Engineering of Death:

Policies of Controlling Silent Bodies

Nour Bader

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Oh Naqab,
Be determined, be glorious and pioneering.
Be a sword. Be a lesson
of the Intifada lessons.
They wanted you to be our grave,
but we turned the grave into gardens,
and bore the sun at dawn.
No… No to patterns of extermination.

Naqab [“Negev”] Prison, 1988

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December 20th 2023

Dedication & Acknowledgment

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Dedication

It was in the corner of that room, by a door overlooking a huge garden full of trees and old buildings expressing life's outer beauty and inner wreckage, where I met your mother, oh Muhammad. It was at Augusta Victoria Hospital that I met this woman in her mid-thirties from the Gaza Strip.

Cancer had exhausted her body and taken hold of her. Counting down her last days, she envisioned you standing by the window – waiting for her return.

Here I am, on your opposite side, showing you another window. I have wrapped myself in your mother's shawl that she gifted me. It makes me feel Gaza's warm sea breeze on my face. I imagine you still standing and waiting for her to come back. Are you indeed doing that, my little one?
There is a war on Gaza as we speak. Although I am standing on the other side, yet my heart is pounding with the stumbles of your feet. I wonder, whose shoulders are you burying your head in right now? Do you hide under her clothes inside of the closet? Are you afraid? Are you crying? Are you still standing by the window waiting for her to come back? Does it matter? I just need to know: Are you alive right now?!

It is for you, my dear, that I dedicate this book.
May 19, 2021

Acknowledgment

I would like to extend my sincere thanks to the women who cooperated with me in this study. No words can describe my appreciation to these women who have suffered from breast cancer, and with whom we shared many moments of pain. Their voices fill the pages of this book, and to them I extend my utmost gratitude.

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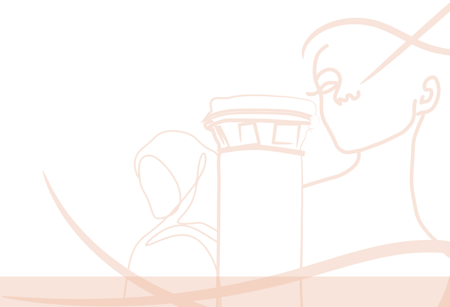

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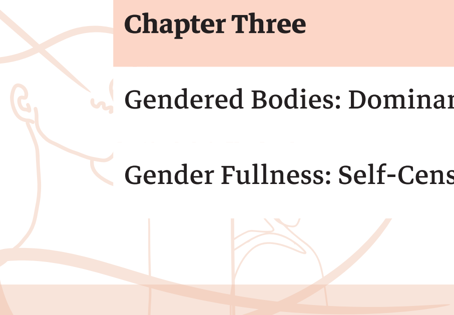

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Preamble

Engineering of Death: Policies of Controlling Silent Bodies

Preamble

> **It was an early morning in December 2018 when I said to myself, as I gathered my hair in a claw clip, “Thank God this nightmare of a year is finally almost over.” I then rushed to my window and took a quick glance outside. The sky seemed to be overcast with dark clouds. It was the type of scene that Iraqi poet Badr Shakir al-Sayyab had brilliantly expressed as he described the rains “pouring down their heavy tears.” I reflected that this must be a beautiful day – the type that lovers share – before I blew on the glass. Something seemed distorted, however. It was “a cloud,” I resolved; “A beautiful cloud without any features.” I smiled and quickly drew with my finger a large love sign. “Just be alright,” I wrote inside it. Alas, that was not the case: We were amid a tough battle with breast cancer.**
>
> **Some days are so heavy that you feel the weight of the entire universe on your shoulders. There are days when you want nothing but for life to take that load aside so that you may breathe a sigh of relief. This disease, with all that it entails, conveys the silent pains and burdens that only those such as yourself share. It conveys their faint voices… their lost stories. This book is here to make the voices of these women heard.**

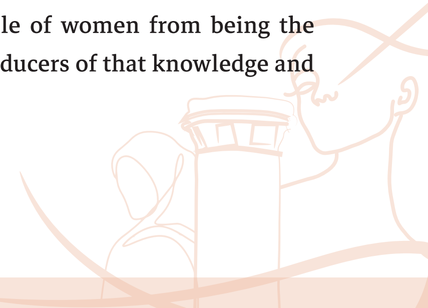
The book highlights the experiences of Palestinian women diagnosed with breast cancer, as they suffer from structural violence in Palestine. It surpasses the idea of reducing disease to a strictly “biological”/medical issue and looks, instead, for what is behind the disease. Hence, it attempts to deconstruct the context (“the whole”) and its manifestations (“the details”) in terms of theory and practice, by means of analyzing; first, the colonial context and policies; second, the societal influence on two dimensions – namely “targeting the health system” and “gender aspects of the body”; and third, the symbolic violence (i.e., “the pains”).

These are the main aspects I examine in this book. My suggestion is that these structures have worked to form and “engineer” disease on the bodies of women suffering from breast cancer, which, in turn, manifested in “physical” as well as “symbolic” violence on these bodies. As a result, the disease extended to a “social identity” that had long been reduced to abstract medical terms and regulations, and that were disconnected from the structures that initially inflicted violence on these bodies.

In his study titled “Illness as a discourse: A study of the politics of illness according to Michel Foucault and its role in contemporary social philosophy”, al-Zawawi Baghurah talks about new attempts to undermine the current concepts and prevailing norms towards establishing different relationships, especially those that link illness to society, norms, economics, politics, and power (Baghurah 2021, p.35). In sovereign countries, deconstructing the structures of illness requires analyzing the disease as a phenomenon that relates to political, economic, and social dimensions. However, in the case of Palestine, this deconstruction is linked to the Palestinian context under colonialism, which in and of itself produced structures of persecution that were imposed on women suffering from breast cancer. This book chooses to deconstruct "the context" to understand and reflect upon the stories of women suffering from breast cancer. What I mean by "context" is the existence of the Zionist enterprise which, as per my argument, has been targeting the bodies of Palestinian men and women in different patterns of extermination as of the Nakba of 1948. This context (i.e., the Zionist enterprise as per settler colonialism) has thereby been a continuous and systemic process and not an interrupted event. Under such a context, the public space has no room for the "state of exception," and the bodies of Palestinian women suffering from breast cancer are thus not exempted from it. Meanwhile, what we mean by "targeting the Palestinian health system" is the structural destruction this system has undergone (such as by military raids, bombardment, closures, and marginalization), along with the rapid institutionalization and bureaucratic structures that took over after the inception of the Palestinian political regime. In parallel, the Israeli military bombardments have continued, especially during the wars on the Gaza Strip. Moreover, in order to understand the gender-related ramifications of suffering from breast cancer, I aim to examine the gender identity of women who suffer from this disease. I tackle this by using two criteria related to the state of loss or possibility of loss due to the disease, namely the "breast" and "hair". Finally, I focus on the "sound of pain" as a symbolic kind of violence as witnessed within the battle between one's self and one's body, as well as the battle between the body and its surroundings.

In doing so, I focus on the effects of settler-colonial Zionist policies against Palestinians – through multiple forms of systematic and sequential extermination) on one side, and the violent societal effects on another side.

In this book, I aim to change the angle of knowledge production by steering from its "system" or "ego" based notions (as represented in the voice of the "expert" from her elitist position) and moving, instead, towards knowledge production that is rooted in the perceptions of women suffering from breast cancer. This approach, as explained by Ghassan Abu-Sittah, is vital because it produces a discourse that is derived from the viewpoints of marginalized persons themselves rather than the parties that dominate and minimize their narratives (Abu-Sittah, 2020). During an interview with Muiz Karajeh, we discussed how the process of knowledge production from marginalized narratives can better present women's perceptions of their reality (this is much better than presenting their viewpoints by other parties). In other words, this transforms the role of women from being the "subjects" of knowledge and policy production to becoming active producers of that knowledge and its policies (Karajeh, Ramallah, May 2021).

