their power and influence for monetary purposes without providing results. However, the argument of religious figures

[60] Literally meaning 'envy', referring to the evil eye as it is perceived to be a cause of infertility.

exploiting the power and influence for monetary gain is also relevant to medical doctors claiming to treat infertility (van Zandvoort, de Koning and Gerrits, 2001).

3. Beliefs, Experiences and Coping Mechanisms

As the previous chapter discussed, the oPt is structured by patriarchal connectivity influencing the understandings of socially valued fertility and the concept of *'amir al beit*. Infertility affects Palestinian infertile women's embodied selves in varying ways. At the psychological level, most of the women interviewed expressed feelings of sadness derived from living without the ability to bear children. At the personal level, identity and perspectives of self are multifaceted, with women's experiences changing and shifting as they worked through negative and positive feelings, as well as their family members' and society's inputs on their lives.

Through patriarchal connectivity, the extended family 'exert strong pressure [on couples and women] to promote the norm of having many children' (Memmi and Du Loû, 2015: 293). During one of my interviews, Leila positioned the state of infertile women and reproduction as an issue associated with the patriarchal conceptualisation of the female role with the pronatalist society as: 'we always assume a woman has to get married to either have children, or raise someone's children. Maybe someone will come to you [for marriage] specifically because [he knows] you cannot have children and he does not want children.'

Leila's comment was confronted with doubtfulness from her friends. The women in the room began a discussion on the purpose of marriage, coming to the conclusion that a woman who finds a spouse that does not want children is a rarity, and that particular woman is 'lucky'. Their uncertainty towards Leila's comment displays the innate ideology of mothering children as an essential societal expectation of growing into womanhood. Nonetheless, their conceptualisation of a woman finding a partner who does not want children as 'lucky', suggests childbearing is a societal norm fulfilled to please society and a woman's husband more than herself. Therefore, if a husband does not want children, a woman may relieve herself of fulfilling this norm and be content in a childless marriage. A similar finding by Inhorn (2012) locates an Arab woman in a relationship with an infertile man will be more likely to stay in a childless marriage than divorce him for children, which is a predominant reaction along with polygyny for a fertile man in a relationship with an infertile woman (see also Miall, 1986).

Childbearing is 'very tightly interwoven with notions of femininity and the achievement of position and status within the household or family' (Peteet, 1991: 184). This is not to argue that all Palestinian women face pressure to get married and reproduce; however, it is the norm of Palestinian culture. As with all norms, it is not subscribed to universally.

Among the Palestinian women interviewed, the ways they experienced and coped with their infertility and childlessness were very much related to the patrilineal kinship system and tied to the idea of family. When confronted with the information that they cannot conceive, women made use of services available to them, from seeking the aid of medical doctors and herbal healers to going to religious figures. In the following sections, I will attempt to provide an insight into the research question: what are the beliefs, experiences and coping strategies of infertile Palestinian women?

3.1. Language

The language women used as they constructed and narrated their stories established a site of reflection on the social, political and gendered atmosphere in which their embodied selves were located. As Fairclough (2003) explains, '[l]anguage is an irreducible part of social life, dialectically interconnected with other elements of social life, so that social analysis and research always has to take account of language' (ibid.; 2). This section seeks to 'take account' of the women's terminology (or lack thereof) of their infertile state.

Fundamentally, the women never referred to themselves as 'infertile', nor did they label their inability to conceive as 'infertility'. The Arabic term for infertility is *'uqm*, which possesses a negative connotation, such as 'barren' in English. Accordingly, the preferred medical term is '*adm alqudrh 'lā al'njāb*. The former suggests the inability to ever have children, while the latter suggests a non-permanent state with future possibility of conceiving and birthing children. Nonetheless, this term was only used in the fertility clinics during my conversations with nurses and doctors. The women I interviewed who were considered infertile referred to their infertility as *mushkilty*, meaning 'my problem'. They were hesitant to apply the medical term when discussing their infertility, yet they utilised the socially-conceived portrayal of infertility, *mushkilty*. This reveals the impact society has on women's definitions of infertility as being a problem, which belongs to the women's body [e.g. Born, Carotta and Ramsay-Seaner, 2018).

Not only did the women disassociate themselves from infertility through the lack of utilising the term, but on more than one occasion they stated their disassociation. For example, when Asmaa, her husband and I went into a separate room following her hormonal injections, once seated, Asmaa quickly commented, 'I do not have infertility. I am not infertile. The doctor informed me the reason for our inability to conceive is unknown, and there may be no reason.' A similar iteration took place during my discussion with Sawsan, who told me

> The issue was not from me; it was from my husband. His sperm count was 50,000 and his sperm mobility was high, but sixty percent of his sperm was abnormal. He had… [tries to recall] do not worry, I am a doctor now. What did he also have? He had low sperm motility and high sperm viscosity.

Smiling at her ability to utilise the correct medical terms, she reverted back to the story of her miscarriage. As Sawsan explains, her husband had difficulty in naturally causing a pregnancy; however, according to her, through IVF, his fertility complications are resolved. Post-IVF, fertility issues arose due to Sawsan's inability to carry the embryos to birth, as they are unable to attach to her uterus wall.

Furthermore, there was frequent reference by the women to the normalisation of their infertility, deriving from their perceptions that there is nothing they are capable of doing that will change their biological state. This is inferred through the frequent utilisation of the term *khalas* meaning 'enough', commonly utilised as an interjectory term signifying 'that is it'. It was used as a means to give in to one's biological framework of infertility. It allowed the women to maintain their everyday life through the acceptance of their fate of biological infertility and childlessness. The void left by infertile women's inability to conceive children becomes a looming part of the women's lives, ultimately becoming, although negatively, ordinary. Simultaneously, these women are required to project continuing attempts to conceive children and/or putting their hope in God. They are not allowed to show signs of accepting their infertility and childlessness.

3.2. Financial Independence

Language constructed the ways in which women told their stories, meanwhile, women's personal financial state constructed the lives of the stories told. This perception of financial independence as being a determining factor in how infertile women perceive themselves is indicated in my encounter with Mariam.

As I sat in a public clinic in Bethlehem, I noticed a young woman who was all smiles. She had been friendly since the moment she walked through the clinic's door. To me, this was a rare sight. Ordinarily, the persons entering the clinic would only smile on particularly occasions, as a gesture of hello to the employees, or when someone was looking their way. Otherwise, the majority of the patients would not smile, typically presenting a nervous look. Of course, I did not speak to each individual that walked through the clinic's doors, so I could only guess at their feelings and reasons behind their apparent lack of enthusiasm.

After almost 30 minutes of watching this particular woman through the corner of my eye with her purple lipstick, colourful clothing and upbeat personality, the nurse introduced me to her. Mariam is a 26 years old female diagnosed with PCOS, and has been attending the clinic for approximately two years.

As I spoke to Mariam, I was soon informed about the secret behind her 'confidence' and 'strong personality'. The reason was her self-reliance, which derived from her financial independence:

> I am stronger now than when I first got married. However, as any infertile woman, I will always feel weak. I studied [at university], I passed and am working now *alhamdulillah*, but this is something in God's hands not in mine. You can try to achieve something, run towards it and get it. On any level, whether it be studies, work, learning how to drive a car, buying a car, etc. If you put in the effort, you will be able to reach your goal and get what you want, what you worked hard for. But there are some things you feel weakness in, and you – no matter what you do – are incapable of reaching your goal. Actually I did not become stronger. I learned to deal with my situation.

Mariam's ability to accept her infertility, as well as remember she is not alone in her struggle, provides her the strength to move on. However, she also explained that a large reason for her confidence and strength was due to her financial state.

> Personally, I say *alhamdulillah* that I work and am capable of paying for my treatments. To tell you the truth, for this current IVF treatment, I did not take anything from my husband, because I feel like it is my problem and it is in me. Him, he fought with me saying 'why are you differentiating between you and me? Differentiating between my money and your money.' I told him, 'No, I am happy to [pay for the treatment] and feel relieved that I am paying for it.'
>
> This current treatment costs more than 10,000 shekels [approximately US $2,700] so it is a big amount. I made a *jam'iya* [collection from a shared pool of money] and got the money, *'adi*', like all the other *jam'iyat*. *Alhamdulillah* my situation is better than others. A woman feels as though when her husband pays for her fertility, he is holding a grudge or a favour over her head. My husband got mad, telling me 'why do you want to pay for it yourself? Why not from my money?' In my head, I am thinking *ya ḥasritak* [oh, you poor fellow], you pay for everything from my clothes to my makeup to the house. Thankfully I am able to save my money in a collection with friends or on the side, and he pays for everything else besides the fertility treatments.

Mariam later discussed her position of an infertile woman benefitting psychologically and emotionally by paying for her own treatment.

> Here I am and here is my husband, my family does not even know I am paying for my own treatments. It is for myself, for my personal well-being. It is *mushkilty*. It is my biological problem and, as such, I should pay. But, sadly, infertility is hard, and harder for others than myself. Unfortunately, infertile women just give into the pressure and reality of their situation by allowing their husbands to get married to a second wife.

In this statement, Mariam takes ownership of the term *mushkilty* by utilising it to describe her body in a way that shifts it from a patriarchal concept into an empowering concept. However, this is possible only in part by her economic standing.

Following this, Mariam advises infertile women to work and pay for their own fertility treatments in order to not feel burdened by the necessity to conceive or, if possible, to refund their husband and his family for their previous financial contributions to the treatment. She posits:

> I give only one piece of advice to infertile women I know, which is 'do not undergo any fertility treatments and IVF – rather, finish your studies, if necessary, and find a job. All the money you need for treatments you will not take from your husband or loans, only from yourself. This way you will not have to depend on anyone or have anyone hold a grudge against you. But, honestly, it is easy to say and hard to do.

Mariam reveals financial independence as relieving the burden of infertility and not feel familial pressure. This financial independence as a means to relieve oneself from the demands of childbearing is also portrayed in the discussion with Sawsan. She, as previously mentioned, paid for all of her fertility treatments herself. Financial independence allowed her to not feel indebted to her ex-husband, easing her decision to get a divorce.

Economic factors, as mentioned, play a crucial role in an infertile woman's relationship with her husband. Take for instance Sawsan's story. As an alternative to an unstable and unsatisfactory marriage, Sawsan divorced her husband. During our discussion, Sawsan reported getting a divorce after eleven years of marriage. She recalls that her husband's family conducted tests on him without her knowledge and without showing her the results; rather, they informed her that they had had their son tested in Amman by a doctor who concluded that he did not have fertility problems. Afterwards, they consequently put the whole responsibility of infertility and the inability to achieve childbirth on her. She recalls her brother-in-law yelling at her, 'my brother is fertile. He is capable of conceiving. He has no issue. You are the issue.'

Subsequent to the tests they conducted, Sawsan explained that her husband and his family 'wanted him to get married a second time for children, because I cannot have children and he has no problem.' Sawsan claimed his family does not understand fertility treatments. She commented on her ex-husband's desire to get married: 'if he does get married he will be an idiot, a son of an idiot, to put people's daughters in an infertile relationship. I accepted it and stayed quiet, but others?'

Furthermore, Sawan's husband's family argued she had gotten older and her ex-husband needed to get married to a younger person. She explains, 'they believe age was a determining factor, not only in getting pregnant but also in the success of fertility treatments.' Her friend remarked mockingly about Sawsan's husband's point of view: 'she got older so he wants to marry someone younger and let the younger woman undergo IVF, hoping that since she is younger, IVF will work.' Sawsan refused to allow her husband to enter into a polygynous relationship.

Unlike the other women interviewed, Sawsan is employed as a full-time teacher. Meanwhile, Mariam is employed and utilises a saving system with her family to pay for her fertility treatments. Sawsan and Mariam are adamant never to allow their husbands to enter into a polygynous relationship. They both also have the financial capabilities of progressing their own agendas, due to their lack of financial dependence on their husbands. For instance, Sawsan had the ability to pay for seven rounds of fertility treatments. Shadia, on the other hand, does not have the economic capabilities of paying for her own treatments, and fears the economic burden of a divorce given her 'family's hardships living in a refugee camp.' Noor, on the other hand, had a few, short spells of employment, but is also dependent on her husband financially. Finally, Rana is unemployed, causing her to be financially dependent on her husband. Rana's family does not have the financial means to support her if a divorce were to occur.

3.3. Womanhood as motherhood

In all of the cases, the women were pressured by their spouse, family members and/or in-laws to seek medical attention and, if financial capable, to undergo fertility treatments. This pressure coupled with this physical, emotional and psychological toll seeking fertility treatments had on the women resulted in various outcomes. Karima's story illustrates her willingness to do what pleases her husband who was determined to find a treatment: 'it was to the degree that we did not leave a doctor unvisited, even in Hebron, Haifa, everywhere we went.' Karima described her husband's relentless quest as hopeful and optimistic, rationalizing his behaviour with the words 'humans are very optimistic beings. Whatever [treatment] he heard about, he has the willingness, even if there is not one cent in his pocket to try what he is introduced to'. Karima expressed being morally supportive of her husband's quest to have a child; however, she found 'the going and coming, the expenses, the medications' to be 'tormenting'. Her previous optimism for children dwindled:

> At that point, my body was prepared [for giving up the treatment] or you could say I had feelings of *burūdah* [coldness]. What made me colder was that there was no more longing inside me, and my feelings became simpler. I became aware of our efforts. My husband did not fall short, and he wants children more than I. If they told him 'go to the sky, you might find a treatment', he would be willing to go. If they said go to any random place and get a treatment, he would be willing. So I was the one who *baradīt* [became cold], because he did not fall short in anything. His compassion, our compassion towards one another, *alhamdulillah* we are believers in God's decision, and believers in what will happen to us. If God wants to *'iṭ'amnā* [feed us], we will do our part and continue our treatment. But if God does not want to *'iṭ'amnā* then this is in God's hands. So, what made me love him and his passion [for children], was the same that led me to become *barda* [cold]… his manner and his words.

Karima depicted this feeling as a result of the toll fertility treatments had on her personality and psychological state. She became indifferent to the subject of children, referring to her husband's optimism as her weakness. She refers to her husband's character as consistently 'staying away from psychological pressure. He believes in God and *qadr* [fate]'. She also adds to this his love for her, through the remembrance of sayings he would express to her, such as 'if I were able to carry you off to space and we could be alone, I would', and 'if the whole world were experiencing an earthquake, I would not allow a piece of dust to land on you'. She posited their love for one another as 'real love between two kind souls'.

During her and her husband's journey for a treatment, she refrained from sharing her feelings with her husband allowing him to continue his quest. Yet when her husband's neurological condition worsened, their prospects of conceiving a child became minimal and he had to stop

seeking, which allowed her to also stop the treatment. Nonetheless, she argues his love rather than her lack of desire to continue treatments, strengthened her to become more accepting of her *qadr* to be childless. This statement combined with her statements on being exhausted and not wanting to continue fertility treatments is telling of her wanting to pursue a life without the burden of childlessness as a means to cope with her infertile state and create meaning in her life. A similar conclusion is found in McCarthy's research, interviewing women after four years of unsuccessful treatment which created 'existential challenges to their sense of self-identity and meaning and purpose of life' compelling them to acknowledge their inability to attain motherhood and create a new meaning for their future (2008: 319).