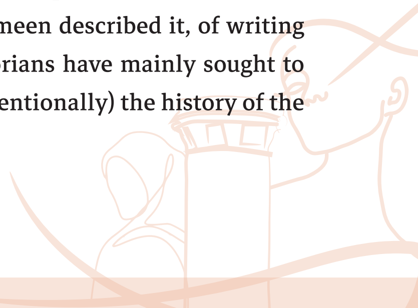


In collecting data within this framework, I applied the ethnographic method. Using this method, all that I acquired contributed to writing the history of “marginalized actors.” Their living history, after all, prevails over academic writing and highlights complex situations; it also enables us to understand their distinctive experiences and authentic stories in more detail and accuracy. My research approach and methodology included conducting in-depth interviews with women from the West Bank and Gaza Strip, albeit knowing that both of these entities are considered “atypical,” as they were formed due to settler colonialism in Palestine and further aggravated by the Palestinian internal division. The justification for the said approach lies within the similarity of structures and policies to which women with breast cancer (in these two units) are subjected to vis-à-vis the diagnosis and treatment of this disease. Ultimately, both geographic units are under Israeli settler colonialism that is enforcing its dominant ideology through coercive measures that shape the daily lives of residents in occupied Palestinian territory. We thus also consider the social influences emanating from this context, including Palestine’s health sector and gender aspects, while highlighting the effects of the violent “invisible pain” suffered within these bodies. This means that similar concepts can be used in analyzing both locations [WB & GS] due to similar structures of persecution in both geographic units. The colonialist policies that persecute women suffering from breast cancer are the same ones that prevented me from reaching the Gaza Strip to talk to these women. For this reason, two researchers from the Gaza Strip assisted me in completing the interviews there, whereas I personally conducted in-depth interviews with breast cancer patients in the West Bank. During these discussions, I did not see the need to follow the tactics of ethnographic work to collect information. Such tactics, such as maneuvering the use of identities, are sometimes used in complex situations. In her book titled “Forensic Medicine in Palestine: Anthropological Study”, Suhad Daher-Nashif shares that she used these tactics as “crossing points” to gather information within a sphere that is filled with small details and obscure complexities (Daher-Nashif 2019, p.7). But since I come from the same society of the study population, I did not see the need to apply such tactics. Being close to my mother throughout this experience, I managed to take notes and document the various situations that we faced. Moreover, my interviews with women suffering from breast cancer ended up being quite interactive and practical, especially because I understood their experiences firsthand. As women from a similar background, we attempted to deconstruct the structures of persecution on “silent bodies,” meaning the bodies [or persons] that undergo the violence of colonial policies, societal influences, and pains of the disease itself. These bodies, which are in dire need of treatment, are obliged to abide by colonial policies to receive their right to treatment. The said patients are also forced to stand in queues, wait for a long time, and move between spaces to obtain treatment. These women have become adept at masking the loss of some organs due to the disease, for fear of exclusion; marginalization; or being treated as a “body devoid of femininity”. They have become masters in suppressing their pain and suffering their fierce battle in silence – a rather lonely battle. Consequently, they are obliged to become “silent bodies.” This enhances the need to listen to the voices of these women regarding the persecution practiced against their silent bodies.

This type of research is crucial to pave the way for the narratives of women who suffer from persecution policies, especially since such narratives are often disregarded by the dominant discourse. Generally speaking, the experiences, daily suffering, and life concerns of ordinary individuals have always been on the back burner while Palestinian dominant discourse has focused primarily on military and political struggles, catchy slogans, and high hopes. Meanwhile, thousands of vitally important narratives have been overlooked. For example, is there currently a narrative related to wounds?! Is there any narrative for cemeteries… for pain… for cold mortuaries… or for detentions?! Unfortunately, such narratives are almost non-existent, for they are overrun by the dominant discourse. Therefore, all discussions of Palestinian internal problems should take into consideration the problematic dominant discourse which keeps reproducing itself. In his book titled “The Narrative of the Palestinian Wound”, Ghassan Abu-Sittah explains the way these bodies carry their narratives in the face of the existing powers that try to mobilize or suppress these painful accounts depending on the harmony [or lack of harmony] of these wounds with the dominant political discourse (Abu-Sittah, 2020). Therefore, the dominant discourse (with its strong terms and grand national slogans) inherently neglects the suffering and daily sacrifices of sick persons. In the case that it does acknowledge them, the dominant discourse most often uses these wounds as objectives to achieve elitist benefit and for fulfilling personal interests.

Muiz Karajeh describes how the dominant discourse, with its current traits and ideological perspectives, has completely infiltrated our language, as per our different settings, and affected our understanding of reality – irrespective of our orientation. This discourse also overshadowed all our media outlets and imposed a logic that governs intellectuals regardless of their viewpoints (Karajeh, 2020). As Karajeh sees it, the danger of the dominant discourse lies in its “compliance” with the details of life, where it assumes that life is “normal” or “regular” to the extent that people – over the long haul – can no longer discern the serious problems of this discourse.

Our desire to produce a narrative on this illness is considered a detachment from the dominant discourse. Moreover, it is an attempt to raise awareness of the structural violence inflicted upon breast cancer patients. The intention is also to provide the space for women to personally narrate their unwritten history, whereas such narratives are almost completely absent in official history. This is especially significant because historic events have mainly focused on political elites, masters, kings, conquests, rulers, and military coups; an extension, as Abbas Ameen described it, of writing history from a colonial perspective (Ameen, 2015). Furthermore, historians have mainly sought to find written documents, all the while forgetting (intentionally or unintentionally) the history of the



marginalized, i.e., the ordinary people who do not have archives that recount their own experiences. The stories of these marginalized persons have thus been included to make room for their narratives and discourses to come to life. These narratives are a testimony to their presence in a world where their discourse is suppressed. As Atouf Elkbir stresses, it is crucial to give these persons a chance to express their feelings and frustrations and to present their perceptions of this world which has stripped them of power and control (Elkbir, 2015).

It is in this respect that, as of the recent years, scholars of colonial studies have no longer been focusing on the role of elites. Rather, they have shown a growing interest in the experiences of marginalized people towards deepening their understanding of the different forms of resistance and the "power from below" (Ballantyne, 2016, p.13). From this perspective came the works of Ranajit Guha and his colleagues: In an attempt to rescue the history of "subordinate groups" from the clutches of elitist historiography, they embarked on reading Indian history from a lens that is greatly aware of marginalized groups and that does not adopt the elitist perspective, i.e., the writing of "history from below" (Al-Kayyal, 2018). Official history, being predominantly elitist, had focused on battles and wars. Therefore, having marginalized persons as the starting point of these narratives shifts people's historic narratives and thus constitutes a change in knowledge production. This enables people to speak up about the structures that were designed and implemented against them, and which have been deeply embedded in their daily lives through subtle, quiet, and [so called] "regular" policies.

Each of the book's chapters attempts to examine the structures of this persecution. Within this context, I provided a theoretical introduction to lay out an epistemological framework pertaining to the stories of women suffering from breast cancer, thus enabling the reader to understand the context of these issues.

In its theoretical introduction, the first chapter focuses on the context of Zionist colonialism as a prelude to understanding Israeli policies and practices on the ground. What is meant by "context" is the Zionist enterprise, which applies multiple patterns of extermination in fulfilment of its motto: "A land without a people for a people without a land." Subsequently, I examine how these colonial policies' violence has impacted the women patients when seeking to access treatment. I particularly analyze the issue of radiotherapy at this point, seeing that this treatment is not available in the West Bank and Gaza Strip, thus requiring travel to Jerusalem and within the Green Zone ["1948 areas"] for treatment – a process that subjects women to various colonial policies that are imposed on the

ground.

In the second chapter, I carefully analyze the health sector in Palestine, which is impossible to understand in isolation of politics. As it happens, the interlink between Palestine's health situation and politics warrant an understanding of social action that is unlike those in other contexts (Hanafi and Linda Tabar, 2004). This chapter thus focuses on Israel's deliberate targeting of health institutions through bombardments and incursions, and considers the marginalization of people under military closures. The second chapter also highlights the neoliberal method of managing Palestinian sectors after the establishment of the Palestinian political regime, in conjunction with continuous bombardment operations. In its second part, chapter two attempts to deconstruct the crises emanating from the weak medical system, as expressed in the narratives of Palestinian women participating in this study.

In the third chapter, the book attempts to analyze the gender-related aspects in the daily lives of these women. It seeks to unravel a woman's relation with herself, as well as the relationship of others with these women. Within this context, I emphasize the authority linked to cultural ideals and systems, images/perceptions, and social expectations regarding "femininity". Since these perceptions were created by the society, they are henceforth justified and legitimized through the biological aspect of "male" and "female". In analyzing gender-related mechanisms, the third chapter also examines what is called "self-censorship", where we trace how women with breast cancer and other persons specify their gender identity, how these women view their bodies, and how others view them. In this section, I claim that the "gender standard" in the case of breast cancer is eliminated because of its strong linkage with two criteria related to the state of loss and the physical aspect of the disease, namely the breast and hair, where these bodies are not viewed as a sick body versus a healthy one but, rather, as a body "amputated from femininity". In this respect, I also analyze how the "gender standard" affects these women's gender identity.

In its fourth chapter, the book aims to describe the violent pain that the weak and fragile bodies of these women suffer, as well as the agony reflected in their words despite their strength to endure. The chapter also probes into these women's concerns and reflections, while shedding light on the inner battles a woman fights against her own body. The agonizing moments and the long waiting are inescapable: The only way is to embrace the pain. In such situations, these women do not look at how to identify with their social surroundings except after the excruciating pain is over. This is because in the most extreme moments, the pain itself becomes one's self.

Chapter One

Engineering of Death: Policies of Controlling Silent Bodies

Zionist Colonialism – Return to the Context

This introduction is based on the premise of Raef Zreik, who stresses that "we must [always] return to the context, and to see everything behind the forest of details" (Zreik, 2006). Understanding the details, therefore, requires going back to the context which – in this respect – refers to the Zionist project that assumes Palestine as "a land without a people for a people without a land." As put by Nur Masalha, its aim is "more land, less Arabs." This chapter thus highlights the context of the Zionist enterprise towards unraveling the painful torments it has imposed on Palestinians and through which it impacts their lives and livelihoods. By and large, this book pays special attention to the agonies that Palestinian women diagnosed with breast cancer endure.

The attempt to decipher the context emanates from the fact that Palestinians are targeted by various forms of extermination. Within that framework, there is no room for "exempted bodies", even if they suffer from breast cancer outside the scope of "extermination". In the first section of this chapter, I attempt to examine the patterns of extermination within the Zionist colonial context, as represented by a set of practices and active policies. Afterwards, in the second section, I examine how such "extermination" has affected Palestinian women suffering from breast cancer by deconstructing the ways in which they were forcefully subjected to colonial policies on the ground.

The Zionist context is characterized as a settler-colonial ideology that aims to exterminate the indigenous people of the country [Palestinians] by "erasing", "removing", and "uprooting" them. According to Patrick Wolfe, this means that the relationship between the settler-colonizer and the indigenous people of the land is not based on controlling the natives or exploiting cheap labor but, rather, on the idea of eliminating them from existence (Wolfe, 2006). Regarding Wolfe's thesis, Maisa Shqeir notes that the existence of the indigenous people in the land is considered a problem for the colonizer, who aims to erase them. Therefore, the extermination of the original inhabitants of the country does not occur due to their color, religion, race, or political affiliation but because of their mere presence on the land, whereas gaining access to the land and expropriating it is the first and foremost goal of settler colonies (Shqeir, 2017).

Wolfe describes the logic of "elimination" as an unceasing and ongoing structural process (Wolfe, 2006). Hence, it is possible to consider the Nakba [catastrophe] of 1948 as a culmination of such types of extermination. This act was perpetrated through systematic mass killings described as massacres, after which mass expulsions and deportations took place. Ismail Nashef, who specifically addressed this subject, sees that the organized destruction of the “Palestinian entity” at the physical level still constitutes a basic aim for the colonial regime in Palestine (Nashef, 2015, pp.9-10). Ultimately, any assessment of the Nakba and its aftermath will highlight the various forms of extermination practiced on Palestinian land and against its inhabitants, and thereby I focus on the marks such practices have left on the bodies of Palestinians who survived in their land. These patterns, after all, penetrated the daily lives of Palestinians and affected their livelihoods. In this chapter, I do not elaborately analyze the ways in which different patterns of extermination were established, but rather highlight on those which culminated in the structural tragedy of 1948. Building on the idea of multiple types of extermination, I attempt to analyze how Palestinian women suffering from breast cancer are subjugated to such patterns; one of which is through controlling their right to treatment, which, according to my claim, is being implemented through a systematic set of colonial policies on the ground.

In their analysis, Mark Levine and Eric Cheyfitz built upon Martin Shaw’s view of collective extermination that Palestinians were subjected to during the 1948 war. Their analysis of that tragedy revealed that these acts were based on a mentality of “settler occupation, “exclusivist supremacy” and the desire to destroy social existence with the use of violence (Levine and Cheyfitz, 2018). Moreover, Ilan Pappe demonstrates what had happened in the afternoon of Wednesday, March 10, 1948, when eleven men gathered in the red building which housed the Haganah paramilitary organization in Tel Aviv. During that meeting, they put the finishing touches on the plan to ethnically cleanse Palestinians, and they issued orders to their field units to prepare for the systematic expulsion of Palestinians from their land. These orders were accompanied by a detailed description of the possible methods by which to forcefully expel people, such as spreading fear and terror; besieging and shelling villages and population centers; burning homes, property, and goods; expulsion; house demolition; and laying mines within the rubble to prevent the expelled residents from returning to their homes (Pappe, 2006, p.4). On the other hand, the pattern of exterminating the Palestinians who remained in their homeland was characterized by subjugating them to military rule, by means of “legitimized” practices of the Israeli Military (which controls all aspects of Palestinian life). The practices that embody “cleansing” included the following: prohibition of travel outside Palestine except under certain conditions, whereas the Military Administration forced all Palestinians who sought to travel outside the country (even for a single day) to stay outside Palestine for six whole months before being able to return. During the months when Palestinians were forced to stay outside the homeland, many of them started working, and some even established families outside Palestine, thus lost their "right to return" according to the colonial perspective. There was also the closure and demolition of many Palestinian homes which, according to Israeli claims, were being used to carry out acts of resistance that undermine Israel's security. During that period, Palestinians were being constantly searched in public and private spaces. Oftentimes, the colonizers gathered Palestinians gathered in public squares and school yards and forced them to lie face down with their hands above their heads. This is not to mention the complete process of censorship on writings and publications that the colonizers implemented, such as imposing the Military Governor's prior approval for publishing any written work in colonized territories. There was also the imposition of curfews which prohibited Palestinians from leaving their homes aside from certain hours of the day. Israeli settler-colonizers also enforced a policy of deporting activists who would venture to strengthen Palestinian steadfastness on the ground. They also divided the space into small, isolated cantons and cut off their geographic contiguity through Israeli settlements. Regarding ethnic cleansing practices, Suhad Daher-Nashif and Nadera Shalhoub-Kevorkian highlighted the racist calls to kill Palestinians during the war on Gaza in 2014. One such example was a t-shirt that Israeli soldiers were wearing, which had the picture of a pregnant veiled woman with a rifle aimed directly at her belly, and below it were the words: "1 shot, 2 kills" (Daher-Nashif and Shalhoub-Kevorkian, 2015). Such practices emphasize the ongoing subjugation of Palestinians, and demonstrate the Israeli military superiority and its control of all passage (Zreik, 2013).

Evidently, these patterns were fiercely organized by a set of regulated policies by which to monitor and control Palestinians. Tariq Dana sheds light on some these policies, which include "the permit regime, face recognition and identification technologies, military checkpoints, electronic barriers, and cement barriers/blocks" (Dana, 2019, p.70), in addition to 'security' denials, intensive searching and inspection, delays of arrival, state of alert, and denial of entry.

Analyzing colonial policies is thus vital to decipher the logic of elimination, which is manifested through anti-Palestinian policies of control under two contexts:

The first context relates to control by means of monitoring every detail of Palestinian life through intertwined colonial policies that converge with the permit policy. A Palestinian woman with cancer gets subjected to these types of policies when she tries to obtain an entry permit; a process that entails dealing with various colonial structures, including the need for an approval from the "Shin Bet". This surveillance agency closely monitors all aspects of Palestinian movement, and "signals" where "good" Palestinians (from the colonial viewpoint) receive a permit. Meanwhile, those who the

Shin Bet sees as “bad” Palestinians receive what is known as “security denial,” and are not granted permits on the premise that they are “a potential threat to Israeli national security.”

The second context relates to physical control, as implemented through military checkpoints. Within these colonial spaces, the control mechanisms are not “individual acts by soldiers at the checkpoint.” Rather, they are part and parcel of the Israeli structure wherein the army imposes its control over Palestinians in the occupied space. Furthermore, this colonial power has developed scientifically advanced techniques to monitor Palestinians within that space. According to investigations conducted by NBC News and Haaretz Newspaper, an Israeli startup company called “AnyVision” – which receives investments from Microsoft – produces face recognition programs and applications that use the biometric technology to surveil Palestinians, thus enabling them to track the people who appear in live video recordings. This software can also track human targets between different surveillance cameras, and it is considered one of the main applications used by the Israeli Military in the West Bank. A statement issued by the Israeli Military confirmed that this application was installed in 27 Israeli checkpoints in the West Bank with the aim of “developing checkpoints” (Reuters, 2019). This leads us to think about the tight relationship between knowledge and power, seeing that knowledge is an essential component of power relations and is a product of power. Ultimately, knowledge and power are strongly intertwined: Knowledge paves the way for power, and power enhances the means of knowledge (Abdul-Aali, 2015). Thus, knowledge appears not as an abstract or neutral notion, but as a means that produces the kind of knowledge which harnesses people’s subjugation and control under Zionist colonial rule.