Mariam, as with many of the interviewees, took her husband's feelings and emotions into consideration, explaining to me,

> My brother's wife got married and has two boys. So, I know and feel with my husband. Here is my brother who has boys, one is three years old and the other is five months old. I think about this and feel bad, because this is not something I can give to my husband.

Mariam navigates her infertility, combined with her husband's desires for a child and society's expectations of motherhood, through her perception of patriarchal bargaining. She accepts her husband's and her family's request for her to undergo fertility treatments on one condition: she funds her treatment independently. Mariam's demand to pay for her fertility treatment, although only her husband knows of this decision, allows her to not feel subject to the financial burden of her husband, in-laws and/or loans.

Her husband was initially sceptical of her desire to pay for the treatments, but Mariam explained that this allowed for her and her husband to have a positive relationship without the financial burden associated with fertility treatments. This maintenance of a good relationship between a husband and his infertile wife provides a source of hope (Mosalanejad et al., 2014), which perhaps partly explains why Mariam seemed less concerned to the outcome of her infertility as she is financially responsible as well as is positively encouraged by her husband.

Meanwhile, Noor's quest for motherhood has overtaken her life and sense of self. Post-marriage, her life revolved around her infertility and attempts to overcome it through actively seeking treatment.

> In my 16 years of marriage, not one month passed without me going to see a doctor. Sometimes I went two or three times not just once. I underwent various types of treatments, but it is useless. Nothing is working for me. I am just waiting to conceive naturally. Fertility treatments have not been successful for me.

Part of overcoming infertility is argued to be subjugating oneself to fertility treatments. Pfeffer (2001) examines women's personal experiences with infertility treatments, resulting in infertile women commonly finding themselves as a problem due to their inability to achieve their desired biological and social state of motherhood, even causing them to describe their bodies as a failure.

However, women who underwent infertility treatments faced multiple changes in their daily life and their life as a whole, with regards to work/studies, the relationships between them and their husbands, friends and family; dealing with the negative social, physical and psychological effects became essentially the women's 'full-time job' (Remennick, 2000). Kirkman and Rosenthal (1999) discovered that women, in order to fulfil their 'prescribed' role as mothers,

would use ARTs mainly for two reasons, firstly by their own will and desire, and secondly due to a lack of strength to reject it and look for alternative ways towards motherhood, for example adoption.

However, not all the infertile women I interviewed consistently sought fertility treatments as a method to fulfil their desire for motherhood and/or the social pressure to achieve motherhood. This was predominantly true for women who underwent treatment and did not wish to continue, such as Rana. However, Rana hoped to naturally conceive a child and attain motherhood, while Karima tried to fulfil her sense of motherhood and mothering through caring for her family members' children.

3.4. Hope as Fate and Faith

As conception in the oPt is an important life stage for women, infertile women tend to be more psychologically distressed in comparison to their fertile counterparts (Katwsa, 2013) because childless women are asked to account for their inability to conceive (Loftus and Andriot, 2012: 226). Sawsan and Asmaa's narratives provided an encompassing picture of medical fertility treatments, inclusive of the hardship, pain and complications associated with women's desires to reach motherhood. Asmaa was in the beginning stages of her fertility treatment and had not experienced a 'failed' treatment; however, her hopes and desires were equivalent to those of Sawsan, who underwent multiple failed treatments, and was currently divorced but still perceived a future with children she would conceive. Asmaa and Sawsan desired and hoped to be able to fulfil motherhood, thus disassociating themselves from the label of infertility. In order to do so, Asmaa stated she had no infertility issues; meanwhile, Sawsan blamed her husband even though from her commentary, she was unable to bring a pregnancy to term.

Hope is considered a vital and necessary coping mechanism among infertile persons. According to Mosalanejad et al. (2014),

> Hope makes self-confidence, internal positive feeling toward a particular thing or event. Materializing a purpose is impossible without hope and conversely, it makes people believe that darkest scenario would not happen to them. Hope predicts physical and mental health as determined by various indicators such as self-reporting health, positive response to medical interventions, mental health, positive mood, effective coping, reassessment, problem solving, avoiding stressful event, seeking support, and health promoting behaviour. (ibid.: 117)

For Noor, hope and positive outlook for the future is illustrated in her imagination as she explains:

> Life is difficult, I know but there is still hope in me that one day I will give birth to a child. When my husband is away or working late, I imagine laying down with my son in my arms sleeping. My husband and I even imagine our children running around the house.

Meanwhile, Rana's hope for the future is determined by her infertility journey, inclusive of both traveling to seek fertility treatment and the decision to refuse fertility treatment. Although she displayed negative emotions towards fertility treatments and the medical field, she still has a positive outlook on her fertility through her continuing feelings of *āmal* (hope). She has *āmal* that she will naturally conceive given her lack of desire to continue fertility treatments due to its psychological and physical toll.

The inability to biologically conceive children creates a negative outlook on their future lives. However, all of the women (aside from Karima whose husband is on bedrest and had refused to remarry, as well as Yasmin who is no longer of reproductive age) have hope that their future will include conceiving children.

Hope in Rana relates to Su and Chen's (2006) conceptualisation of 'transforming hope', referring to the reality of infertility after the failure of fertility treatments, which is necessary for infertile women to live in the world through healing and recovery. This transformation includes three categories: '(1) accepting the reality of infertility, (2) acknowledging the limitations of treatment involving high technology, and (3) re-identifying one's future' (ibid.: 48). Transforming hope allows Rana to live her life through accepting her state of infertility by balancing the acceptance of her infertility, refusing fertility treatments, and renegotiating her identity with herself and with her family who are supportive of her. Through this process, Rana allows herself to focus on her life with the hope of having a child, but without the constant need to be accountable for being involuntarily childless. This allows her to live her life without children in a non-destabilising manner.

Hope is also closely associated with God and the idea of fate in childbearing as a will of God, consequently leading to hope in having a child as a will of God. This is portrayed in Jenine's explanation that although she had tried multiple routes to acquire money to pay for fertility treatments all of which have been unsuccessful, she is still hopeful asserting, 'I do not give up hope. All hope is in God's hands.'

She then added, 'we cannot do anything but say *alhamdulillah*. Hopefully one day our situations will change'. After Jenine reflected on her situation, commenting that she will always be thankful to God, Leila recited a verse from the Qur'an, '*la-in shakartakoum la azidanakoum*', which translates to 'if ye are grateful, I will add more (favours) unto you' (Qur'an, 14: 7). Jenine was comforted by these words, acknowledging her agreement with the verse.

All of the women I spoke to referred to infertility, as well as prospective childbearing, as being the will of God. They shaped their perspective on infertility as God's choice, utilising it as their belief system, allowing fate and faith in their experience of infertility to form a coping mechanism. This follows the use of religion as a solace for women to overcome societal and cultural expectations (Czarnecki, 2015), which in this case is the societal, cultural and religious expectation of motherhood.

Karima illustrates the ability to cope with the burden of childbearing through her marriage as it compromised of 'the two things you need in your life: faith and love. Your faith in God and love towards your spouse are more sufficient for you than the whole world.' These "two things", she argued, provided her the strength to endure her *'athab* [torment] of trying different methods to attain motherhood.

Furthermore, in the case of the oPt, regardless of whether an individual is Christian or Muslim, both men and women 'have strong beliefs in God, their faith helps them to accept their sickness. Most feel that being a member of a religious group gives them strength to accept their illness with grace' (Saca-Hazboun and Glennon, 2011: 282). Religion is a form of active coping through means of prayer and through the constant reminder that their state of infertility is 'God's will' and not their own. Women identified their infertility frequently as the 'wisdom of God'.

Jenine, for instance, although she continues to seek financial assistance for IVF, accepts her state of involuntary childlessness, revealed in her comment, 'we cannot do anything but say *alhamdulillah*.' For Karima, thinking about her and her husband's childlessness makes her cry, although she states:

> I do not cry because I am hurt or want a child. I cry for him [her husband]. I am scared something will happen to me and the *miskeen* [helpless person], he will be alone. I laugh quickly though. I cry and get sad, but I right away I laugh again. Very quickly. I always remember what my husband used to say, '*ma qadr Allah fa'al*' [what God decrees, He does]. So, you see, this is my life story. From [wanting] children to my husband. Even with all of this, I tell you: love, and faith in God's will, allow you to *'istaghnā 'an kul aldunyā* [abandon all the world, i.e. to stop worrying about earthly things]. If your husband is righteous and has a yearning for faith in God and love, your life will be happy.

Most of these women sought and/or continue to seek medical attention to achieve pregnancy; however, faith in their fate as determined by God dictates their outlook on their infertility, rather than what is determined by their biology. This was also present in a saying the women utilised: '*Allah yiṭ'mni*'. This means, 'may God feed me children', as though a state of childlessness is a similar to a state of hunger, which only God could alleviate if He wishes. This correlation is also mentioned by interviewees during Granqvist's (1947) field research: ''If He will feed me with sons, He does not mistake where my mouth is, and if He shuts me out He does not trouble himself about me' (ibid.: 34); 'God has fed thee with three sons' (ibid.: 34); 'It is God who feeds her with sons' (ibid.: 35); and, 'The one that feeds is He, and He is the one who gives the food' (ibid.: 35).

Moreover, Rana, believes her lack of children is God's fate, as her and her husband's personalities would not be able to manage children:

> Look, my personality is calm, and I like order. I like children, well, specific types of children, and they all like me, even though I am strict with them. My husband is the opposite of me, he quickly gets very nervous and frustrated with children. He also likes specific types of children. Some children he will be able to endure, while others he will not. He and I do not like loud noise. Occasionally, I see him *bḍūj* [becoming agitated] from a child. I think God probably had the wisdom to not grant us children. We would not have been able to handle them. Do not get me wrong though, I would like to be a mother, of course. There is just a conflict of interest. I am sure God did not grant us specifically children. We would not be able to cope with countless situations or handle life with children.

Similarly, Sawsan expressed, 'Of course, of course. I still have hope that I will become a mother. Maybe God did not want me to get pregnant and have children from my first husband. *InSha'Allah* I will have children in the future.' Although she sees being in another relationship and marriage as impossible for her, she still wants children even though it requires a second marriage. Her social and personal attachment to the norm of childbearing and motherhood are viewed through this statement in which she frames God's will as the reason it is unattainable.

Even Yasmin, who referred to her living situation as depressing and sad, was also grateful for not having children. She reports:

> In the end, I do not know. Maybe this was God's will and wisdom. Maybe if I had a child, he would have driven me crazy and made problems for me. I am not knowledgeable about the unknown. My son could also have helped me, taken care of me, worked, brought me things and taken me places. Yet at the end of the day, it is God's wisdom.

In general, 'the will of God' was a persistent reason for explaining infertility, as well as determining whether a couple would conceive children. For all the women interviewed, God ultimately determined their fertility. They visited traditional healers, medical doctor fertility clinics, and/or sought financial assistance to fund treatments, but religion and the will of God were the basis of their explanation for being unable to achieve and carry out a pregnancy. Furthermore, this reliance on religion and fate being in God's hands rather than their own provided them solace. It also allowed them to refute criticism and comments about their fertility from their family members, in-laws and society as a whole, by referencing God as the justification of their infertility.

3.5. Mothers to others

As Karima and I sat conversing, women walked in and out of the bedroom, one of whom said to Karima '*salāmtik*'.[61] The woman walked up to the bedside and asked Karima's husband how he was doing. Karima introduces the young woman to me as '*binti*', meaning 'my daughter'. The woman replies, 'yes, *bintik* [your daughter]'. The young woman stood above Karima with one hand on her shoulder as Karima clarified,

> By the way, do not say about me that I did not give birth. *Alhamdulillah* I have young women as daughters. She is one of my daughters. She recently got married, almost a month ago. We got both of my brother-in-laws' daughters married within the past few months.
>
> Thankfully *banāti bi'abū ḥayāty* [my daughters fill my life]. I consider her to be my eldest daughter. In my house, I call them 'mama'[62]. Actually all of my in-laws' children, I call them 'mama'. I satisfy myself through them.

Later into our conversation Noor, she expressed 'women have an innate desire to love and care for children. We love to be surrounded by children. For me to fulfil this innate desire, I have my in-laws' children.'

In addition to the social and economic benefits of childbearing, there are other equivalent although less tangible significant benefits. Rana complained that her house is always quiet and her daily routine is monotonous without children. Accordingly, Rana along with majority of the women interviewed such as Yasmin and Jenine believe that having children contributes to daily pressures of alleviating loneliness and depressive symptoms.

However, motherhood was not only limited to family members and humans per se. Two interviewees noted the reflection of their mothering tendencies on animals and pets. Jenine, for instance, takes care of birds; as her niece jokingly commented, 'my aunt and her husband raise birds [like children], look', pointing to a bird cage in the corner of the living room. Jenine then commented on how she takes care of her birds everyday by feeding them, talking to them and cleaning them.

Yasmin also described herself as not being childless, referring to her cats as her children:

> I take care of cats. I have a lot of cats and kittens that I take care of. They wait for me outside of my house. Young and old. I love cats a lot and they love me a lot. I used to have almost 200. A lot

---

[61] Literally meaning 'your safety', but meant as 'I hope you get well'.
[62] Arab mothers tend to call their children 'mama'.

of them passed away or left. Now, I mainly have kittens, possibly around 50. I keep them outside because I have asthma and have to throw them food a bit further away from my house. *SubhanAllah* though, when I wake up to pray the morning prayer they know I am awake and come to the house. When I leave my house, they follow me. They are like children. When they see me, they will be far away, but start running towards me.

Once I had a blonde cat, I do not know where it went. Last summer, I was walking, and I usually get them bones from the butcher in bag. Suddenly, the blonde cat came up to me and started to walk right beside me like it was my child. The neighbours even started saying, 'look at the cat walking next to Im Yahya as if it was her child walking next to her.' I named it KutKut. It was beautiful. I do not know where it went now. I had a cat named Sundus that gave birth in my house. She gave me four kittens.

Originally, I used to raise them in the house but because of my asthma and becoming allergic to them, I could not keep them in the house. The doctors also told me I breathed in cat hair leading to a ball of cat hair stuck in my body. They told me I can undergo surgery to remove it. However, I have asthma and shortness of breath, so I was scared to undergo surgery. Thankfully the doctors got scared too, and did not pressure me.

Women did not reject motherhood. The majority of the women interviewed had individuals and/or animals they related to as their children. Many infertile women do not live a life without children. Some of the women interviewed were taking care of others' children as a reassurance and implementing their 'motherhood' instincts through taking care of these children. Thus, being infertility and childless does not necessarily mean living life without children and the joyful company of children, or indeed animals.

4. Conclusion

Traced throughout these women's stories were their embodied selves, as they explained how their understanding of self is impinged upon by their physiological state of infertility. The women experienced a myriad of emotions as they pursued, underwent or refused fertility treatment. As Sawsan's story revealed, regardless of numerous failed attempts, women desired children, as well as the full ability to medically understand her condition. Sawsan constructs her infertility as a perplexing medical condition, reliant on her husband's low sperm count, uncovering her desire to disassociate herself from her infertility. She proudly assumed the title of a '*doktora*' rather than accepting being labelled as merely an infertile woman who has considerable knowledge of her diagnosis.