In this respect, the logic of elimination was perpetuated as a structural process with different patterns and various policies on the ground, and further enhanced the idea of “punishment” and “surveillance” in this context. In his book, “Discipline and Punish: The Birth of the Prison”, Michel Foucault examines the practices of surveillance and punishment. He notes that such practices were first established in isolated settings, such as prisons, military establishments, hospitals, factories, and schools, and were then applied more broadly as methods of social regulation and control (Foucault, 1975). Moreover, Aurelia Armstrong builds on the theory of how these practices, when exercised on human beings, subjugated them to continuous inspection mechanisms to produce docile bodies (Armstrong, 2021, p.2). In our context, we find that these patterns were used against Palestinians to punish and surveil their individual bodies. Examples of this include acts that Israel defines as “threat to security;” the repercussions of which will ultimately impact the assumed perpetrator’s entire

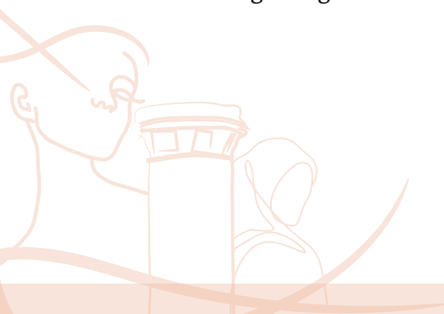
surrounding and extended family (children, siblings, nephews/nieces, cousins, etc.), all of whom will personally suffer the consequences. This type of collective punishment, based on colonial policies, gets manifested in all aspects of one's life, including the need for treatment, travel, and work. There have been various cases where individuals were so fearful of and in need to avoid that "punishment" to the point that they actually started exercising an internal monitoring system against their own selves, families, and surroundings. These persons, who enforced a policy of repression against themselves and their surroundings, were considered "good Palestinians" according to the colonial viewpoint. This transformed many colonized persons into submissive and malleable bodies that may, as per the Zionist logic, become "permissible."

This book shows how the engineering of oppression affects breast-cancer-suffering women's ability to obtain or access treatment due to their association with a Palestinian resistance fighter or for merely being suspected of performing any act that is deemed "harmful to Israeli security." This entails a long and arduous journey for women suffering from breast cancer, who at that point need to resort to human rights institutions and cross borders "illegally," all the while being under close surveillance policies and practices, as they attempt to obtain their right to treatment.

In the second section of this chapter, I have included stories of study participants [i.e., Palestinian women suffering from breast cancer] who had been subjected to harsh colonial policies when trying to obtain radiotherapy, especially since this treatment is unavailable in the West Bank and Gaza Strip. Essentially, these women have been forced to succumb to colonial policies when trying to receive radiotherapy in Jerusalem and within the Green Zone ("1948 areas").

Radiotherapy with a Colonial Flavor

The path to receiving radiotherapy exposes Palestinian patients to various policies that are intertwined and interrelated through a regulated colonial regime. To comprehend this, we must look at these policies comprehensively, and not in an isolated manner. For example, it is not logical to understand why there is a checkpoint at a given place without distinguishing the related roads that allow Palestinian access. This is closely linked to the permit regime, which cannot be comprehended without taking into consideration the relevant mechanism of approval from the "Shin Bet" surveillance agency. Moreover, one cannot understand the subjugation of people to domination without recognizing the essence of the Palestinian indigenous presence on the land, which [in the



colonizers’ mindset] is considered a ‘problem’ that warrants structural elimination.

In a meeting with Rana “S” from the West Bank suffering from breast cancer, the respondent spoke about the “punishment” women patients undergo when given the “security denial” status. Rana also spoke about the intertwinement between this status and other active colonial policies on the ground. She noted the following about the mechanisms and tools imposed against her as a cancer patient:

> **After I finished my chemotherapy sessions in a hospital in Beit Jala[1] (on May 7, 2020), I was supposed to start receiving my radiotherapy sessions the following month (June 2020). Knowing this, I brought my medical papers from Beit Jala [Al-Hussein] Hospital and submitted them as needed to the Palestinian Civil Liaison[2] in Ramallah (which is my city of residence). This was done to receive a permit[3] that will allow me to cross Qalandia checkpoint[4] to reach Augusta Victoria Hospital in Jerusalem. Shortly afterwards, I was contacted by the Palestinian Civil Liaison, who informed me that I must visit the Israeli Liaison[5] in Beit El[6] due to the suspension of civil coordination[7] between the**

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[1] Al-Hussein Government Hospital (also called “Beit Jala Government Hospital”) is one of the 14 Palestinian public hospitals operating in the West Bank. It is in the Bethlehem Governorate.

[2] The Palestinian Civil Liaison is the Palestinian party responsible for implementing the civil and legal aspects of the agreements between the Israeli and Palestinian sides with regards to people’s daily needs, such as medical permits, court cases, prayer/worship, weddings, consular visits, trade activities, work, search for jobs, etc.

[3] A document issued and required by Israel for Palestinians to be allowed to move between the West Bank and Gaza Strip or between the 1948 areas or Occupied Jerusalem.

[4] This is an Israeli military checkpoint located near the town of Qalandia south of Ramallah in West Bank, Palestine. It was established by the Israeli military after the Second Intifada (which started in the year 2000). It is the main checkpoint separating northern West Bank from Jerusalem, and it is one of the few entrances to Jerusalem from the West Bank, where Palestinian movement is strictly controlled within the Apartheid Wall. Israel prevents Palestinians from crossing this checkpoint, except for the residents of East Jerusalem and holders of permits to enter Israel, provided that they are subjected to prior inspection. According to various human rights organizations, this checkpoint is considered one of the most congested and humiliating checkpoints among the approximately 100 permanent Israeli checkpoints in the West Bank, where large numbers of Palestinians from the north and center of the West Bank cross daily to Jerusalem or 1948 areas for work or other reasons, such as worship/prayer and transportation. Therefore, people lose a lot of time on these long humiliating queues. See: http://bit.ly/2O6tEq0

[5] The body responsible for communicating with the Palestinian Civil Liaison regarding permits and ‘security’ denials. Instead of Palestinian residents communicating directly with the Israeli Liaison to receive a travel or medical permit (as was the case before the Oslo Accords), they must now go to the office of the Palestinian Ministry of Civil Affairs, who in turn sends the request to the Israeli Liaison, who then decides whether to approve or reject the application. The Palestinian Ministry of Civil Affairs will then transmit the answer to the Palestinian citizen. See: http://bit.ly/2N58Tue

[6] Beit El is an Israeli settlement located northeast of al-Bireh. It was built on the lands of Palestinian residents of al-Bireh and Ramallah, and it houses the headquarters of the Civil Administration, which reports to the Israeli Ministry of Defense (Civil Administration is responsible for managing different matters related to the West Bank).

[7] This is the used mechanism for information exchange, permit issuance, etc. between the Palestinians and Israelis. For

Palestinian National Authority (PNA) and Israel – after Israel declared its intention to implement the annexation plan. For a period of two weeks, my son went daily to follow up my application at the [Israeli] Liaison Office in Beit El. Eventually, he was told that my application was denied for security reasons.[8] My son objected to that and told them that I am a cancer patient and must receive radiotherapy. However, they rejected his objection and told him that I received denial from the Shin Bet.[9] I contacted Augusta Victoria Hospital, who told me that they will contact the [Israeli] Liaison office in Beit El. I received a permit ten days later, but it was only for one day, which I did not notice at the time. On the following day, I went to Augusta Victoria Hospital and did the mammogram screening (which determines the required treatment's location), and then I returned to Ramallah. I was scheduled to start my first radiotherapy session the day after, so I headed to Qalandia Checkpoint to reach the hospital. Upon my arrival to the checkpoint, a soldier told me: "Go back to Ramallah, you cannot cross this checkpoint!" I told him that I have a permit. He told me to get lost. Then a female soldier came and told me that I must go back and that I cannot cross the checkpoint, under the claim that I have security rejection from the Shin Bet. Then they took my identity card,[10] threw it in my face, and they ordered me to leave the checkpoint. Afterwards, the female soldier told me that my permit was only good for one day and not three months. I went back home and contacted Augusta Victoria Hospital and explained my situation. They assured me that they will try to obtain another permit soon,[11] throughout the treatment period without returning to Ramallah. In the following two months, the hospital kept trying to issue a permit for me. When a permit was finally issued, the hospital reserved a room for me in Jerusalem. I stayed in that hotel throughout my radiotherapy treatment, which lasted for about 40 days. I was all alone during that period and had to shower by myself, which was quite exhausting. I also felt dizzy all the time and would wash my clothes by myself (which was very difficult) because Israel did not grant a permit to my accompanier. For me, the medical treatment journey was accompanied with a

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example, Israel obtains information from the Palestinian side through this mechanism, including data related to newborns, residents, and so on. For more information, see: http://bit.ly/2N58Tue

[8] The security denial (also called "security ban" or "security rejection") is a directive from "Shin Bet" security agency to the issuing party to invalidate or prevent the issuance of permits for people who are considered a danger or potential threat to Israeli national security: https://bit.ly/3ryeR6a

[9] Shin Bet (also called "Shabak") is the internal intelligence agency in Israel. It reports directly to the Prime Minister: https://en.wikipedia.org/wiki/Shin_Bet

[10] An identity card (also called an ID card) is a card that every person carries in the occupied territories. It includes his/her personal information, such as the name, nationality, age, and date of birth.

[11] To remain within what is considered as "Israeli borders" according to the Israeli state without having an approved permit issued by occupation authorities.

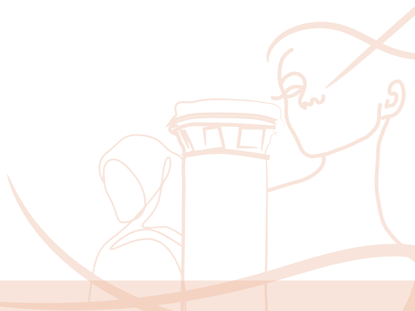
> **trip of punishment and torment. Although chemotherapy is more painful, yet I suffered much more during radiotherapy because I had to live as a fugitive – away from my children and family. Throughout that period, I was afraid of walking the streets of Jerusalem for fear of being asked by a soldier to present my identity card (which would show that I was there without a permit). I used to move in between the hotel and hospital in disguise... I'd receive radiotherapy and rush back quickly to my room.**

The story of Rana "S" shows how one's entrance to Jerusalem requires what Israel calls a "clean record". A person would have such a record if s/he and all his/her family members did not commit any act which Israel considers "harmful to its security." This entry denial ("or non-permission") could be due to throwing stones at an Israeli patrol, participating in a popular demonstration, or for merely sharing a certain opinion or post on social media. The participant's story shows the way in which these policies are implemented and intertwined as a tool of punishment, especially against those who defy the system through resistance or have kinship ties with anyone that Israel considers a "security threat."

The participant also mentioned that she had never been called for interrogation, and she was never arrested. She believes the reason she was prevented from reaching Jerusalem was most probably because there are anti-occupation activists in her family. In this respect, she mentioned:

> **I was raised in a family that resisted injustice and had been politically active for generations. My father saw that Palestine was occupied... We were forcefully expelled from our lands and are humiliated daily. Some of our family members were killed for no reason except for suspicion. I personally had never been arrested or interrogated. Our family simply rejects this Occupation, and I just happen to be a member of that family.**

Another participant in this study had a mother who lost the battle with cancer and died six years ago. This participant explained in detail the suffering that cancer patients and their families undergo due to colonial policies on the ground. Such horrid practices transform Palestinians from being physically and mentally drained individuals looking for their right to be cured into bodies aiming to sidestep these policies by "illegal entry" and tremendous risks. In this regard, she mentioned the



following:

> **My mother and I, as her accompanier, applied for and received an entry permit. I managed to use the permit during my mother's first two sessions. However, on the day of her third session, a soldier at the checkpoint asked me to present my permit and to place it in a window where they check permits and IDs. She then returned and told me [in broken Arabic]: "You do not have a permit, go home!" I told her that my mother is ill, and I must accompany her as she is not in good shape. She exclaimed: "You are forbidden to enter the State of Israel. We do not care whether your mother is sick or not; you are required to go home!" (My mother did not have any other accompanier; I was the one who stayed with her all the time, including at night. I was most aware of her health condition, and she was used to having me around her). My prevention from entry was very hard for my mother. She needed me to accompany her in Jerusalem. She was a cancer patient and needed my support. My mother was in deep grief when she found out that they did not allow me to accompany her. I am very sad until this very day. I knew that she was waiting for me on the other side of the checkpoint under the burning sun and she was very tired. I still cry to this day when I remember how she was waiting for me on the other side of the checkpoint, especially because she was completely shattered and exhausted. Eventually, we lost all hope. They did not allow me to cross the checkpoint in any way. I kept being asked to go see the Israel Intelligence for permission... Shortly afterwards, I contacted a friend from the 1948 occupied territories[12] whose husband helps smuggle Palestinians into Israeli-controlled areas. They told me that it would only be possible to pass through an "illegal" road towards August Victoria Hospital at night, and that all persons present there will be men, and that the smuggling will involve passing through natural passageways.[13] I was also told that I will have to walk a long distance in that passageway before reaching a large plain full of plants and small trees, and that there will be police dogs and Israeli guards there. After that stage, I will reach the separation wall,[14] which I will have to climb up with a rope and jump**

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[12] The territories occupied by Israel in 1948 and 1967.

[13] Narrow passages between two banks of a valley or river.

[14] It is a long wall built by Israel inside the West Bank to prevent the entry of West Bank Palestinians into Israeli

to the other side into Jerusalem. I was told that this trip will be arduous and risky for a girl like me. But since I had no other choice, I decided to face this risk to be with my mother during her cancer treatment. On that evening, we waited in the 'Anata area[15] and gathered next to a familiar supermarket. We then rode on a big bus until we reached the described [natural] passageway. It was so dark that we could only see through the light of mobile phones and small torches. We entered the passageway, and it was pitch black inside. We walked through it for more than half an hour until we reached the end of it. Then we jumped towards a land full of plants and trees. It was a large and illuminated area, surrounded by a fence. We would run for half a minute and then lie face down until the soldiers' searchlights turned off, and then would run and hide again in between their searchlights. We did this until we reached the separation wall. Some Palestinian laborers [who work in Israel] were throwing a rope from the other side of the wall, which we managed to catch and used it to climb the wall. The height of that wall was about two meters, so it was possible to jump to the other side. This was not at all easy, but I did it successfully. It was a nerve-wrecking experience knowing that I could get caught at any moment and get sent to jail, if not killed. I remember how I reached the hospital that night; it was quite late, and my mother had lost all hope of me being with her. I vividly recall how happy she got when I showed up at Augusta Victoria Hospital. After that experience, I would start entering Jerusalem in different ways, such as by the "Zaytouna" entrance point, located between Eizariya [Bethany] and Jerusalem. Can you imagine how I used to sneak in through it? The soldiers would open the gate to let people enter one-by-one and show their permits. As they were busy checking the permit of the

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territories and Israeli settlements near the Green Line. According to Palestinians, this is an Israeli attempt to disrupt the lives of Palestinian residents, as well as annexing more West Bank lands into Israel. The separation wall [also called "Apartheid Wall" and "Annexation and Expansion Wall"] consists of fences and patrol roads. In densely populated areas (such as the Arab Triangle area Jerusalem areas), there was the building of walls instead of fences. The construction of this separation wall started in 2002 in light of the Second Intifada, and its length reached 402 km. in 2006. It passes a winding path and surrounds most parts of the West Bank. In certain places, such as Qalqilya, it forms ghetto-like enclaves, meaning that it led to some towns being surrounded by the wall from almost all sides. The Palestinian National Authority and Palestinian organizations strongly oppose the building of the Annexation and Expansion Wall. See: https://en.wikipedia.org/wiki/Israeli_West_Bank_barrier

[15] The village of 'Anata is located in the northeastern part of Jerusalem and belongs to Jerusalem Governorate. The land area of this village is among the largest in the West Bank, but most of it was confiscated. See: https://en.wikipedia.org/wiki/%27Anata

> **person before me, I would quickly rush to the front. This was a very dangerous technique, but I had no other choice. I learned this from students at Al-Quds University in Abu Dis; this was their method to reach their university. But if by any chance I got caught, I would have gotten arrested. One time, while I was using this method, they caught a guy who was doing the same thing... They beat him up, pointed their rifles at him, and then put him on arrest. I was just behind him when that happened, but I nevertheless took the risk and entered the same way. On another occasion, I crossed the checkpoint using the ID of a friend: She was a university colleague with a Jerusalem ID[16] and looks a lot like me. I remember how it took me more than half an hour memorizing and practicing how to pronounce her name and the rest of the details on her ID, in Hebrew. One other time, I got on the bus carrying a schoolbag: I pretended to be a school student who was sleeping. The soldier stood just next to me, grabbed my bag, and tried to shake me and call me, but I did not respond, so she left. On another occasion, the soldiers caught me next to the town of az-Za'ayyem... They searched me intensively and gave me a beating.**

Besides highlighting the violence of colonial policies on occupied land, this story exposes a type of persistence that transcends the makeup of artificial borders on the land. Within these borders there are gaps, which the indigenous custodians of the land are well-aware of. Israel may keep upgrading its state-of-the-art techniques and instilling agencies of intelligence and information for surveilling and monitoring Palestinians, yet the people will nevertheless create new ways of passage by using different gaps within the land itself. After all, they are the indigenous inhabitants of the land, and therefore they know its most elaborate details!