Asmaa was at the beginning stages of her fertility treatments. She was, as such, hopeful in her future as a biological mother. On the other hand, Rana has given up hope in fertility treatments. However, through this process, she has been able to move away from her feelings of being a *maẓlūma* [oppressed and maltreated], with a transformation of a non-destabilising hope: a hope in her bodily abilities, as well as hope in what God has granted her (or not granted her) as fate.

Meanwhile, Mariam discussed the importance of financial dependency. She claims that severing financial dependency for fertility treatment from one's husband and his family, can prevent the husband and/or his family from disrespecting or wrongfully treating an infertile woman. Mariam's ability to finance her treatments provided her the ability to construct her 'problem' as her own, and disallow vulnerability inclusive of the involvement, criticism or comments of others to hinder her embodied self.

Furthermore, women's experiences of and desire for children were typically expressed through the domestic, social and future paradigms of motherhood. However, most women did not allow their infertile state to prevent them from constructing and identifying themselves as 'mothers'. Motherhood as a non-biological concept was utilised by these women to describe their relationship with children, in most instances their in-laws' children. It was also projected onto animals the women cared for. The ability to regain the concept of 'motherhood' and portray one's self as a 'mother', allowed these women to compensate for their 'failed' life trajectory of never becoming biological mothers, by attributing the feelings and duty of a mother-child relationship to their relationships with other people and/or animals.

PART FOUR

FEMALE INFERTILITY BETWEEN SETTLER COLONIALISM AND THE EVERYDAY

CHAPTER X: CONCLUSION

There is no such thing as a single-issue struggle because we do not live single-issue lives.
Audre Lorde (2012: 138)

Infertility does not occur in a vacuum; therefore, this thesis traces the multiple struggles impacting the everyday experiences of Palestinian infertile women in the Bethlehem area of the oPt. I argued that Palestinian social and reproductive norms cannot be understood without taking into account the Zionist settler colonial logic of elimination, which influences political, economic and social systems inclusive of a series of reproductive health policies designed to restrict population growth in the oPt. Moreover, this research focuses on individual case studies that inductively teach us about the possible causes of as well as prolongation of infertility and its impact on women's everyday lives.

As research on infertility in the oPt is scarce, this thesis is written under the conviction that infertility plays a critical role in women's lives. This thesis, therefore, attempted to tackle the issues through an inductive research, based on fieldwork in Bethlehem. It sought to understand how infertile women situate emotional and social distress in connection with moral, political and familial relations of power. In this concluding chapter, I intend to offer a summary of the main research's findings as well as provide suggestions as to how and why infertility should be incorporated into future research within the field of settler colonialism.

1. Research Findings

The initial goal of this study was to shed light on the different ways through which infertile Palestinian women understand and form their gender identity, in opposition to the gendered norm of motherhood and necessary female reproduction being consistent with other studies (e.g. Inhorn, 1996; Loftus and Andriot, 2012; Todorova and Kotzeva, 2006; Throsby, 2004; Upton, 2001). However, the themes that emerged from the interviews and the subsequent analysis were geared towards the political, economic and social nature of these women's lives. This led to the realisation that as a settler colonial project, Zionism's operations are a determinant factor in formulating the women's reproductive lives. Accordingly, this research makes a theoretical contribution to the analysis of settler colonialism as an on-going structure rather than a past event that utilises Indigenous women's bodies to prevent reproduction as a means to eliminate the native population.

As there is little research on infertility in settler colonial regimes, let alone infertility in the oPt, I revisited my research questions, seeking to better understand the experience of infertility for women within the context for their everyday lives in the particular area of Bethlehem. Accordingly, the following research questions were posed:

1. How does the Zionist settler colonial project affect infertile Palestinian women?
2. What constitutes infertility locally, and how do individuals, couples and the wider community respond to infertility?

3. What are the beliefs, experiences and coping strategies of infertile Palestinian women?

These three research questions merge into the interconnected nature of the macro-level political and socioeconomic context in which infertile women are placed, as well as the micro-level context of household framings, individual meanings and strategies, and everyday challenges of female infertility.

Concurrently, the first research question revealed the multifarious and complex nature of these women's lives created by Israeli policies and practices as informed by Zionist ideology, through the examination of the primary and secondary data. At the macro-level, the settler colonial structure, particularly prolonged occupation, has fundamentally influenced the political, economic and social conditions in the oPt. It has shaped policies, norms and expectations around in/fertility.

In chapter five, I provided extensive space for Karima's narration of her infertility journey, which is intertwined and encompassed within the lack of a proper health care system, economic inabilities and the political situation (e.g. Israeli checkpoints hampering Palestinian movement around the West Bank). Through this narration, the complex nature of infertility, as well as the techniques settlers utilise in pursuant of causing *political* infertility, not merely "infertility", is established.

Political infertility becomes the most consequential meta-framework for Karima and other infertile women's situational context as indigenous infertile women living within the settler colonial regime. This chapter demonstrated the importance of conceptualising political infertility as a variety of infertility deriving from Israel's policies. These policies although not necessarily directly or deliberately influencing the inability to conceive children. As such, it is pivotal for future research to tackle the barriers implemented by settler colonial policies towards overcoming infertility.

In chapter six, I traced the link between health care, health care systems and reproductive health in relation with infertility globally, as well as factors specific to the case of the oPt. The influence of Israel's spatial control policies, and the weakening state of the Palestinian Ministry of Health, have fragmented the healthcare sector within the oPt and have led to the deficiency of reproductive health. This fragmentation and deficiency have not only intrusively and in/directly affected Palestinian infertile women's trust in the healthcare system, but has also rendered their infertile state.

In chapter seven, I examined the influence of the weakening socioeconomic sector as a result of the settler colonial reality, which influence the power structures that formulate the lives of infertile women, as a negative influence. It creates what is later examined in part three as a kinship-based patriarchy, in which women are dependent on men as providers due to the lack of social security. Through economic dependency, patriarchal power structures including pro-natalism are strengthened. Elderly infertile women without male kin are rendered powerless and, therefore, dependent on the kindness of male figures within their society. Moreover, the socioeconomic sector influences the in/ability to undergo assisted reproductive technologies as a method of overcoming infertility.

Emerging from these three chapters are the various ways in which the settler colonial project affects the lives of infertile Palestinian women. The intertwining of external and internal, as

well as the political, health and socioeconomic power structures, have brought about a multitude of different and often ambiguous forms of control over Palestinian infertile women's lives. Israeli policies do not always have a direct impact on infertility and/or infertile Palestinian women; however, Israel has indirectly impacted infertile women's lives on a daily basis through economy, patriarchy, borders, checkpoints, and other manifestations of occupation. I attempted to provide space for infertile women's unobstructed narratives, in addition to analysing and disentangling the stories the women narrated, by providing this contextual discussion and following it with a more nuanced, everyday perspective on the societal, familial and individual practices infertility manifests in these women's lives.

The second research question tackles the infertility discourse as a disciplinary discourse of exclusion, aiming at locating infertile women within fixed and defined spaces that are considered the norm and most appropriate for them by the power structures at play. This second question seeks to appreciate wider meanings, motivations and behaviours relating to infertility, inclusive of the local social world in which these women lived.

In chapter eight, I described how infertility motivated kinship relations and marital in/stability. Infertility was the predominant stimulus of behaviour determining familial and individual wellbeing, as well as shaping marriages and familial/societal relationships. The local political and cultural environment reflected and shaped societal exceptions around the 'normal' woman as a fertile mother. This is projected through Lamis's self-description as a mother who does not have a 'problem', and who was constantly referring to the infertile, non-biological mothers through a literal means of othering by labelling them as 'the rest', and constantly differentiating herself from patients in the clinic. This differentiation demonstrates the crucial necessity to challenge and change the normalised gender roles of women as mothers, which is primarily a result of infertile women being marginalised, stigmatised and not provided with a platform to counter gender roles (see Throsby, 2004).

With regards to marriage in/stability, this chapter related that the effects of infertility were nuanced and varied with each infertile woman interviewed. Whilst these women were more vulnerable than childbearing women to the proposition of polygyny, only one interviewee had been in a polygynous marriage. For most women, infertility was not a legitimate cause for divorce by men. The pro-natalist, patrilocal system at hand also prevented women from physically leaving a marriage and getting a divorce. A concern for infertile women, as echoed by Noor, is staying in an unstable marriage, for the fear that remarriage following a divorce is not possible since men only have one purpose for women they marry, which is childbearing. The one interviewee, Sawsan, who did divorce her husband, described it as not for reasons associated with childlessness, but due to her husband's stinginess, unwillingness to pay for fertility treatments and disregard for her emotional state throughout her experiences with ARTs. Nevertheless, the issues of her marriage, which led to her divorce, was her childlessness. Moreover, her and Noor discussed the fear of psychological torment in a future marriage due to their infertility.

The absence of children arguably de-stabilises marriages and social relations, as problems result directly from infertility. A few women reported social stress caused by familial pressure to conceive children, neighbours gossiping, mistreatment by their husbands and/or in-laws, and the financial burden of ARTs causing marital and familial issues. This burden is exacerbated with the cultural necessity to *'amir al beit* through strictly biological means, as adoption was not widely accepted. Furthermore, living within military occupation has created a society

reliant on kinship ties to maintain mental, physical and financial wellbeing as such couples, particularly women, go to great lengths to maintain a good relationship with their kin (see Spellings, 2014).

However, as Karima, Rana and Mariam showed, infertile women are capable of having strong marital relationships. These women were supported and highly valued by their husbands. Also, unlike other infertile women interviewed, they were not pressured by their in-laws to conceive children. Presumably, marital in/stability is influenced by the spousal relationship, societal and familial influence, and socioeconomic status. Moreover, individual personality, self-perception and the desire or lack thereof to prescribe to the normalised gender roles, are also crucial influencers in women's marital in/stability.

The final research question was pondered throughout chapter nine. In this chapter, I traced the impingements of infertility on the realm of infertile women's everyday lives through their perception of beliefs, experiences and coping strategies. Infertility was found to be particularly challenging for the affected women, and was considered an important health problem in the wider community. Infertile women experienced a range of moral and biological experiences due to their infertile state.

No woman interviewed defined her inability to bear children as *'uqm* (infertility). Rather, they described it as *mushkilty* (my problem). This negative perception of their physiological state is influenced and compelled by societal perceptions of childbearing as a norm and a necessary life course transition into adulthood. This self-perception was intensified by the financial dependency of many infertile women. Additionally, infertile women distanced themselves from their biology by attributing their infertility to the will of God.

Women sought various types of fertility treatments, from traditional (herbal) medicine, to religious activities and ceremonies, to clinic/hospital-based treatments. Attending fertility clinics was viewed as the ideal route as well as the most sought out route to childbearing. Couples within the first years (0-5 years) of marriage sought help for their inability to conceive through clinics. However, given none of the public health care institutions provide treatment for infertility, medical-based ARTs are not a blanket method reflecting the economic burden of attending and undergoing clinic-based fertility treatments.

The discourse of infertility shaped infertile women's understandings of themselves. The women felt compelled to demonstrate their desire to have children, through undergoing fertility treatments, praying, continuing hopefulness, and other means such as accepting polygyny, in order to show that their childlessness was involuntary. These methods were also part of their coping strategies, which were otherwise limited due to the societal, economical and political climate. This provided very few alternative routes to infertile marriages and motherhood, besides mothering children within their familial circle and/or animals, staying in an often unhappy and unstable marriage, or getting a divorce without a positive expectation for remarriage. They were dissuaded by the community and/or themselves from adopting a child.

Women in different stages of treatments had varying perspectives on their childlessness. In the initial stages of treatment, or prior to undergoing treatment, women were hopeful, viewing the services offered by physicians and herbalists as reassurance of their projective fertility and childbearing capabilities. However, as women underwent more than one fertility treatment, they became less optimistic in treatment-seeking, defining themselves as *maẓlūma* (oppressed and mistreated) and more reliant on the 'will of God' to conceive. Reliance on God was also

utilised by women as a means to transform *āmal* (hope) from seeking treatment to formulating a belief system placing their experience of childlessness in the 'hands of God' rather than themselves, creating a method of self-coping with infertility.

Infertile women, although they lived in a patriarchal, pro-natalist society that promoted the interests of the patriline, were able to utilise patriarchal bargaining to negotiate their resources and routes as a method of securing the best outcome possible in their situation. These societal and individualistic reactions to infertility portrayed by the interviewees provide a basis for understanding the continuing importance of fertility within marriage, culture and politics, and its affects on everyday life.

Infertility, as Feldman-Savelsberg's (1999) analysis regarding infertility in Cameroon concludes, cannot be understood without a reflection on the interconnectedness of the body, the mind and the state of society with social reproduction as an emergence from a particular historical, political, economic and cultural context. This was similarly found in a recent study on the everyday lives of infertile women in Jordan, who find themselves marginalised and stigmatised due to the inability of 'contributing to patriarchal patrilineal lineage' resulting in 'potential, economic and social losses' (Daibes et al., 2018: 526, 527).

In conclusion, the empirical findings show an asymmetrical impact of Zionism's occupation on the inability of Palestinian women to reproduce. They also provide a glimpse into Palestinian infertile women's everyday experiences in confronting, challenging and reconstructing reproductive norms within a settler colonial setting. It puts into perspective the multiple methods Palestinian infertile women utilise to navigate their lives under Israel's oppressive regime of military occupation and gender norms of biological motherhood on a daily basis. In this evaluative summary of the study's findings, we see how infertile women encounter challenging political, social and economical restrictions involving their reproductive status.

2. Towards the Horizons of Decolonisation

Within the field of Palestine studies and, more broadly, settler colonial studies, the conceptualisation and understanding of infertility for individuals within a settler colonial paradigm has rarely been addressed. Accordingly, the aim of this study was not to generalise about female infertility in the oPt or in settler colonies; rather, it was to study the everyday lives of infertile women in a specific area within a specific political and socio-economic setting. It also sought to provoke wider thought and exploration, and shed light on the subject of infertility. The findings in this research might be insightful for the rest of the oPt, in addition to other settler colonial settings. These are settings in which indigenous infertile women stand out most, due to the settler goal of elimination of the Native and its effects on creating women as the carriers of future Indigenous peoples.

As I attempted to portray, infertility in settler colonies necessitates a crucial discussion on the interrelationship between reproductive norms, demography, race, kinship, gender and structural power relations. The understanding of these interrelationships may help direct focus and lead to the de-marginalisation of infertile Indigenous women by portraying these discourses as inherently political and unconsciously internalised. By becoming aware of these forces and problematizing settler colonial influences and policies, Indigenous infertile women can seek out a counter-discourse and various strategies to help them overcome their individual and societal portrayal. This will allow infertile Indigenous women to problematize their

existing assumptions and practices, as well as find empowering strategies to counter the assumption of the necessity of biological motherhood.