Another note worth mentioning is that although some women in the West Bank (who need medical treatment but lack a permit) might sneak into or secretly smuggle into Jerusalem through risky attempts, yet women in the Gaza Strip are completely unable to do so. Evidently, the Gaza Strip is an open-air prison under intense monitoring by the Israeli colonial regime, and anyone who needs to leave (for any reason) is required to get an entry permit. Women with cancer, therefore, are up to a long struggle: They will get whatever medical treatment they can in Gaza, and, once this option ends, they will strive to receive a medical referral that might entitle them to go to Augusta Victoria Hospital (in Jerusalem). After receiving the medical referral, they must receive a security approval,

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[16] The space and common life experienced by the residents located in and classified within the city of Jerusalem and its villages and towns (As'ad, 2018).

which is a precondition for getting a permit that may allow them to leave the Gaza Strip and go to Jerusalem. Under this permit regime, Israel decides whether that woman “deserves” to leave the Gaza Strip or not. Najah “M”, a breast cancer patient from the Gaza Strip, explained the difficulties she faced regarding this matter. Although she had received a medical referral, she did not manage to obtain a permit (from Israel) to leave the Gaza Strip through the Erez checkpoint:

> **I obtained a referral to receive radiotherapy at Augusta Victoria Hospital. When it was time for me to leave Gaza, the Israeli side refused to grant me a permit to pass through Erez Checkpoint.[17] I contacted a non-governmental organization in the Gaza Strip to help me leave Gaza to receive treatment. During one of my visits at the center, I broke down in tears and fell on the ground. I am very ill, yet I did not get a permit to go to the hospital. At the time, the manager of the center promised to help me and contacted a human rights organization in Jaffa. They also pledged to follow up on my file until I receive a permit from the Israeli side. However, my permit application was rejected twice, so they then submitted a petition on my behalf at the Israeli court. At long last, I received a ruling that allowed me to leave Erez Checkpoint and reach the August Victoria Hospital. (Gaza, February 2021).**
>
> **A report published by the Palestinian Centre for Human Rights (PCHR) demonstrates Israel’s deliberate denial of permits for Palestinian patients who are in need to pass through Erez Checkpoint to receive treatment in Israel, the West Bank, occupied Jerusalem, and neighboring countries. This exacerbated after an Israeli governmental decision (in September 2007) to tighten the grip on the Gaza Strip and restrict its residents’ movements. These restrictions made the departure of Gaza Strip patients, who suffer from serious and chronic diseases and lack the necessary treatment in Gaza’s hospitals, quite daunting and complicated. The same report states that Israel applies a policy of denying medical travel by distinguishing between “life rescue” (referring to patients who suffer from life-threatening diseases) vs. “quality of**

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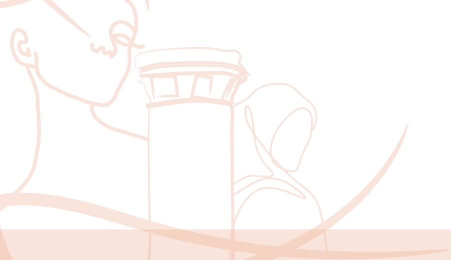
[17] Erez Checkpoint (also called “Beit Hanoun Crossing” or “Erez Crossing”) is in the far northern part of the Gaza Strip, between Gaza and Israel. It is intended for pedestrians and cargo and is under full Israeli control. This military checkpoint is currently being used to transport sick and injured persons for their treatment in Jordan, Israel, or the West Bank. Moreover, diplomats, foreign missions, journalists, Palestinian workers and merchants, and other persons who have a permit use it to cross to Israel. Notwithstanding, this checkpoint is occasionally closed by the Israelis. See: https://en.wikipedia.org/wiki/Erez_Crossing

> life" (which is vague and unclear). The PCHR affirms that Israel uses the latter ambiguous term to deprive hundreds of patients (including those who suffer from serious illnesses) of their right to travel to receive medical treatment. Such deprivation has largely aggravated these patients' health conditions. The PCHR's follow-up activities also indicated that most Gaza Strip patients who are transferred outside Gaza do not have available treatment in Gaza's hospitals. They are referred to external hospitals after exhausting all means of treatment in local hospitals and dealing with medical equipment malfunction and depletion of certain types of medicines and health supplies. Moreover, the Legal Department of the PCHR indicated that, in 2018, the Centre received a total of 811 complaints from patients who were prevented by Israeli authorities from traveling abroad or to the West Bank, Jerusalem, or other areas to receive treatment in hospitals. The said department intervened in this matter and contacted relevant Israeli parties to enable these patients to travel for treatment. Among the requests made by this department, 280 were approved, 208 were denied, and the other applications are still on the waiting list. The Israeli authorities justified these denials by stating that the said treatment is available in the Gaza Strip hospitals, or under the claim that the disease does not threaten one's life – classifying it as a "quality of life" case (PCHR, "Banned from Treatment", 2018). In itself, the principle of "quality of life" versus "life rescue" carries the idea of "punishment and reward" within the colonial logic.

During a conducted interview, study respondent Osama Tanous discussed how a Palestinian seeking to receive treatment must first be considered "innocent". Therefore, it is not sufficient for one to be a human being in need of care to receive treatment. Rather, the right to treatment is contingent on how the colonial powers classify one as "innocent", "harmless", and "non-politicized" (Tanous, America, May 2021). It is even worse for women who suffer from breast cancer, as their entire health condition is determined by Israel's remote decision of whether or not they have available treatment in the Gaza Strip! It basically decides who deserves to live and who deserves to die while it puzzles over what treatment is available in Gaza and what is not!

Another important consequence of these policies is some women's decision to get a mastectomy (surgical breast removal), even at an early stage, as a proactive step to prevent the spreading of cancer cells in the body. Some women may choose to do so due to their anticipation of what might happen to them due to the siege on the Gaza Strip. As they are aware, the blockage will ultimately lead to great



delays in receiving treatment, prevention of travel, and non-availability of medicines. Rima “S”, a breast cancer patient from the Gaza Strip, shared that her doctor advised her to get a mastectomy as soon as possible in order to avoid delays in treatment. She noted the following:

> **I was shocked when he advised me to remove my breast, whereas he gave me a choice between full and partial mastectomy. I told him: “You have baffled me, doctor!” He answered: “You are in the initial stage of this disease, but do you know what will happen? You will wait for a long time to receive a travel permit and you will be greatly delayed, which is definitely not in your favor.” Hence, I decided to have him completely remove my breast in order to avoid delays in hospitals and travel procedures.” (Gaza, February 2021).**

On her part, cancer patient Ghada “M” (also from the Gaza Strip) spoke about her decision to get a mastectomy without hesitation to avoid the complicated procedures related to treatment. She pointed out the following:

> **Although the disease was in its initial stage, I asked the doctor to remove the entire breast. He told me that there are other treatments, but I asked him to do a full mastectomy. I am from Gaza and do not want to wait until the disease spreads all over my body.” (Gaza, February 2021).**

The long-lasting siege on Gaza, along with the Palestinian internal division, led to negative expectations among women regarding potential risks, and several stories spread about women who died because they were not allowed to leave the Gaza Strip. An example of this was Farha al-Fayoumi, who passed away as a result of being deprived of travel to receive cancer treatment outside the Gaza Strip. Consequently, women face several dilemmas due to unjust policies, such as having to resort to radical treatment wherein they would lose an important part of their body, thus abandoning an organ of “femininity” due to the complexity of other treatment methods in their case. This supposed “loss of femininity,” which is stigmatized by society, is an additional form of punishment, and it often overrides the thoughts of finding available treatment.[18]

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[18] This aspect was elaborately discussed in chapter three.

Checkpoint Space: Intertwinement of Colonial Policies

The study participants' stories highlight a major "space," known as "the checkpoint," wherein colonial policies intertwine. In essence, the Israeli military checkpoint is the place of dominant power which "allows" or "denies" Palestinians passage to receive treatment. This process also depends on the presence/absence of security bans, as well as physical searches, ID inspections, iris recognition/eye scans, and others. According to the stories of study respondents, there are two main checkpoints for passage into Jerusalem: Erez Checkpoint (used by Gaza Strip patients) and Qalandia Checkpoint (used by West Bank patients).

During their discussion about checkpoints, study respondents shared the harsh physical inspections and long queues endured in these hostile places. They added that they are also not allowed to carry any water or food during passage. Study respondent and breast cancer patient, Su'ad "A" from the Gaza Strip, described the applied procedures at Erez checkpoint as follows:

> **While passing through Erez checkpoint, the soldier told me to open my legs to be searched while standing. But I could not fulfil her request because I have a cartilage problem in my back. I told her: "This is the furthest that I can bend!" I was also deeply disturbed and emotionally shattered because they took my water bottle and threw away my hormone pills. Fortunately, a Palestinian girl from the occupied territories assisted me. She brought me some water and biscuits and stayed with me throughout the road until I was admitted to hospital. (February 2021).**

During another interview, a breast cancer patient named Amneh "T" from the Gaza Strip spoke about the crossing procedures at Erez checkpoint, emphasizing on the long queues and complicated inspection processes:

> **My husband used to accompany me despite his heart disease (he uses an artificial valve). Young men are generally not allowed to be our accompaniers. We used to wait for a long time at Erez checkpoint because my husband's heart valve device causes a technical alert. Therefore, they would strip off all his clothes and search him for hours as I wait for him. This was such a hassle. My husband eventually told me to start going alone, so I began to go by myself to Jerusalem for my radiotherapy (radiation therapy) sessions. We are also forbidden to take water and food with us. Since I also suffer from diabetes, I**

> **need to carry water and sandwiches with me, but they take them and throw them in the garbage. (Gaza, February 2021).**

Respondent Khadija "A", a breast cancer patient from the Gaza Strip, explained the witnessed procedures as follows:

> **The 'security' procedures were humiliating. The Israelis put me under inspection from eight in the morning until five in the afternoon. During that process, they forced me to take off my clothes – including my underwear – and they tore down my pants. They only left me with underpants, and the [female] soldier asked me to open my legs and hands to take my "imprint". And although I told them that I was not feeling well, they didn't show any sympathy. They subjected me to strict inspection measures despite my health condition. I could not explain my situation to the female soldier, but my husband did because he speaks Hebrew. Nevertheless, they did not show any mercy or consideration. (Gaza, February 2021).**

These testimonies show how the "checkpoint" became a space where violence is perpetrated against women suffering from breast cancer, as well as their accompaniers. This is done through physical inspection that includes forcefully undressing these women and depriving them of carrying any food or drink. The occupier demands that these women would be "submissive" and "abiding" during the physical inspection, forceful undressing, and imposed violence, thus transforming these women from free bodies into ones that are "owned" and dominated by the colonial state. Consequently, everything within the space of the checkpoint becomes the "property" of the colonial state – forcing individuals to abide by its own principles of discipline and compliance to access treatment. Meanwhile, any act that may be perceived as objection or resistance would inevitably lead to the punishment of these women, including assault, detention, and obstruction/denial of passage, thus eliminating the right to receive treatment.

Another practice related to checkpoints was discussed by respondent Aida "A", a breast cancer patient from the West Bank. Aida highlighted the idea of the checkpoint being a humiliating space that allows rapid killings/murder/being a "death trap", as follows:

> **During my treatment period, I had a broken leg. When I reached the checkpoint, I thought that they will allow me to pass easily because of my severe injury. But they forced me to go down the bus and walk with a crutch. I had to remain on foot throughout the inspection procedure and queue, and I was accompanied**

> **by my son and sister. I kept jumping forward with my other leg and felt quite exhausted by the time I reached the checkpoint. When we got there, my sister pointed at my leg to the soldier to show him that I could not walk, and she put herself in great danger by doing so. Only after she approached the soldiers (which was quite risky) and pointed at my leg did they open the gate and allow us to walk forward. During these moments, the soldiers were totally ready for any sudden movement from us in order to shoot us. When I entered the gate, I kept standing. I was in too much shock to walk. I told my sister to take my son and leave. I said that because I sensed we might get shot, especially from the strange way that they were looking at us. My sister and son refused to leave me alone, and I forced myself to walk to the end despite the great difficulty. I was so afraid they would shoot us if we stopped walking or if my son or sister make a sudden move. (Ramallah, January 2021).**

This testimony shows that the "checkpoint" space can be considered a "death trap". Within these narrow spaces, Palestinians are subject to murder in the blink of an eye. Several women were previously killed on checkpoints just because they walked through the lane designated for vehicles instead of pedestrians. Hence, not knowing the correct lane at the checkpoint can be considered sufficient justification to murder a person. Take, for example, the case of the two siblings, Maram Abu-Ismail (24 years old) and Ibrahim Taha Abu-Ismail (16 years old) at Qalandia Checkpoint – north of occupied Jerusalem. On April 27, 2016, Maram and Ibrahim walked through the car lane instead of the pedestrian lane, and this led to their death. Investigations and video recordings showed that the two siblings did not in any way threaten the lives of the Israeli soldiers at the checkpoint, and that Ibrahim was trying to redirect his sister towards the pedestrian lane. However, the soldiers ruthlessly shot and killed the two siblings. It is also worth noting that the Israeli Public Prosecution closed its investigation against the two soldiers [who committed the murder] under the claim that the first was not guilty, and that there was "insufficient evidence" regarding the other soldier.[19]

Another testimony highlights the imminent danger faced by a woman who aimed to go to hospital for treatment and then to pray at Al-Aqsa Mosque and have some food in the city with her son and mother. This is crucial evidence of how women are not allowed to reach Jerusalem even for their right of worship except if they have a permit. This is why the women who do manage to get a permit make it a habit to visit Al-Aqsa Mosque and eat by its external courtyard.

Study respondent and breast cancer patient, Aida "A" from the West Bank, stated the following:

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[19] http://bit.ly/2ZkeYpT

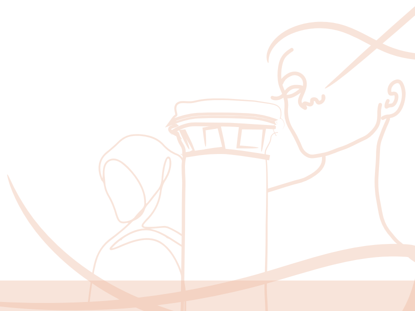
> **One time when I was at the checkpoint with my son and mother, I had some vegetables and canned food with me, and I had put a small knife in the bag to slice the cold cuts later. Fortunately, that bag was with my mother. Once the soldiers found the knife during inspection, my mother lifted up the cold cuts and indicated to them that the knife is for the purpose of cutting that food. Thank God we passed that day. We could have easily been shot or arrested. (Ramallah, January 2021).**

The same respondent spoke about the high state of alert that occurs if for any reason Israeli soldiers get suspicious of a Palestinian at the checkpoint.

On time, they suspected that a person might be carrying a knife, so they completely closed the checkpoint. I waited for a long time, hoping that they will reopen it so that I can pass, but a great state of alert persisted. I knew that if I attempted to approach the soldiers to ask about the time of reopening the checkpoint, I might immediately get shot by them. So, I decided to go back home and informed Augusta Victoria Hospital that I will not be able to make it that day.

This quote indicates that, in addition to the Occupation forces' fixed policies on the ground, there are instantaneous and sudden practices that happen on a daily basis which lead to the closure of checkpoints, high state of alert, and denial of entry for passengers. This means that even if these women could overcome the fixed policies, they are still likely to get prevented from passage due to sudden or urgent policies in subsequent days. A breast cancer patient from the West Bank, Fida' "H", describes the sudden cases that occur at the checkpoint as follows:

> **I often arrived late to my medical appointments due to the checkpoint. For example, when youngsters crowded together at the checkpoint, soldiers would immediately close it before everyone. I personally witnessed how some people who wanted to pass the checkpoint for treatment purposes had to sit on the floor for hours because they could not keep standing on their feet. The soldiers mainly relied on their personal mood and arbitrarily decided when to open or close the checkpoint. If the voice of the alarm is heard during a person's inspection, everyone will have to wait until the meticulous search process is completed, leading to a great delay. The alarm sound usually erupts due to a metallic button (such as buttons of pants); a belt; a watch, or even the metallic heel of a shoe. (Ramallah, January 2021).**



Oftentimes, Palestinian resistance activities happen next to Qalandia checkpoint, leading to its closure and heavy mobilization of Israeli soldiers. Leen “Kh”, a breast cancer patient from the West Bank, explained how the Israeli soldiers entirely closed Qalandia checkpoint[20] after the eruption of clashes following the burning of the Palestinian child Muhammad Abu-Khdeir by Zionist settlers:

> The period of my treatment coincided with the [Jewish] settlers’ burning of Palestinian child Muhammad Abu-Khdeir.[21] Consequently, the checkpoint was completely closed, and strict inspection procedures were imposed after its re-opening. (Beit Rima, February 2021).

Colonial violence (with the revolutionary response countering it) is visible in the public space, specifically on the road linking Qalandia refugee camp with the checkpoint. Practically a battle zone, this road has stood witness to countless shootings and gas canisters by the Israeli forces, as well as burning tires and pelting stones from the side of Palestinians. Such events constantly prompt a “state of alert” that lead to the closure of the checkpoint altogether, and women seeking treatment, as a result, are denied entry. As mentioned by French sociologist Pierre Bourdieu, this field of power is largely structured by the opposition between the “dominating” and the “dominated”, and this force is strongly interdisciplinary (Boutahri, 2020, p.26). In other words, the clash between the dominating checkpoint and the dominated refugee camp constitutes a space for opposition: It creates a space to resist physical domination inside the checkpoint and to demand the end of hegemony exercised over Palestinian bodies in all spheres.