Likewise, there is a crucial necessity to centre settler colonialism within gender and women's studies in order to expose the still-existing structure of settler colonialism. This is in line with the arguments made by Indigenous women activists who 'have refused the false binary between fighting for "women's issues" and fighting for "Native issues," which for Indigenous women are always coiled together' as heteropatriarchy and heteropaternalism are settler colonialism's strategies (Arvin, Tuck, and Morrill, 2013: 15). However, Native feminism is a relatively new paradigm for discussing settler colonialism. Within a gendered analysis, Native feminist theory is equipped to conceptualise and understand the settler colonial project. It offers a richer, more productive discourse on the bond between national struggles, sovereignty, liberation and, of course, decolonisation.

Native feminist theory also provides a clear conceptualisation of the deconstruction of oppression and decolonisation of knowledge. Decolonising settler colonies can be complex and problematic, as settler colonialism is dynamic, ambiguous and puts Indigenous peoples in unpredictable and/or challenging situations. Cavanagh and Veracini write, '[t]here is no such thing as neo-settler colonialism or post-settler colonialism because settler colonialism is a resilient formation that rarely ends' (Cavanagh and Veracini, 2013). Therefore, decolonisation 'requires an imagination that is alternative from traditional accounts of decolonising passages' (Veracini, 2010: 114). Conceptually, utilising the paradigm of settler colonialism allows 'linking indigenous peoples from one context to another' (Krebs and Olwan, 2012: 142).

Native feminist theorists have encountered difficulties in grappling with actual decolonisation (i.e. envisaging what comes after decolonisation). Nonetheless, this should not detract from the appropriateness of Native feminist theory, and the utilisation of it as a framework for understanding and moving towards Indigenous decolonisation. As Morgensen (2012) stresses, contributors to settler colonial studies 'have the chance to build an intellectual space that does not present gender or sexuality as secondary or additive to some deeper, and presumably separate principle' (ibid.: 15). With this in mind, I strongly suggest that future research, including my own, needs to position a gendered analysis on settler colonialism through Native feminist theory and ask the tough question: what next?

I do not claim to frame a method of decolonisation, let alone map out a future post-decolonisation for Indigenous peoples. I do attempt to stipulate that in order to work jointly towards decolonisation, assumptions, generalisations and normalisations of gender and individual duties, must be dismissed. A renewed conversation towards decolonisation is required through which prior assumptions need to be changed, as well as ensuring the demarginalisation of Indigenous individuals. Accordingly, I will present a few practical recommendations.

In settler colonial settings, there is an asymmetry of power between settlers and Natives. Therefore, a method to achieve real measures towards decolonisation is through the use of commonalities and solidarity between Indigenous women, men and society as a whole. Working towards decolonisation must ensure women's emancipation as an integral part of the aim. In order to allow for this, women must not be marginalised within wider society, and infertile women should not be doubly marginalised among women.

Infertile Indigenous individuals are living a reproductive, social and political struggle. It is necessary that future research attempts to make a connection and changes the methods of writing and language chosen. In order to project and form resilience among Indigenous people, it should be understood that resilience is 'a complex interplay of multiple forces' including politics, culture and social support (Moran et al, 2011: 467).

Woollett posits 'infertile women are marginalized in feminist writing and given no part in developing an understanding of, for example, the diverse meanings of motherhood' (Letherby, 2002b: 279 quoting Woollett, 1996: 75-76). In my research, I found that the ability of an individual to present and experience gender differently and, ultimately, to identify their womanhood in new ways, was intricately linked to the gender paradigms, their social class, and relationship with their husband and his family. Accordingly, the reproduction-oriented knowledge of women must be a priority for feminist scholarship, and needs to celebrate and give voice to the diversity of non-reproductive women, and emphasising need to counter the privileging of birth-mothers and the seeming 'naturalness' of motherhood (Malson and Swann, 2003).

Going beyond the discussion of reproduction and political fertility, exploring infertility allows for the capture of the difficulties and circumstances of daily life for women in the oPt, offering a more substantive notion of the methods of decolonisation and the requirements needed for the population as a whole, not only by mainstream discourses. Following this, a further recommendation is that issues around infertility are carefully discussed within gender studies, reproductive tendencies and Native elimination in settler colonial settings. When infertility is omitted from the conversation, a significant albeit statistically small group is marginalised, silenced and left out of the conversation on decolonisation. Moreover, in a daily perspective, infertility threatens social values and is purported by NGOs promoting reproductive health through the guise of family planning.

Future research could be directed onto two further paths. The first is intervention into the healthcare system, with particular focus on reproductive health. Infertility is a health as well as a human rights issue, requiring more in-depth research into infertile person's, particularly women's, lives linking it their economic and social status (Bennett, 2017). Moreover, fertility care is a basic human right, yet it is often neglected or considered a minor issue in considerations of policies and programs (Giacaman et al, 2008: 84). The second is for further analysis on the effects of settler colonialism on female and male infertility. Future work may also observe more comprehensively how social and economic sectors affect the experience and treatment of infertility.

Given the exploratory nature of this research, additional theoretical and empirical research is necessary to better understand the meanings of and responses to infertility. Additionally, the conceptual framework proposed warrants further exploration. Concerning empirical research, the results of this study indicate a necessity for additional exploration dedicated to the political, social and economic effects of infertility on females, as well as on males. It is difficult to influence policy based on qualitative research especially with a limited number of women. Therefore, in order to go from research to policy, more measurable changes and commonalities that are representative of the population must be provided (Giacaman et al, 2008: 91).

In conclusion, it is important for researchers to determine the prevalence of Indigenous persons with infertility in settler colonial settings; determine the availability and accessibility as well as the usage and legality of fertility services; to understand the ways and types (core or

acquired) of infertility; to further explore the attitude, impacts and experiences of female as well as male infertility; and to investigate and assess the experiences of fertility services for women, as well as men, inclusive of the factors that contributed to the continuing or end fertility services. However, it is also imperative that this future research be inclusive and mainly implemented by us, Indigenous peoples, as a means of reclaiming our voice and implementing our perspective (see Sunseri, 2007).

This thesis challenges binary nationalist ideologies and patriarchal gender norms through the portrayal of infertile women who fit into neither category. In order to relate this thesis to the real world, I will concentrate on practical applications of the findings of this research. I hope the implications that arise from this study go beyond a conceptual analysis of narratives and discourse, into a meaningful outcome for infertile Indigenous women and, moreover, Indigenous people as a whole towards decolonisation.

In the oPt as well as in other settler colonial settings, the recommendations of this study would be to improve the health system for Indigenous people, and educate communities on women's status as a means to overcome stigmatisation of infertility. Improving knowledge surrounding women's and men's reproductive health including the understanding of the acquired causes of infertility as a means to prevent infertility.

There needs to be a refocusing on reproductive health to include discussions about fertility protection, rather than family planning and fertility restriction. Infertile women's experiences, coping strategies and fertility treatments (if desired) need to be anchored into reproductive health and legal marriage rights, if change is to come about.

As previous studies have found, there is a lack of preventive health screening that could lead to the prevention of infertility. These screenings need to be more readily incorporated into the reproductive health services providing access for men and women to prevent future infertility. In resource-poor settings, there needs to be a strong focus on prevention of infertility, as treatments for infertility are expensive as well as having limited success rates. There may be an opportunity to reduce acquired infertility in tangible ways, such as by education.

Moreover, there is the necessity of having funding available for fertility treatments. As Dr. Barghouti states:

> Funding will create progress. It is a topic I am strict and patient about. I cannot understand a couple, married for 15 years, experiencing infertility and unable to have children because they do not have money. It is unacceptable. Unfortunately, IVF centres cannot afford to provide treatments free of charge, because it is a very expensive service. Therefore, it is the role of the Ministry of Health, or a third party, to help these people to have children, at least one child. I have come across a lot of couples and families who do not have children and reach their forties without children. These couples will most likely live and die without having children. This is unacceptable, and to know it is only because they do not have money… Unacceptable.

For Palestinian women, women's health is not just about the physical, but also relates to legal and psychological needs for which '[t]heir own support structures, traditional skills and sense of personal dignity cannot be disregarded' (Holt, 1996: 65). Women often mentioned the commodification of infertility by clinics and fertility specialists, offering few, expensive and, at times, what the women believed were incorrect, services. Dismissing women's fears and mistrust with the health system is ineffective, and creates greater distress for infertile women such as desperation and laying blame on the specialists rather than themselves.

This dismissal and stigmatisation may be overcome through infertility awareness events. For example, in Australia, ACCESS is a national infertility organisation, which began National Infertility Awareness Week, allowing infertile persons to publicly narrate their lives in order to change the public narrative and perceptions of infertile persons into one of normalcy (Kirkman, 2001: 533). Further awareness may include, but is not limited to the unlearning of settler-colonial heteropatriarchy; empowering of Indigenous women; and information on and awareness of other pathways to parenthood, primarily adoption, which would best be approached by religious figures and religious knowledge on the subject in respective religions.

However, in a report on infertility among the Indigenous Māori people, it is argued that it is unlikely that the government would support the funding of education programs on assisted reproduction, infertility and implications/experiences of infertile persons, as well as providing fertility services, due to the government's agenda to contain the Māori population (Glover, 2008). Therefore, it is necessary for Indigenous communities to undertake these actions, particularly through education and raising awareness, on their own.

BIBLIOGRAPHY

Abdo, N. (2011) *Women in Israel: Race, Gender and Citizenship*, London: Zed.

Abdo, N. and Yuval-Davis, N. (1995) 'Palestine, Israel and the Zionist Settler Project', in Stasiulis, D. and Yuval-Davis, N. (eds.) *Unsettling Settler Societies: Articulations of Gender, Race, Ethnicity and Class*, London: SAGE.

Abed, George T. (2015) *The Palestinian Economy: Studies in Development under Prolonged Occupation*, London and New York: Routledge.

Abou-Tabickh, L. (2010) 'Women's Masked Migration: Palestinian Women Explain Their Move upon Marriage', in Kanaaneh, R.A. and Nusair, I. (eds.) *Displaced at Home: Ethnicity and Gender Among Palestinians in Israel*, Albany: SUNY Press.

Abu-Lughod, L. (1989) 'Zones of Theory in the Anthropology of the Arab World', *Annual Review of Anthropology*, 18.

Abu-Lughod, L. (1998) 'Introduction: Feminist Longings and Postcolonial Conditions', in Abu-Lughod, L. (ed.), *Remaking Women: Feminism and Modernity in the Middle East*, Princeton: Princeton University Press.

Abu-Lughod, L. (ed.) (1998a) *Remaking Women: Feminism and Modernity in the Middle East*, Princeton: Princeton University Press.

Abu-Musa, A. A. et al. (2008) 'Effect of war on fertility: a review of the literature', *Ethics, Bioscience and Life*, 3(2).

Abu-Zahra, N. (2008 'Identity cards and coercion in Palestine', in Pain, R. and Smith, S. J. (eds.) *Fear: Critical geographies and everyday life*, Burlington: Ashgate.

Abu-Zaineh et al. (2008) 'Equity in health care financing in Palestine: The value-added of the disaggregate approach', *Social Science & Medicine*, 66.

Addameer (2016) 'Occupied Lives: Imprisonment of Palestinian Women and Girls', *Addameer: Prisoner Support and Human Rights Association*. Available from: http://www.addameer.org/sites/default/files/publications/international_womens_day_factsheet_0.pdf. Last accesses 6 May 2019.

Addameer (2019) 'The Prisoners – Statistics', *Addameer: Prisoner Support and Human Rights Association*. Available from: http://www.addameer.org/statistics. Last accessed 6 May 2019.

Agarwal et al. (2015) 'A unique view on male infertility around the globe', *Reproductive Biology and Endocrinology*, 13(37).

Ahmed, L. (1992) *Women and Gender in Islam*, New Haven: Yale University Press.

Al-Krenawi, A. (2010) 'A study of psychological symptoms, family function, marital and life satisfactions of polygamous and monogamous women: The Palestinian case', *International Journal of Social Psychiatry*, 58(1).

Al-Krenawi, A. (2014) *Psychosocial Impact of Polygamy in the Middle East*, New York: Springer.

Al-Krenawi, A., Slonim-Nevo, V. and Graham, J. (2006) 'Polygyny and its Impact on the Psychosocial Well-being of Husbands', *Journal of Comparative Family Studies*, 37(2).

Allan, H. (2007) 'Experiences of infertility: liminality and the role of the fertility clinic', *Nursing Inquiry*, 14(2).

Allen, L. (2009) 'Mothers of Martyrs and Suicide Bombers: The Gender of Ethical Discourse in the Second Palestinian Intifada', *The Arab Studies Journal*, 17(1).

Allen, L. (2013) *The Rise and Fall of Human Rights: Cynicism and Politics in Occupied Palestine*, Stanford: Stanford University Press.

Allison, J. (2011) 'Conceiving Silence: Infertility as Discursive Contradiction in Ireland', *Medical Anthropology Quarterly*, 25(1).

Altorki, S. (1988) 'At Home in the Field', in Altorki, S. and El-Solh, C. (eds.) *Arab Women in the Field: Studying Your Own Society*, Syracuse: Syracuse University Press.

Altorki, S. and El-Solh, C. (eds.) (1988) *Arab Women in the Field: Studying Your Own Society*, Syracuse: Syracuse University Press.

Amireh, A. (2003) 'Between Complicity and Subversion: Body Politics in Palestinian National Narrative', *The South Atlantic Quarterly*, 102(4).

Amiri, F. N. et al. (2014) 'Female Gender Scheme is Disturbed by Polycystic Ovary Syndrome: A Qualitative Study from Iran', *Iran Red Crescent Medical Journal,* 16(2).

Arvin, M., Tuck, E. and Morrill, A. (2013) 'Decolonizing Feminism: Challenging Connections between Settler Colonialism and Heteropatriarchy', *Feminist Formations,* 25(1).

Ashiru, O. A. and Odusanya, O. O. (2009) 'Fertility and Occupational hazards: Review of the Literature', *African Journal of Reproductive Health*, 13(1).

Atkinson, R. and Flint, J. (2001) 'Accessing Hidden and Hard-to-Reach Populations: Snowball Research Strategies', *Social Research Update*, 33.

Awwad, J. (2016) 'Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan', Geneva: World Health Organisation, A69/INF./6.

Bahun, S. and Rajan, V. (eds.) (2008) *Violence and Gender in the Globalized World*, Aldershot: Ashgate.

Baidoun, S., Salem, M. and Omran, O. (2018) 'Assessment of TQM implementation Level in Palestinian Healthcare Organisations: The Case of Gaza Strip Hospitals', *The TQM Journal*.

Balen, A. H. (2017) 'Polycystic ovary syndrome (PCOS)', *The Obstetrician & Gynaecologist*, 19(2).

Balen, F. (2002) 'The Psychologization of Infertility', in Inhorn, M. and Balen, F. (eds.), *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technology*, Berkeley: University of California Press.

Balen, F. and Inhorn, M. (2002) 'Introduction. Interpreting Infertility: A View from the Social Sciences', in Inhorn, M. and Balen, F. (eds.), *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technology*, Berkeley: University of California Press.

Barber, B. et al. (2014) 'Politics drives human functioning, dignity, and quality of life', *Soc Sci Med,* 122.

Barker, A. (2012) 'Locating Settler Colonialism', *Journal of Colonialism and Colonial History*, 12(3).

Bateman, F. and Pilkington, L. (2011) 'Introduction', in Bateman, F. and Pilkington, L. (eds.) *Studies in Settler Colonialism*, Basingstoke and New York: Palgrave Macmillan.

Batniji, R. et al. (2009) 'Health as human security in the occupied Palestinian territory', *The Lancet,* 373(9669).

Baxter, D. (2007) 'Honor Thy Sister: Selfhood, Gender, and Agency in Palestinian Culture', *Anthropology Quarterly*, 80(3).

Beckman, L. J. and Harvey, S. M. (2005) 'Current Reproductive Technologies: Increased Access and Choice', *Journal of Social Issues*, 61(1).

Bennet, L. R. (2017) 'Infertility and inequity across the globe', *Asian Population Studies*, 13(1).

Benninghaus, C. (2017) 'Silences: Coping with Infertility in Nineteenth-Century Germany', in Davis, G. and Loughran, T. (eds.), *The Palgrave Handbook of Infertility in History: Approaches, Contexts and Perspectives*, London: Palgrave Macmillan.

Berda, Y. (2017) *Living Emergency: Israel's Permit Regime in the Occupied West Bank*, Stanford: Stanford University Press.

Berg, A. (2002) *Mothering the Race: Women's Narratives of Reproduction, 1890-1930*, Urbana and Chicago: University of Illinois Press.

Berk, E. (2014) *Beyond Numbers: Political Fertility in Palestine*, Department of Jewish, Islamic, and Near Eastern Languages and Cultures, Washington University, Master's thesis.

Birenbaum-Carmeli, D. (2009) 'The politics of 'The Natural Family' in Israel: State policy and kinship ideologies', *Social Science & Medicine*, 69.

Birenbaum-Carmeli, D. and Dirnfield, M. (2008) 'In Vitro Fertilisation Policy in Israel and Women's Perspectives: The More the Better?', *Reproductive Health Matters*, 16(31).

Birenbaum-Carmeli, D. and Inhorn, M. C. (2009) ‘Masculinity and Marginality: Palestinian Men’s Struggles with Infertility in Israel and Lebanon’, *Journal of Middle East Women’s Studies*, 5(2).

Birenhaum-Carmeli, D. and Carmeli, Y. S. (eds.) (2010) *Kin, Gene, Community: Reproductive Technologies among Jewish Israelis*, New York and Oxford: Berghahn Books.

Blaxter, L., Hughes, C. and Tight, M. (2010) *How to Research*, Maidenhead: Open University Press.

Blystad, A. (1999) ‘‘Dealing with Men's Spears’: Datooga Pastoralists Compting Male Intrusion on Female Fertility’, in Moore, H.L., Sanders, T. and Kaare, B. (eds.), *Those Who Play with Fire: Gender, Fertility and Transformation in East and Southern Africa*, London: Athlone Press.

Bocco, R. (2010) ‘UNRWA and the Palestinian Refugees: A History within History’, *Refugee Survey Quarterly*, 28(2&3).

Bongaarts, J. (1978) ‘A Framework for Analyzing the Proximate Determinants of Fertility’, *Population and Development Review*, 4(1).

Born, S. L., Carotta, C. L. and Ramsay-Seaner, K. (2018) ‘A Multicase Study Exploring Women’s Narratives of Infertility: Implications for Counselors’, *The Qualitative Report*, 23(12).

Bosmans, M. et al. (2008) ‘Palestinian Women’s Sexual and Reproductive Health Rights in a Longstanding Humanitarian Crisis’, *Reproductive Health Matters*, 16(31).

Boston Women's Health Book Collective and Norsigian J. (2011) *Our Bodies, Ourselves*, New York City: Simon & Schuster.

Butler, J. (2004) *Precarious Life: The Powers of Mourning and Violence*, London and New York: Verso.

Callahan, C. and Elliot, C. S. (1996) ‘Listening: A narrative approach to everyday understandings and behavior’, *Journal of Economic Psychology*, 17.

Carsten, J. (2004) *After Kinship*, New York: Cambridge University Press.

Cavanagh, E. and Veracini, L. (2013) ‘Editors Statement’, *Settler Colonial Studies*, 3(1).

Charrad, M. M. (2000) ‘Becoming a Citizen: Lineage Versus Individual in Morocco and Tunisia’, in Joseph, S. (ed.), *Gender and Citizenship in the Middle East*, Syracuse: Syracuse University Press.

Clarke, L. H., Martin-Matthews, A. and Matthews, R. (2006) 'The Continuity and Discontinuity of the Embodied Self in Infertility', *Canadian Review of Sociology,* 43(1).

Colen, S. (1995) ‘‘Like a mother to them’: Stratified reproduction and West Indian childcare workers and employers in New York’, in Ginsburg, F. and Rapp, R. (eds.) *Conceiving the New World Order: The Global Politics of Reproduction*, London: University of California Press.

Comfort, M. et al. (2005) '"You Can't Do Nothing in This Damn Place": Sex and Intimacy Among Couples With an Incarcerated Male Partner', *J Sex Res.*, 42(1).

Cook, R. J., Dickens, B. M. and Fathalla, M. F. (2003) *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law*, New York: Oxford University Press.

Courbage, Y. (1999) 'Reshuffling the Demographic Cards in Israel/Palestine', *Journal of Palestine Studies*, 28(4).

Courbage, Y. (2011) 'Quantitative Versus Qualitative Approaches in Demography', in Heacock, R. and Conte, É. (eds.) *Critical Research in the Social Sciences: A Transdisciplinary East-West Handbook*, Birzeit: Birzeit University.

Cousineau, T. M. and Domar, A. D. (2007) 'Psychological impact of infertility', *Best Practice & Research Clinical Obstetrics and Gynaecology*, 21(2).

Cover, R. (2011) 'Biopolitics and the Baby Bonus: Australia's national identity, fertility, and global overpopulation', *Continuum: Journal of Media & Cultural Studies*, 25(3).

Creswell, J. W. (2003) *Research design: Qualitative, quantitative and mixed method approaches*, London: Sage Publications.

Czarnecki, D. (2015) 'Moral Women, Immoral Technologies: How Devout Women Negotiate Gender, Religion, and Assisted Reproductive Technologies', *Gender & Society*, 29(5).

Daibes, M. A. et al. (2018) 'Half a woman, half a man; that is how they make me feel': a qualitative study of rural Jordanian women's experience of infertility', *Culture, Health & Sexuality*, 20(5).

Das, V. (2008) 'Violence, Gender, and Subjectivity', *Annual review of anthropology*, 37.

Davis, A. (2017) 'Oral History and Women's Accounts of Infertility in Postwar England', in Davis, G. and Loughran, T. (eds.) *The Palgrave Handbook of Infertility in History: Approaches, Contexts and Perspectives*, London: Palgrave Macmillan.

Davison, J. (1997) *Gender, Lineage, and Ethnicity in Southern Africa*, Boulder: Westview Press.

Dhawan, B. et al. (2014) 'Diagnostic efficacy of a real time-PCR assay for *Chlamydia trachomatis* infection in infertile women in north India', *Indian Journal of Medical Research*, 140.

Díaz, M. Y. (2016) 'Enacting Motherhood: time and social change in Chile', *Journal of Gender Studies*, 27(4).

Director-General (2018) 'Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan', Cairo: World Health Organization, A71/27.

Dudgeon, M. and Inhorn, M. (2003) 'Gender, Masculinity and Reproduction: Anthropological Perspectives', *International Journal of Men's Health*, 2(1).

Dyer, S. J. and Patel, M. (2012) 'The Economic Impact of Infertility on Women in Developing Countries – a Systematic Review', *Facts, Views & Vision in ObGyn*, 4(2).

Dykstra, P. A. and Hagestad, G. O. (2007) 'Childlessness and Parenthood in Two Centuries: Different Roads Different Maps?', *Journal of Family Issues,* 28(11).

Edmonds, P. & Carey, J. (2013) 'A New Beginning for Settler Colonial Studies', *Settler Colonial Studies*, *3*(1).

Eich, T. (2008) 'Decision-Making Processes among Contemporary '*Ulama*': Islamic Embryology and the Discussion of Frozen Embryos', in Brockopp, J. and Eich, T. (eds.) *Muslim Medical Ethics: From Theory to Practice*, Columbia: University of South Carolina Press.

El Feki, S. (2013) *Sex and the Citadel: Intimate Life in a Changing Arab World*, New York: Pantheon Books.

El Qouqa, I.A. et al. (2009) 'Prevalence of *Chlamydia trachomatis* among women attending gynecology and infertility clinics in Gaza, Palestine', *International Journal of Infectious Diseases*, 13.

El-Kholy, H. A. (2002) *Defiance and Compliance: Negotiating Gender in Low-Income Cairo*, New York and Oxford: Berghahn Books.

El-Kholy, H. and Al-Ali, N. (1999) 'Inside/Out: The "Native" and the "Halfie" Unsettled' in Shami, S. and Herrera, L. (eds.) *Between Field and Text: Emerging Voices in Egyptian Social Science*, Cairo: AUC.

El-Shakry, O. (2007) *The Great Social Laboratory: Subjects of Knowledge in Colonial and Postcolonial Egypt*, Stanford: Stanford University Press.

El-Shakry, O. (2016) 'Reproducing the Family: Biopolitics in Twentieth-Century Egypt', in Solinger, R. and Nakachi, M. (eds.) *Reproducing States: Global Perspectives on the Invention and Implementation of Population Policy*, Oxford: Oxford University Press.

Eldib, A. and Tashani, O.A. (2018) 'Infertility in the Middle East and North Africa Region: A Systematic Review with Meta-Analysis of Prevalence Surveys', *Libyan J Med Sci*, 2(2).

Elie, S. D. (2004) 'The harem syndrome: Moving beyond anthropology's discursive colonization of gender in the Middle East', *Alternatives*, 29.

Emerson, R., Fretz, R. and Shaw, L. (2001) 'Participant Observation and Fieldnotes', in Atkinson, P. et al. (eds.) *Handbook of Ethnography*, London: SAGE.

Fairclough, N. (2003) *Analysing Discourse: Textual analysis for social research*, London: Routledge.

Fanon, F. (1963) *The wretched of the earth*, New York: Grove Press.

Fares, I. (2014) 'Medical Malpractice Law: Palestine and United States', in Campbell, D. (ed.) *Journal of the International Institute for Law and Medicine*, Salzburg: Yorkhill Law Publishing.

Farsakh, L. (2005) *Palestinian Labour Migration to Israel: Labour, Land and Occupation*, London: Routledge.

Farsakh, L. (2016) 'Undermining Democracy in Palestine: The Politics of International Aid since Oslo', *Journal of Palestine Studies*, 45(4).

Fassin, D. (2009) 'Another Politics of Life is Possible', *Theory, Culture & Society*, 26(5).

Fassino, S. et al. (2003) 'Eating Behaviors and Attitudes in Women with Infertility: A Controlled Study', *International Journal of Eating Disorders*, 33(2).

Feldman-Savelsberg, P. (1999) *Plundered Kitchens, Empty Wombs: Threatened Reproduction and Identity in the Cameroon Grassfields*, Ann Harbor: University of Michigan Press.

Fenge, L. A. et al. (2019) 'The Impact on Sensitive Research on the Researcher: Preparedness and Positionality', *International Journal of Qualitative Methods*, 18.

Fertility Society of Australia (2016) 'Lack of data on infertility among Aboriginal and Torres Strait Islander people', Annual Society Meeting, Media Release.

Fido, A. and Zahid, M. A. (2004) 'Coping with Infertility Among Kuwaiti Women: Cultural Perspectives', *International Journal of Social Psychiatry*, 50(4).

Forman, R. G., Gilmour-White, S. K. and Forman, N. H. (1996) *Drug-Induced Infertility and Sexual Dysfunction*, Cambridge: University of Cambridge.

Frenk J. (2004) 'Health and the economy: A vital relationship', *OECD Observer*, 243.

Foucault, M. (1978) *The History of Sexuality – Volume I: An Introduction*, translated by Roberty Hurley, New York: Pantheon Books.

Foucault, M. (2003) *"Society Must Be Defended": Lectures at the Collège de France, 1975-76*, translated by David Macey, New York: Picador.

Ghannam, F. (2013) *Live and Die Like a Man: Gender Dynamics in Urban Egypt*, Stanford: Stanford University Press.

Giacaman, R. and Johnson, P. (2013) '"Our Life is Prison": The Triple Captivity of Wives and Mothers of Palestinian Political Prisoners', *Journal of Middle East Women s Studies,* 9(3).

Giacaman, R. et al. (2004) 'Imprints on the consciousness: The impact on Palestinian civilians of the Israeli Army invasion of West Bank towns', *The European Journal of Public Health,* 14(3).

Giacaman, R. et al. (2005) 'The politics of childbirth in the context of conflict: Policies or de facto practices?', *Health Policy,* 72(2).

Giacaman, R. et al. (2007) 'Quality of life in the Palestinian context: an inquiry in war-like conditions', *Health Policy,* 81(1).

Giacaman, R. et al. (2008) 'Palestinian women's pregnancy intentions: analysis and critique of the Demographic and Health Survey 2004', *Health Policy,* 85(1).

Giacaman, R. et al. (2011) 'Mental health, social distress and political oppression: The case of the occupied Palestinian territory', *Global Public Health,* 6(5).

Gijsels, M., Mgalla, Z. and Wambura, L. (2001) 'No child to send: context and consequences of female infertility in northwest Tanzania', in Boerma, J. T. and Mgalla, Z. (eds.) *Women and infertility in sub-Saharan Africa: a multi-disciplinary perspective*, Amsterdam: KIT Publishers.

Gilbert, D. and Majury, D. (2006) 'Infertility and the Parameters of Discrimination Discourse' in Pothier, D. and Devlin, R. (eds.) *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law*, Vancouver and Toronto: UBC Press.

Ginsburg, F. and Rapp, R. (1991) 'The Politics of Reproduction', *Annual Review of Anthropology*, 20.

Glenn, E. N. (2015) 'Settler Colonialism as Structure: A Framework for Comparative Studies of U.S. Race and Gender Formation', *Sociology of Race and Ethnicity,* 1(1).

Glover, M. (2008) *Māori Attitudes to Assisted Human Reproduction: An Exploratory Study*, Department of Social & Community Health, Auckland: University of Auckland.

Goeman, M. R. and Denetdale, J. N. (2009) 'Native Feminisms: Legacies, Interventions, and Indigenous Sovereignties', *Wicazo Sa Review*, 24(2).

Gordon, N. (2008) *Israel's Occupation*, Berkeley and Los Angeles: University of California Press.

Granqvist, H. N. (1935) *Marriage Conditions in a Palestinian Village Vol 2*, Helsingfors: Societas Scientiarum Fennica.

Granqvist, H. N. (1947) *Birth and Childhood among the Arabs: Studies in a Muhammadan village in Palestine*, Helsingfors: Söderströms.

Greil, A. L. (2002) 'Infertile Bodies: Medicalizatioin, Metaphor, and Agency' in Inhorn, M. and Balen, F (eds.), *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technology*, Berkeley: University of California Press.

Greil, A. L. and McQuillan, J. (2010) '"Trying" Times: Medicalization, Intent, and Ambiguity in the Definition of Infertility', *Medical Anthropology Quarterly*, 24(2).

Greil, A. L., Slauson-Blevins, K. and McQuillan, J. (2010), 'The experience of infertility: A review of recent literature', *Sociological Health and Illness*, 32(1).

Grekul, J., Krahn, H. and Odynak, D. (2004) 'Sterilizing the "Feeble-minded": Eugenics in Alberta, Canada, 1929-1972', *Journal of Historical Sociology*, 17(4).

Hajikhani, B. et al. (2013) 'Classical and Molecular Methods for Evaluation of *Chlamydia trachomatis* Infection in Women with Tubal Factor Infertility', *Journal of Reproduction and Infertility*, 14(1).

Hamadeh, N. S. (1999) 'Wives or Daughters: Structural Differences between Urban and Bedouin Lebanese Co-wives', in Joseph, S. (ed.) *Intimate selving in Arab families: gender, self, and identity*, Syracuse: Syracuse University Press.

Hamayel, L., Hammoudeh, D. and Welchman, L. (2017) 'Reproductive health and rights in East Jerusalem: the effects of militarisation and biopolitics on the experiences of pregnancy and birth of Palestinians living in the Kufr 'Aqab beighbourhood', *Reproductive Health Matters*, 25(S1).

Hammersley, M. and Atkinson, P. (1995) *Ethnography: Principles in Practice*, London: Routledge.

Hammoudeh, D. et al. (2013) 'Effect of infertility on women in the occupied Palestinian territory: a pilot qualitative study', *The Lancet*, 382(S15).

Hammoudeh, D., Hamayel, L. and Welchman, L. (2016) 'Beyond the Physicality of Space: East Jerusalem, Kufr 'Aqab, and the Politics of Everyday Suffering', *Jerusalem Quarterly*, 65.

Hansson, L. (2012) *Beyond Numbers: Political Fertility in Palestine*, University of Copenhagen, Department of Public Health, Master's thesis.

Hansson, L. et al. (2013) 'Political fertility in the occupied Palestinian territory: an ethnographic study', *The Lancet*, 382(S17).

Harsha, N. et al. (2016) 'Well-being and associated factors among adults in the occupied Palestinian territory (oPt)', *Health Qual Life Outcomes,* 14(122).

Hassan, N. (2016) 'Colonialism and Gender', in Naples, N. A. (ed.), *The Wiley Blackwell Encyclopedia of Gender and Sexuality Studies*, Hoboken: John Wiley & Sons, Ltd.

Hawari, M. (2020) '*hkdh' qllṣt "'srā'l" mu'dlāt alwlāda alfalasṭīniyya*' [This is how Israel reduced Palestinian birth rates], *Metras*, 23 February 2020. Available from: https://metras.co/الولادة-معدلات-إسرائيل-قلصت-هكذا-الفل/?fbclid=IwAR3DEalHx5_EOqieMmWFm8KcdOeuQFvasEreL1TY0Ct09wSwD-_qmdkJsuE. Last accessed 22 March 2020.

Hemmings, J. (2007) *Infertility and Womens Life Course in Northern Malawi*, London School of Hygiene & Tropical Medicine, PhD thesis.

Hodges, S. (2008*) Contraception, Colonialism and Commerce: Birth Control in South India, 1920-1940*, Aldershot and Burlington: Ashgate.

Holt, M. (1996) *Women in Contemporary Palestine: Between Old Conflicts and New* Realities, Jerusalem: PASSIA.

Inhorn, M. C. (1996) *Infertility and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt*, Philadelphia: University of Pennsylvania Press.

Inhorn, M. C. (2004) 'Privacy, privatization, and the politics of patronage: ethnographic challenges to penetrating the secret world of Middle Eastern, hospital-based in vitro fertilization', *Social Science & Medicine*, 59(10).

Inhorn, M. C. (2011) 'Globalization and gametes: reproductive 'tourism,' Islamic bioethics, and Middle East modernity' *Anthropology and Medicine*, 18(1).

Inhorn, M. C. (2012) *The New Arab Man: Emergent Masculinities, Technologies, and Islam in the Middle East*, Princton and Oxford: Princeton University Press.

Inhorn, M. C. and Balen, F. (eds.) (2002) *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technology*, Berkeley: University of California Press.

Inhorn, M. C. and Patrizio, P. (2015) 'Infetrility around the Globe: New Thinking on Gender, Reproductive Technologies, and Global Movements in the 21st Century', *Human Reproduction Update*, 21(4).

Isaac, R. K. (2010) 'Palestinian Tourism in Transition: Hope, Aspiration, or Reality?', *The Journal of Tourism and Peace Research*, 1(1).

Isaksson, R. and Tiitinen, A. (2004) 'Present concept of unexplained infertility', *Gynaecological Endocrinology*, 18(5).

Issa, Y. et al. (2010) 'Fecundability among newly married couples in agricultural villages in Palestine: a prospective study', *Human Reproduction*, 25(8).

Jacobs, M. D. (2009) *White Mother to a Dark Race: Settler Colonialism, Materialism and the Removal of Indigenous Children in the American West and Australia, 1880-1940*, Lincoln and London: University of Nebraska Press.

Jad, I. (2011) 'Islamist women of Hamas: between feminism and nationalism', *Inter-Asia Cultural Studies*, *12*(2).

Janus, T. (2013) 'The political economy of fertility', *Public Choice*, 155.

Jarallah, Y. (2008) 'Marriage Patterns in Palestine', *Population Reference Bureau*, MENA Working Paper Series.

Jefferis, D. C. (2012) 'The "Center of Life" Policy: Institutionalizing Statelessness in Easy Jerusalem', *Jerusalem Quarterly*, 50(94).

Johnson, K. M. and Fledderjohann, J. (2012) 'Revisiting "her" infertility: Medicalized embodiment, self-identification and distress', *Social Science & Medicine*, 75(5).

Jones-Gailani, N. (2017) '*Qahqa* and *Kleiche*: Drinking Coffee in Oral History Interviews with Iraqi Women in Diaspora', *Global Food History*, 3(1).

Jones, M. (1989) *Child by Any Means*, London: Piatkus.

Joseph, S. (1988) '*Fe*minization, Familism, Self and Politics: *Research as a* Mughtaribi', in Altorki, S. and El-Solh, C. (eds.) *Arab Women in the Field: Studying Your Own Society*, Syracuse: Syracuse University Press.

Joseph, S. (1996) 'Patriarchy and development in the Arab World', *Gender and Development*, 4(2).

Joseph, S. (1999) 'Introduction: Theories and Dynamics of Gender, Self, an Identity in Arab Families', in in Joseph, S. (ed.) *Intimate selving in Arab families: gender, self, and identity*, Syracuse: Syracuse University Press.

Joseph, S. (2000b) 'Gendering Citizenship in the Middle East', in Joseph, S. (ed.), *Gender and Citizenship in the Middle East*, Syracuse: Syracuse University Press.

Joseph, S. (ed.) (2000a) *Gender and Citizenship in the Middle East*, Syracuse: Syracuse University Press.

Joseph, S. (2005) 'The kin contract and citizenship in the Middle East', in Friedman, M. (ed.) *Women and Citizenship*, Oxford: Oxford University Press.

Kaare, B. (1999) '*Saisee Tororeita*: An Analysis of Complementarity in Akie Gender Ideology', in Moore, H.L., Sanders, T. and Kaare, B. (eds.) *Those Who Play with Fire: Gender, Fertility and Transformation in East and Southern Africa*, London: Athlone Press.

Kabeer, N. (2005) 'Gender Equality and Women's Empowerment: A Critical Analysis of the Third Millennium Development Goal', *Gender and Development*, 13(1).

Kabeer, N., Khan, A. and Adlparvar, N. (2011) 'Afghan Values or Women's Rights? Gendered Narratives about Continuity and Change in Urban Afghanistan', *IDS Working Paper*, 387.

Kahn, S. M. (2000) *Reproducing Jews: A Cultural Account of Assisted Conception in Israel*, Durham and London: Duke University Press.

Kaliarnta, S., Nihlén-Fahlquist, J. and Roeser, S. (2011) 'Emotions and Ethical Considerations of Women Undergoing IVF-treatments', *HEC Forum*, 23.

Kanaana, S. (1998) 'Women in the Legends of the Intifada', in Sabbagh, S. (ed.) *Palestinian Women of Gaza and the West Bank*, Bloomington: Indiana University Press.

Kanaaneh, R. A. (2002) *Birthing the Nation: Strategies of Palestinian Women in Israel*, Berkeley: University of California Press.

Kanaaneh, R. A. and Nusair, I. (2010) 'Introduction', in Kanaaneh, R.A. & Nusair, I. (eds.) *Displaced at Home: Ethnicity and Gender Among Palestinians in Israel*, Albany: SUNY Press.

Kandiyoti, D. (1988) 'Bargaining with Patriarchy', *Gender & Society*, 2(3).

Kandiyoti, D. (1996) 'Contemporary Feminist Scholarship and Middle East Studies', in Kandiyoti, D. (ed.) *Gendering the Middle East: Emerging Perspectives*. New York: Syracuse University Press.

Kassem, F. (2011) *Palestinian Women: Narrative histories and gendered memory*, London and New York: Zed Books.

Katrak, K. H. (1996) 'Post-colonial Women's Colonised States: Mothering and m-othering in Bessie Head's A Question of Power and Kamala Das' My Story', *Journal of Gender Studies*, 5(3).

Katwsa, L. (2013) 'Psychological Distress Among Infertile Women Attending Razan Center in West Bank in Palestine: Quantitative Study', An-Najah National University, Faculty of Graduate Studies, Master's thesis.

Kauanui, J. K (2016) '"A structure, not an event": Settler Colonialism and Enduring Indigeneity', *Lateral 5.1*.

Kawar, A. (1998) 'Palestinian Women's Activism After Oslo', in Sabbagh, S. (ed.) *Palestinian Women of Gaza and the West Bank*, Bloomington: Indiana University Press.

Kelly, T. (2004) 'Access to Justice: The Palestinian Legal System and the Fragmentation of Coercive Power', *Development Research Centre*, 41.

Khalidi, W. (1988) 'Plan Dalet: Master Plan for the Conquest of Palestine', *Journal of Palestine Studies*, 18(1).

Khawaja, M. (2000) 'The Recent Rise in Palestinian Fertility: Permanent or Transient?', *Population Studies*, 54(3).

Khawaja, M. (2003) 'The Fertility of Palestinian Women in Gaza, the West Bank, Jordan and Lebanon', *Population-E*, 58(3).

Khodarahimi, S., Hosseinmirzaei S. and Bruna, M. M. O. (2014) 'The Role of Infertility in Mental Health, Psychological Distress and Sexual Dysfunction in a Sample of Iranian Women', *Women & Therapy,* 37(1-2).

Kildea, S. and Bowden, F. (2000) 'Reproductive health, infertility and sexually transmitted infections in Indigenous women in a remote community in the Northern Territory'. *Australian and New Zealand Journal of Public Health*, 24(4).

Kilomba, G. (2015) 'Decolonising Knowledge' [lecture], *Voice Republic*, 'We Don't Contemporary' series.

King-Irani, L. (1999) 'Kinship, Class, and Ethnicity', in Gerner, D. (ed.) *Understanding the Contemporary Middle East*, Boulder: Lynne Rienner Publishers.

Kirkman, M. (2001) 'Thinking of Something to Say: Public and Private Narratives of Infertility', *Health Care for Women International*, 22(6).

Kirkman, M. and Rosenthal, D. (1999) 'Representations of Reproductive Technology in Women's Narratives of Infertility', *Women & Health*, 29(12).

Kitabayashi, H. et al. (2017) 'Association Between Maternal and Child Health Handbook and Quality of Antenatal Care Services in Palestine', *Maternal and Child Health Journal*, 21(12).

Kitamura, A. et al. (2018) 'Health and dignity of Palestine refugees at stake: a need for international response to sustain crucial life services at UNRWA', *The Lancet*, 392(10165).

Kohler, H. P. (2001) *Fertility and Social Interaction: An Economic Perspective*, Oxford: Oxford University Press.

Krause, E. L. and De Zordo, S. (2012) 'Introduction. Ethnography and biopolitics: tracing 'rationalities' of reproduction across the north-south divide', *Anthropology & Medicine*, 19(2).

Krebs, M. and Olwan, D. M. (2012) ''From Jerusalem to the Grand River, Our Struggles are One': Challenging Canadian and Israeli Settler Colonialism', *Settler Colonial Studies,* 2(2).

Kuumba, B. (2001) 'Population Policy in the Era of Globalisation: A Case of Reproductive Imperialism', *Agenda: Empowering Women for Gender Equality*, 48.

Landertinger, L. (2011) *The Biopolitics of Indigenous Reproduction: Colonial Discourse and the Overrepresentation of Indigenous Children in the Canadian Child Welfare System*, Department of Sociology, Queen's University, Master's thesis.

Lawrence, B. (2003) 'Gender, Race, and the Regulation of Native Identity in Canada and the United States: An Overview', *Hypatia,* 18(2).

Letherby, G. (2002a) 'Childless and Bereft?: Stereotypes and Realities in Relation to 'Voluntary' and 'Involuntary' Childlessness and Womanhood', *Sociological Inquiry*, 71(1).

Letherby, G. (2002b) 'Challenging Dominant Discourses: identity and change and the experience of 'infertility' and 'involuntary childlessness'', *Journal of Gender Studies,* 11(3).

Lloyd, D. (2012) 'Settler Colonialism and the State of Exception: The Example of Palestine/Israel', *Settler Colonial Studies*, 2(1).

Lloyd, D. and Pulido, L. (2010) 'In the Long Shadow of the Settler: On Israeli and U.S. Colonialisms', *American Quarterly,* 62(4).

Loftus, J. and Andriot, A. L. (2012) ''That's What Makes A Woman': Infertility And Coping With A Failed Life Course Transition', *Sociological Spectrum,* 32.

Long, J. C. (2006) 'Border Anxiety in Israel/Palestine'. *Antipode*, 38.

Lorber, J. (1994) *Paradoxes of Gender*, New Haven: Yale University Press.

Lorde, A. (2012) *Sister Outsider: Essays and Speeches*, Berkeley: Crossing Press.

Loughran, T. and Davis, G. (2017) 'Introduction: Infertility in History: Approaches, Contexts and Perspectives', in Davis, G. and Loughran, T. (eds.), *The Palgrave Handbook of Infertility in History: Approaches, Contexts and Perspectives*, London: Palgrave Macmillan.

Maconochie, N., Doyle, P. and Carson, C. (2004) 'Infertility among male UK veterans of the 1990-1 Gulf war: reproductive cohort study', *BMJ*, 329(7459).

Macoun, A. and Strakosch, E. (2013) 'The ethical demands of settler colonial theory', *Settler Colonial Studies,* 3(3-4).

Madeira, J. L. (2012) 'Woman Scorned: Resurrecting Infertile Women's Decision-Making Autonomy', *Maryland Law Review,* 71(2).

Makdisi, S. (2011) 'Zionism Then and Now', in Bateman, F. and Pilkington, L. (eds.) *Studies in Settler Colonialism: Politics, Identity and Culture*, New York: Palgrave Macmillan.

Malson, H. and Swann, C. (2003) 'Re-producing 'woman's' body: reflections on the (dis)place(ments) of 'reproduction' for (post)modern women', *Journal of Gender Studies,* 12(3).

Mansour, A. (2015) 'The West Bank Economy: 1948 – 1984', in Abed, G. T. (ed.) *The Palestinian Economy: Studies in Development under Prolonged Occupation*, London: Routledge.

Masalha, N. (1992) *Expulsion of the Palestinians: The Concept of "Transfer" in Zionist Political Thought, 1882-1948*, Washington, D.C.: Institute for Palestine Studies.

Mataria, A. et al. (2004) 'A stated preference approach to assessing health care-quality improvements in Palestine: from theoretical validity to policy implications', *Journal of Health Economics*, 23(6).

Mataria, A. et al. (2006) 'Impoverishment and patients' "willingness" and "ability" to pay for improving the quality of health care in Palestine: An assessment using the contingent valuation method', *Health Policy*, 75(3).

Mataria, A. et al. (2009) 'The quality of life of Palestinians living in chronic conflict: assessment and determinants', *Eur J Health Econ,* 10(1).

Mattson, I. (2005) 'Adoption and Fostering: Overview', in Joseph, S. and Naǧmābādī, A. (eds.) *Encyclopedia of Women and Islamic Cultures: Family, Law and Politics*, Leiden: Brill.

Mbembe, A. (2003) 'Necropolitics' [translated by Meintjes, L.], *Public Culture*, 15(1).

McCarthy, M. P. (2008) 'Women's Lived Experience of Infertility After Unsuccessful Medical Intervention', *Journal of Midwifery & Women's Health*, 53(4).

McLeod, C. and Ponesse, J. (2008) 'Infertility and Moral Luck: The Politics of Women Blaming Themselves for Infertility', *International Journal of Feminist Approaches to Bioethics,* 1(1).

McNeely, C. et al. (2014) 'Human Insecurity, chronic economic constraints and health in the occupied Palestinian territory', *Global Public Health*, 9(5).

McNeely, C. et al. (2015) 'Political Imprisonment and Adult Functioning: A Life Event History Analysis of Palestinians', *Journal of Traumatic Stress,* 28(3).

Meari, L. (2015a) 'Reconsidering trauma: Towards a Palestinian Community Psychology', *Journal of Community Psychology,* 43(1).

Meari, L. (2015b) 'Re-signifying 'Sexual' Colonial Power Techniques: The Experiences of Palestinian Women Political Prisoners', in Said, M.E., Meari, L. & Pratt, N. (eds.) *Rethinking Gender in Revolutions and Resistance: Lessons from the Arab World*, London: Zed Books.

Memmi, S. (2012) 'Sex selection in the Palestinian society: A pilot study', *The Lancet*, 380(S41).

Memmi, S. and Du Loû, A. D. (2015) 'Gender Relations and Contraceptives Practices of Palestinian Couples', *Population-E*, 70(2).

Merlan, F. (2009) 'Indigeneity: Global and Local', *Current Anthropology*, 50(3).

Mezzadra, S., Reid, J. and Samaddar, R. (2013) 'Introduction: Reading Foucault in the Postcolonial Present', in Mezzadra, S., Reid, J. and Samaddar, R. (eds.) *The Biopolitics of Development: Reading Michel Foucault in the Postcolonial Present*, New Delhi: Springer.

Miall, C. E. (1986) 'The Stigma of Involuntary Childlessness', *Social Problems*, 33(4).

Miller, T. (2005) *Making sense of motherhood: a narrative approach*, Cambridge and New York: Cambridge University Press.

Million, D. (2009) 'Felt Theory: An Indigenous Feminist Approach to Affect and History', *Wicazo Sa Review*, 24(2).

Mitnick, J. (2016) 'With smuggled Sperm, Palestinians Sire Children from Behind Israeli Prison Bars', *Los Angelos Times*, 20 July 2006. Available from: https://www.latimes.com/world/middleeast/la-fg-israel-prisoner-ivf-snap-story.html. Last accessed 8 April 2019.

Moane, G. (2010) *Gender and Colonialism: A Psychological Analysis of Oppression and Liberation*, Basingstoke: Palgrave.

Moghadam, V. M. (2003) *Modernizing Women: Gender and Social Change in the Middle East*, Boulder and London: Lynne Rienner Publishers.

Monga, M. et al. (2004) 'Impact of Infertility on Quality of Life, Marital Adjustment, and Sexual Function', *Urology*, 63(1).

Moon, P. (2016) ''Blond Beasts of Prey': A Nietzschean interpretation of the language of Britain's colonisation of New Zealan', *Settler Colonial Studies*, 6(1).

Moran, M. et al. (2011) 'Introduction: Violent conflict and population health in the Middle East', *Global Public Health,* 6(5).

Moreton-Robinson, A. (2007) 'Writing Off Indigenous Sovereignty: The Discourse of Security and Patriarchal White Sovereignty', in Moreton-Robinson, A. (ed.) *Sovereign Selves: Indigenous Sovereignty Matters*, Crows Nest: Allen and Unwin.

Moreton-Robinson, A. (2013) 'Towards an Australian Indigenous Women's Standpoint theory', *Australian Feminist Studies*, 28(78).

Morgan, D. (1985) ‘Making Motherhood Male: Surrogacy and the Moral Economy of Women’, *Journal of Law and Society*, 12(2).

Morgensen, S. L. (2011) ‘The Biopolitics of Settler Colonialism: Right Here, Right Now’, *Settler Colonial Studies,* 1(1).

Morgensen, S. L. (2012) ‘Theorising Gender, Sexuality and Settler Colonialism: An Introduction’, *Settler Colonial Studies,* 2(2).

Mosalanejad, L. et al. (2014) ‘Increasing and decreasing factors of hope in infertile women with failure in infertility treatment: A phenomenology study’, *International Journal of Reproductive Biomedice*, 12(2).

Mumtaz, Z., Shahid, U. and Levay, A. (2013) 'Understanding the impact of gendered roles on the experiences of infertility amongst men and women in Punjab', *Reproductive Health,* 10(3).

Murphy, E. and Dingwall, R. (2001) ‘The Ethics of Ethnography’, in Atkinson, P. et al. (eds.) *Handbook of Ethnography*, London: SAGE.

Musleh, R. (2008) ‚People Behind Walls, Women Behind Walls’, in Bahun, S. and Rajan, V. (eds.) *Violence and Gender in the Globalized World*, Aldershot: Ashgate.

Musmar, S., Afaneh, A. and Mo’alla, H. (2013) ‘Epidemiology of polycystic ovary syndrome: a cross sectional study of university students as An-Najah national university-Palestine’, *Reproductive Biology and Endocrinology*, 11(47).

Muylaert, C. J. et al. (2014) ‘Narrative interviews: an important resource in qualitative research’, *Rev. esc. Enferm.*, 48(2).

Nahar, P. and Richters, A. (2011) ‘Suffering of childless women in Bangladesh: the intersection of social identities of gender and class’, *Anthropology & Medicine,* 18(3).

Najmabadi, A. (1997) ‘The Erotic Vatan [Homeland] as Beloved and Mother: To Love, to Possess, and to Protect’, *Comparative Studies in Society and History*, 39(3).

Najmabadi, A. (1998) ‘Crafting an Educated Housewife in Iran’, in Abu-Lughod, L. (ed.), *Remaking Women: Feminism and Modernity in the Middle East*, Princeton: Princeton University Press.

Najmabadi, A. (2000) ‘(Un)Veiling Feminism’, *Social Text 64*, 18(3).

Naser-Najjab, N. A. (2015) ‘Polygamy, Family Law, and the Crisis of Governance in Palestine’, *Journal of Family Issues*, 36(8).

Neff, D. L. (1994) ‘The social construction of infertility: the case of the matrilineal Nayars in south India’, *Social Science & Medicine,* 39(4).

Noer K. U. (2012) ‘Land, Marriage and Social Exclusion: The Case of Madurese Exile Widow’, *Procedia - Social and Behavioral Sciences*, 65.

Oakley, A. (1981) ‘Interviewing women: a contradiction in terms’ in Roberts, H. (ed.) D*oing Feminist Research*, London: Routledge and Kegan Paul.

Ofovwe, C. E. and Agbontaen-Eghafona, K. A. (2009) ‘Infertility in Nigeria: A Risk Factor for Gender Based Violence’, *Gender & Behaviour,* 7(2).

Ola, T. M. (2014) ‘Gender Dimensions of Seeking Treatment for Infertility In Nigeria’, *Journal of Research in Gender Studies*, 4(2).

Oleson, J. C. (2016) ‘The New Eugenics: Black Hyper-Incarceration and Human Abatement’, *Social Sciences*, 5(4).

Ollerenshaw, J. A. and Creswell, J. W. (2002) ‘Narrative Research: A Comparison of Two Restorying Data Analysis Approaches’, *Qualitative Inquiry*, 8(3).

Olmsted, J. C. (2005) ‘Gender, Aging, and the Evolving Arab Patriarchal Contract’, *Feminist Economics*, 11(2).

Ombelet, W. et al. (2008) ‘Infertility and The Provision of Infertility Medical Services in Developing Countries’, *Human Reproduction Update,* 14(6).

Padovan, D. (2003) ‘Biopolitics and the Social Control of the Multitude’, *Democracy & Nature*, 9(3).

Pappé, I. (1992) *The Making of the Arab-Israeli Conflict, 1947-1951*, London and New York: I. B. Tauris.

Pappé, I. (2018) ‘Indigeneity as Cultural Resistance: Notes on the Palestinian Struggle within Twenty-First-Century Israel’, *The South Atlantic Quarterly*, 117(1).

Paradies, Y. C. (2006) ‘Beyond Black and White: Essentialism, hybridity and Indigeneity’, *Journal of Sociology*, 42(4).

Parizot, C. (2017) ‘Viscous Spatialities: The Spaces of the Israeli Permit Regime of Access and Movement’, *Halshs*, 01528861.

Pashigian, M. J. (2002) ‘Conceiving the Happy Family: Infertility and Marital Politics in Northern Vietnam’ in Inhorn, M and Balen, F. (eds.) *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technology*, Berkeley: University of California Press.

Pashigian, M. J. (2009) ‘The Womb, Infertility, and the Vicissitudes of Kin-Relatedness in Vietnam’, *Journal of Vietnamese Studies,* 4(2).

PCBS (2017) *The Status of the Rights of Palestinian Children, 2016*, Ramallah: PCBS.

Peteet, J. (1991) *Gender in Crisis: Women and the Palestinian Resistance Movement*, New York: Columbia University Press.

Peteet, J. (1994) ‘Male Gender and Rituals of Resistance in the Palestinian "Intifada": A Cultural Politics of Violence’, *American Ethnologist,* 21(1).

Peteet, J. (1997) 'Icons and Militants: Mothering in the Danger Zone', *Signs*, 23(1).

Peteet, J. (2017) *Space and Mobility in Palestine*, Bloomington and Indianapolis: Indiana University Press.

Peteet, J. (2018) 'Closure's Temporality: Cultural Politics of Time and Waiting', *The South Atlantic Quarterly*, 117(1).

Pfeffer, N. (1993) *The Stork and the Syringe: A Political History of Reproductive Medicine*, Cambridge: Polity Press.

Pfeffer, N. (2001) 'Pioneers of Infertility Treatment' in Hardy A. and Conrad, L. (eds.) *Women and Modern Medicine*, Amsterdam and New York: Rodopi.

Pulido, L. (2017) 'Geographies of race and ethnicity III: Settler colonialism and non-native people of color', *Progress in Human Georgraphy*, 42(2).

Qur'an 14:7 (2013) Translation by Abdullah Yusuf Ali, Istanbul: Asir Media.

Ralstin-Lewis, D. M. (2005) 'The Continuing Struggle against Genocide: Indigenous Women's Reproductive Rights', *Wicazo Sa Review*, 20(1).

Ramirez, R. (2007) 'Race, Tribal Nation, and Gender: A Native Feminist Approach to Belonging', *Meridians*, 7(2).

Rattani, A., Kaakour, A. and Miller, J. (2017) 'Moral and professional responsibilities in the context of Palestinian health-care: a qualitative study on the role of medical associations and professional societies', *The Lancet*, 390(2).

Remennick, L. (2000) 'Childless in the Land of Imperative Motherhood: Stigma and Coping Among Infertile Israeli Women', *Sex Roles*, 43(11/12).

Repo, J. (2015) *The Biopolitics of Gender*, Oxford: Oxford University Press.

Richter-Devroe, S. (2012) 'Defending their Land, Protecting their Men: Palestinian Women's Popular Resistance after the Second Intifada', *International Feminist Journal of Politics,* 14(1).

Richter-Devroe, S. (2018) *Women's Political Activism in Palestine: Peacebuilding, Resistance, and Survival*, Urbana: University of Illinois Press.

Riessman, C. K. (2002) 'Positioning Gender Identity in Narratives of Infertility: South Indian Women's Lives in Context', in Inhorn, M. and Balen, F. (eds.) *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technology*, Berkeley: University of California Press.

Reissman, C.K. (2013) 'Analysis of Personal Narratives', in Fortune, A. E., Reid, W. J. and Miller, R. L. (eds) *Qualitative Research in Social Work: Second Edition*, New York: Columbia University Press.

Riessman, C. K. (2015) 'Ruptures and structures: time, audience and identity in an illness narrative', *Sociology of Health & Illness*, 37(7).

Rifkin, M. (2013) 'Settler Common Sense', *Settler Colonial Studies*, *3*(3-04).

Rothenberg, C. E. (2004) *Spirits of Palestine: Gender, Society, and Stories of the Jinn*, Lanham: Lexington Books.

Rouhana, N. N. and Sabbagh-Khoury, A. (2019) 'Memory and the Return of History in a Settler-Colonial Context: The Case of the Palestinians in Israel', *Interventions*, 21(4).

Roy, S. (2004) 'The Palestinian-Israeli Conflict and Palestinian Socioeconomic Decline: A Place Denied', *International Journal of Politics, Culture, and Society*, 17(3).

Rubenberg, C. A. (2001) *Palestinian Women: Patriarchy and Resistance in the West Bank*, Boulder: Lynne Rienner Publishers.

Rubinstein, R. A. and Lane, S. D. (2002) 'Population, Identity and Political Violence', *Social Justice: Anthropology, Peace and Human Rights*, 3(3-4).

Ryan, C. (2015) *Bodies, Power, and Resistance in the Middle East: Experiences of subjectification in the occupied Palestinian territories*, London and New York: Routledge.

Sa'ar, A. and Yahia-Younis, T. (2008) 'Masculinity in Crisis: The Case of Palestinians in Israel', *British Journal of Middle Eastern Studies*, 35(3).

Saca-Hazboun, H. and Glennon, C. A. (2011) 'Cultural Influences on Health Care in Palestine', *Clinical Journal of Oncology Nursing*, 15(3).

Salaita, S. (2016) *Inter/Nationalism: Decolonizing Native America and Palestine*, Minneapolis: University of Minnesota Press.

Salamanca, O. J. (2014) 'Hooked on electricity: the charged political economy of electrification in Palestine', working paper (February) presented in the symposium "Political Economy and Economy of the Political" at Brown University.

Salih, R. and Richter-Devroe, S. (2018) 'Palestine beyond National Frames: Emerging Politics, Cultures, and Claims', *The South Atlantic Quarterly*, 117(1).

Sandelowski, M. and de Lacey, S. (2002) 'The Uses of a "Disease": Infertility as Rhetorical Vehicle', in Inhorn, M. and Balen, F. (eds.) *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technology*, Berkeley: University of California Press.

Sayigh, R. (1998) 'Gender, Sexuality, and Class in National Narrations: Palestinian Camp Women Tell Their Lives', *Frontiers: A Journal of Women Studies*, 19(2).

Serour, G. I. (2008) 'Medical and Socio-cultural aspects of infertility in the Middle East', *ESHRE Monographs*, 2008(1).

Shahd, L. (2003) 'Historical and Theoretical Background', *An Investigation of the Phenomenon of Polygyny in Rural Egypt*, New York: American University in Cairo Press.

Shalhoub-Kevorkian, N. (2009) *Militarization and Violence against Women in Conflict Zones in the Middle East: A Palestinian Case-Study*, Cambridge: Cambridge University Press.

Shalhoub-Kevorkian, N. (2019) *Incarcerated Childhood and the Politics of Unchilding*, Cambridge: Cambridge University Press.

Shami, S. (1988) 'Studying Your Own', in Altorki, S. and El-Solh, C. (eds.) *Arab Women in the Field: Studying Your Own Society*, Syracuse: Syracuse University Press.

Sharoni, S. (1995) *Gender and the Israeli-Palestinian Conflict: The Politics of Women's Resistance*, Syracuse: Syracuse University Press.

Shigley, S. B. (2017) 'Great Expectations: Infertility, Disability, and Possibility', in Davis, G. and Loughran, T. (eds.), *The Palgrave Handbook of Infertility in History: Approaches, Contexts and Perspectives*, London: Palgrave Macmillan.

Simpson, A. (2016) 'The State is a Man: Theresa Spence, Loretta Saunders and the Gender of Settler Sovereignty', *Theory & Event,* 19(4).

Smith, A. (2005) *Conquest: Sexual Violence and American Indian Genocide*, Cambridge: South End Press.

Smith, A. (2007) 'Unmasking the State: Racial/Gender Terror and Hate Crimes', *Australian Feminist Law Journal,* 26(1).

Smith, A. (2008) 'American Studies without America: Native Feminisms and the Nation-State', *American Quarterly,* 60(2).

Smith, A. (2010) 'Queer Theory and Native Studies: The Heteronormativity of Settler Colonialism, *A Journal of Lesbian and Gay Studies*, 16(1-2).

Smith, A. and Kauanui, J. K. (2008) 'Native Feminisms Engage American Studies', *American Quarterly,* 60(2).

Smith, R. J. (2011) 'Graduated incarceration: The Israeli occupation in subaltern geopolitical perspective', *Geoforum*, 42(3).

Snelgrove, C., Dhamoon, R. K. and Corntassel, J. (2014) 'Unsettling settler colonialism: The discourse and politics of settlers, and solidarity with Indigenous nations', *Decolonization: Indigeneity, Education & Society*, 3(2).

Snyder, K. A. (1999) 'Gender Ideology, and the Domestic and Public Domains among the Iraqw', in Moore, H.L., Sanders, T. and Kaare, B. (eds.) *Those Who Play with Fire: Gender, Fertility and Transformation in East and Southern Africa*, London: Athlone Press.

Sollom, R. and Atkinson, H. G. (2012) *Weaponizing Tear Gas: Bahrain's Unprecedented Use of Toxic Chemical Agents Against Civilians*, Cambridge: Physcians for Human Rights.

Sousa, C. and Hagopian, A. (2011) 'Conflict, health care and professional perseverance: a qualitative study in the West Bank', *Global Public Health,* 6(5).

Spellings, C. R. (2014) *The Role of Family in Wellbeing and Quality of Life among Palestinian Adults*, Doctor of Philosophy, University of Tennesse, Knoxville, PhD thesis.

Steinberg, D. L. (1990) 'The Depersonalisation of Women through the Administration of '*In Vitro* Fertilisation', in McNeil, M., Varvoe, I. and Yearley, S. (eds.) *The New Reproductive Technologies*, London: Macmillan.

Stoler, A. L. (1995) *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things*, Durham and London: Duke University Press.

Stoler, A. L. (2006a) 'Intimidations of Empire: Predicaments of Tactile and Unseen', in Stoler, A. L. (ed.), *Haunted by Empire: Geographies of Intimacy in North American History*, Durham and London: Duke University Press.

Stoler, A. L. (2006b) 'Tense and Tender Ties: The Politics of Comparison in North American History and (Post) Colonial Studies', in Stoler, A. L. (ed.), *Haunted by Empire: Geographies of Intimacy in North American History*, Durham and London: Duke University Press.

Stoler, A. L. (2010) *Carnal Knowledge and Imperial power: Race and the Intimate in Colonial Rule*, Berkeley: University of California Press.

Stoler, A. L. (2016) *Duress: Imperial Durabilities in Our Times*, Durham: Duke University Press.

Su, T. and Chen, Y. (2006) 'Transforming Hope: The Lived Experience of Infertile Women Who Terminated Treatment After *in Vitro* Fertilization Failure', *Journal of Nursing Research*, 14(1).

Suckow, J. (2008) 'Dependence of the Values of Children on Socio-Structural Characteristics: The Case of Israel and Palestine', in Zheng, G., Leung, K. and Adair, J. G. (eds.) *Perspectives and progress in contemporary cross-cultural psychology: Proceedings from the 17th International Congress of the International Association for Cross-Cultural Psychology*,

Sunseri, L. (2007) 'Indigenous Voice Matters: Claiming our Space through Decolonising Research', *Junctures*, 9.

Svirsky, M. and Ben-Arie, R. (2019) 'Settler Colonialism and the Logic of Double Elimination', *International Journal of Postcolonial Studies*, 21(4).

Sykes, B. L. and Pettit, B. (2010) *Choice or Constraint? Mass Incarceration and Fertility Outcomes Among American Men*, Washington: University of Washington.

Tabi, M. M., Doster, C. and Cheney, T. (2010) 'A qualitative study of owmen in polygynous marriages', *International Nursing Review*, 57(1).

Taghdisi-Rad, S. (2011) *The Political Economy of Aid in Palestine: Relief from Conflict or Development Delayed?*, London and New York: Routledge.

Taraki, L. (1997) 'Palestinian Women: A Status Report', *Women's Studies Program*, Birzeit University.

Thapan, M. (2010) 'Marriage, well-being, and agency among women', *Gender & Development*, 11(2).

Therborn, G. (2004) *Between Sex and Power: Family in the World, 1900-2000*, London: Routledge.

Thompson, C. (2002) 'Fertile Ground: Feminists Theorize Infertility', in Inhorn, M. and Balen, F. (eds.) *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technology*, Berkeley: University of California Press.

Throsby, K. (2004) *When IVF Fails: Feminism, Infertility and the Negotiation of Normality*, New York: Palgrave Macmillan.

Todd, Z. (2016) 'An Indigenous Feminist's Take On The Ontological Turn: 'Ontology' Is Just Another Word for Colonialism', *Journal of Historical Sociology*,

Todorova, I. L. G. and Kotzeva, T. (2006) 'Contextual shifts in Bulgarian women's identity in the face of infertility', *Psychology and Health,* 21(1).

Tuck, E. & Yang, K.W. (2012) 'Decolonization is not a Metaphor', *Decolonization: Indigeneity, Education & Society*, *1*(1).

Turner, M. (2014) 'The Political Economy of Western Aid in the Occupied Palestinian Territory Since 1993', in Turner, M. and Shweiki, O. (eds.) *Decolonizing Palestinian Political Economy: De-development and Beyond*, London: Palgrave Macmillan.

Ulrich, M. and Weatherall, A. (2000) 'Motherhood and Infertility: Viewing Motherhood through the Lens of Infertility', *Feminism & Psychology*, 10(3).

United Nations Office for the Coordination of Humanitarian Affairs (2018) 'Over 700 road obstacles control Palestinian movement within the West Bank', *The Monthly Humanitarian Bulletein*. Available from: https://www.ochaopt.org/content/over-700-road-obstacles-control-palestinian-movement-within-west-bank. Last Accesses 29 April 2019.

UNRWA (2018) 'UNRWA in Figures', *Communications Division*, Jerusalem: UNRWA Headquarters. Available from: https://www.unrwa.org/sites/default/files/content/resources/unrwa_in_figures_2018_eng_v1_31_1_2019_final.pdf. Last accessed 6 May 2019.

Upton, R. L. (2001) ''Infertility Makes You Invisible': Gender, Health and the Negotiation of Fertility in Northern Botswana', *Journal of Southern African Studies,* 27(2).

Van Krieken, R. (2004) 'Rethinking Cultural Genocide: Aboriginal Child Removal Policy and Settler-Colonial State Formation', *Oceania*, 75(2).

Van Zandvoort, H., de Koning, K. and Gerrits, T. (2001) 'Viewpoint: Medical infertility care in low income countries: the case for concern in policy and practice', *Trpoical Medicine and International Health*, 6(7).

Vanderlinden, L. K. (2009) 'German genes and Turkish traits: Ethnicity, infertility, and reproductive politics in Germany', *Social Science & Medicine,* 69(2).

Varley, E. (2012) 'Islamic logics, reproductive rationalities: family planning in northern Pakistan;, *Anthropology & Medicine*, 19(2).

Veracini, L. (2006) *Israel and Settler* Society, London and Ann Arbor: Pluto Books.

Veracini, L. (2010) *Settler Colonialism: A Theoretical Overview*, London: Palgrave Macmillan.

Veracini, L. (2011) 'Introducing: settler colonial studies', *Settler Colonial Studies,* 1(1).

Veracini, L. (2019) 'Israel-Palestine Through a Settler-colonial Studies Lens', *Interventions*, 21(4).

Verhaak et al. (2001) 'Stress and marital satisfaction among women before and after their first cycle of in vitro fertilization and intracytoplasmic sperm injection', *Fertility and Sterility*, 76(3).

Vertommen, S. (2017a) 'Babies from Behind Bars: Stratified Assisted Reproduction in Palestine/Israel', *Assisted Reproduction Across Borders: Feminist Perspectives on Normalizations, Disruptions and Transmissions*, New York and London: Routledge.

Vertommen, S. (2017b) *State of the //ART// of the State: A Political Economy of Assisted Reproduction in Palestine/Israel*, Department of Conflict and Development Studies, Ghent: Ghent University, PhD thesis.

Volscho, T. W. (2010) 'Sterilization Racism and Pan-Ethnic Disparities of the Past Decade: The Continued Encroachment on Reproductive Rights', *Wicazo Sa Review*, 25(1).

Wahbe, R. M. (2012) 'Physical and mental health of long-term Palestinian political prisoners: a qualitative study', *The Lancet*, 380(S23).

Waldby, C. (2015) ''Banking time': egg freezing and the negotiation of future fertility', *Culture, Health & Sexuality*, 17(4).

Webair, H. H., Ismail, T. A. T. and Ismail, S. B. (2018) 'Patient-centered infertility care from an Arab perspective: A review study', *Middle East Fertility Society Journal*, 23(1).

Weeks, J. (2011) *The Languages of Sexuality*, London and New York: Routledge.

Welchman, L. (2007) *Women and Muslim Family Laws in Arab States: A Comparative Overview of Textual Development and Advocacy*, Amsterdam: Amsterdam University Press.

WHO (2010) 'Mother or Nothing: the agony of infertility', *World Health Organization*, 88.

WHO (2017) *Sexual helath and its linkages to reproductive health: an operation approach*, Department of Reproduction Health and Research, Switzerland: WHO.

Wick, L. (2011) 'The practice of humanitarianism: A village birthing clinic in Palestine', *Global Public Health,* 6(5).

Wiersema et al. (2006) ‘Consequences of infertility in developing countries: results of a questionnaire and interview survey in the South of Vietnam’, *Journal of Reanslational Medicine*, 4(54).

Williams, C. L. and Heikes, E. J. (1993) ‘The Importance of Researcher’s Gender in the In-Depth Interview: Evidence from Two Case Studies of Male Nurses’, *Gender and Society*, 7(2).

Wischmann, T. et al. (2001) ‘Psychosocial characteristics f infertile couples: a study by the ‘Heidelberg Fertility Consultation Service’’, *Human Reproduction*, 16(8).

Wolfe, P. (1999) *Settler Colonialism and the Transformation of Anthropology: The Politics and Poetics of an Ethnographic* Event, London and New York: Cassell.

Wolfe, P. (2006) ‘Settler colonialism and the elimination of the native’, *Journal of Genocide Research,* 8(4).

Woliver, L. R. (2002) *The political Geographies of Pregnancy*, Urbana and Chicago: University of Illinois Press.

Wood, E. (2006) ‘The Ethical Challenges of Field Research in Conflict Zones’, *Qualitative Sociology*, 29(3).

Wood, E. J. (2009) ‘Armed Groups and Sexual Violence: When Is Wartime Rape Rare’, *Politics & Society*, 37(1).

Woollett, A. (1996) ‘Infertility-from ‘inside/out’ to ‘outside/in’’, in Wilkinson, S. & Kitzinger, C. (eds.) *Representing the Other: a feminism and psychology read*, London: Sage.

Woolley, O. (2002) *The Earth Shakers of Madagascar: An Anthropological Study of Authority, Fertility and Creation*, London and New York: Continuum.

Yasin, A. L et al. (2016) ‘The Epidemiology of Anti-Sperm Antibodies Among Couples with Unexplained Infertility in North West Bank, Palestine’, *Journal of Clinical and Diagnostic Research*, 10(3).

Ying, L., Wu, L. and Loke, A. (2015) ‘Gender differences in experiences with and adjustments to infertility: A literature review’, *International Journal of Nursing Studies*, 52.

Young, E. G. (2003) ‘A feminist politics of health care: The case of Palestinan women under Israeli occupation’ in Mayer, T. (ed.) *Women and the Israeli Occupation: The Politics of Change*, London: Routledge.

Yuval-Davis, N. (1997) *Gender and Nation*, London: SAGE.

Zaragocin, S. (2019) ‘Gendered Geographies of Elimination: Decolonial Feminist Geographies in Latin American Settler Contexts’, *Antipode*, 51(1).

Zinngrebe, K. J. (2019) ‘Palestinian women in Israel: embodied citizen strangers’, *Settler Colonial Studies*, 9(1).

Zureik, E. (2001) ‘Constructing Palestine through Surveillance Practices’, *British Journal of Middle Eastern Studies*, 28(2).

Zureik, E., Lyon, D. and Abu-Laban, Y. (2010) *Surveillance and Control in Israel/Palestine: Population, Territory and Power*, London and New York: Routledge.