Bypass Roads... Long Turns Between Isolated Areas

The testimonies of several study participants confirmed the presence of the colonial policy of bypass roads. These arrangements, as Elayan al-Hindi, a researcher in Israeli affairs, explains, have divided the West Bank into isolated areas and small enclaves (“Bantustans”) to disconnect the population. Bypass roads were utilized as tools to fragment Palestine and Palestinians geographically and demographically by confiscating and annexing their territories while seeking to erase their people. Ultimately, such methods boosted Israeli hegemony and colonialism (Al-Hindi, 2020). From the

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[20] Qalandia Refugee Camp was established in 1949 on a land plot with an area of 0.35 square-kilometers. It is located about 11 kilometers north of Jerusalem, and the main road between Jerusalem and Ramallah passes through this camp. The refugees of Qalandia Refugee Camp originate from approximately 52 villages within the areas of Lod, Ramleh, Haifa, Jerusalem, and Hebron. Similar to other West Bank refugee camps, this camp was established on a plot of land leased by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) from the Jordanian government. See: https://www.unrwa.org/where-we-work/west-bank/kalandia-camp

[21] Muhammad Abu-Khdeir was a 16-year-old Palestinian child from Shuafat neighbourhood in Jerusalem. He was kidnapped, tortured, and burned to death by extremist settlers on 2 July 2014. His charred body was later found in the forest of Deir Yassin [“Givat Shaul”] in Jerusalem.

procedural point of view, bypass roads obliged many ill women to travel for long hours, while preventing them from using the main roads – that are designated for settlers and prohibited for Palestinians. An example of this is the main road between Beit Jala Government Hospital and Ramallah, which takes about an hour but could take up to three hours for Palestinians who are forced to only use bypass roads. Respondent Leen "Kh'", a breast cancer patient from the West Bank, touched on these obstacles as follows:

> **The road was very long and costly. We spent half a day in transit! The food at the cafeteria was also quite expensive, and the whole process was quite exhausting." (Ramallah, February 2021)**

Rula "J", a breast cancer patient from the West Bank, also indicated that their bypass road was linked to a gate near the entrance of her town Silwad, and that the Israel military would sometimes close that gate and only open it in certain hours. She noted the following:

> **The process of receiving treatment in Beit Jala is more mentally than physically draining, because the road itself is exhausting. Upon leaving Silwad, I sometimes found the gate of the nearby 'Ofra' settlement closed, and they wouldn't open it before 10:00 a.m. The road from Beit Jala to Ramallah would sometimes take three hours, and there is often a lot of traffic at the 'Container' (Wadi a-Nar) crossing." (Ramallah, January 2021).**

Jurist and scholar Raef Zreik explains how bypass roads are a colonial tool of containment, exclusion, erasure, and fragmentation. On the one hand, bypass roads divide villages into two parts, and on the other hand they link Israeli settlements together, thereby strengthening the economy of settlements while weakening that of colonized populations (Zreik, 2012). This wastes the time of all Palestinians, whether healthy or not. It also leads to great physical and psychological pain for Palestinian women who wait for the gate to open before they can access arduous bypass roads to receive treatment.

In the next chapter, I explain how the Israeli military rule and the shelling and raids of its forces have attacked, marginalized, and shut down the Palestinian health sector. I also discuss the neoliberal methods used in administering Palestinian sectors after the emergence of the Palestinian political structure in parallel with ongoing bombardment (especially during the wars on Gaza). I also show how it is impossible to understand the Palestinian health system in isolation from politics, thus clarifying the crisis in the Palestinian health sector as manifested in the stories of women suffering from breast cancer.

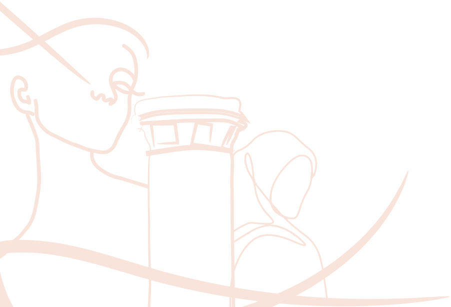
Chapter Two

Engineering of Death: Policies of Controlling Silent Bodies

From Revolution to Institutionalization to Military Targeting

It is impossible to understand the medical situation in Palestine in isolation from politics. The two are connected in such an atypical way that calls for a different understanding of social action (Sari Hanafi and Linda Tabar, 2004). To deconstruct social action with reference to health in Palestine, we must identify the reasons for the failure in establishing a robust Palestinian health system. This chapter tackles this issue and underlines the deliberate attacks of the Israeli shelling and raids against the Palestinian health sector, as well as the military rule's marginalization, closure, and overall neoliberal methods in parallel with the steady bombardments (especially during the wars on Gaza). Having a solid grasp of the ways in which the Israeli occupation targets the Palestinian health system (especially through shelling, destruction, and closures) thus requires an understanding of the broader colonial context that aims to eliminate the locals by destroying the places that seek to rescue, heal, and alleviate their pain.

The Palestinian revolution, which erupted in the mid-1960s, prioritized the liberation of Palestine as its core framework. In parallel with this goal to maintain the perseverance and steadfastness of the people, it established several social institutions. These included the Palestine Red Crescent Society (PRCS), Social Affairs Commission, Social Security Organization, General Union of Palestinian Women (GUPW), Society for the Care of Palestinian Martyrs and Prisoners, Arab Women Union Society, Ghassan Kanafani Foundation, Palestinian Women's Development Society ("Annajdah"), Palestinian Association of Visually Impaired Persons, Higher Council for Youth Care, SAMED (Palestine Martyrs Works Society), General Federation of Trade Unions, and consumer cooperatives (Badran, 1980, p.75). These organizations stood out for being voluntary entities based on individual initiatives and collective/participatory work. Most of them did not have organizational structures or hierarchies but were based on individual initiatives from the standpoint of revolutionary action and public participation. Through these organizations, large numbers of doctors and nurses joined forces to respond to public needs, such as the Palestinian Red Crescent Society (PRCS) and the General Medical Services, in support of displaced Palestinians in refugee camps and assistance to different communities (Badran, 1980, pp.54-65). These medical associations provided services during revolutionary events, where the doctors and medical staff did not dissociate from the events on the ground but were an integral part therein. They were always next to wounded and tortured persons in the streets and alleys of camps and hospitals, and their own lives were subject to torture and killing, much like those in revolutionary combat.



The greatest destruction of hospitals and medical personnel was witnessed during Israel's invasion of Lebanon in 1982, which aimed to disarm the Palestinian resistance and destroy the PLO (Palestinian Liberation Organization) infrastructure. This invasion greatly demolished buildings and establishments and killed thousands of Palestinians. During these attacks, neither medical establishments nor personnel were spared from damage and destruction. In fact, medical personnel were considered an integral part of the infrastructure, and hospitals were thus subjected to Israeli shelling and raids. Numerous doctors, nurses, and paramedics suffered from intimidation, torture, kidnapping, and murder.

Bayan al-Hout documented the night of storming into Akka Hospital in Sabra and Shatila refugee camp in Lebanon on September 17, 1982. She quoted the words of a nurse, Nuzha, who spoke about the incidents she saw in that hospital upon her return that night: "The hospital had caught fire. The curtains were burnt; fridge smashed to the ground; food on the floor trampled underfoot; and glasses were shattered. I saw the broken photo of Dr. Fathi Arafat lying on the ground, bearing traces of trampling by feet. There were also three corpses inside the hospital which were not buried yet. The cafeteria was destroyed and there were traces of eating and drinking. The beddings were pulled out and thrown outside, as several people slept there that night..." (Al-Hout 2002, pp.109-136).

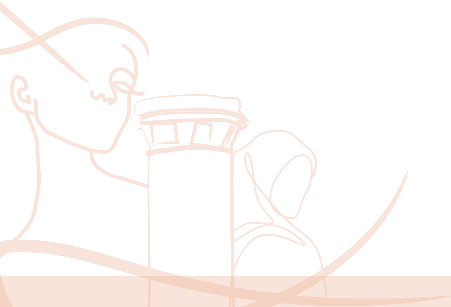
Just a night before the raid, the hospital had housed hundreds of Palestinian refugees who departed at dawn. The only persons remaining at the hospital were doctors and nurses, each of whom had a different fate. Bayan al-Hout presented testimonies from eyewitnesses who saw the torture inflicted upon Dr. Ali Othman: "A young female eyewitness who was there that day saw everything firsthand. She told me how they tormented him in an unimaginable manner. She said the doctor's teeth were broken and thrown on the ground. She saw them dragging him on the floor while he screamed, 'For God's Sake!' Until this day, no one knows what happened to Dr. Ali Othman. They say he was killed, which makes sense, but where is his corpse!?"

Another example of Israel's attacks against medical personnel is what happened to Dr. Sami Khatib. His colleague, Ann Sondi, recounts how he was taken to the main entrance of Shatila and made to stand with his face towards the wall, together with 10-15 other people. When she got closer, Sondi heard him pleading with the gunmen to allow him to return to the hospital, where he was the only pediatrician. The hospital was full of sick children; they needed him there. After that incident, Dr. Khatib and the others disappeared from the area. Ann Sondi heard from some people that someone saw him later at the sports complex, and someone else witnessed the doctor going through great torture before he was killed.

There was another account (from a woman) regarding the murder of three paramedics, who had been transporting a patient to Gaza Hospital in a Red Cross ambulance.: “I saw the loss of Nizar, Jihad, and Ziyad all in one day. They were all killed in that slaughter. Nizar was the ambulance officer, and all three of them were paramedics. They were transporting a wounded person called Hatem, and successfully managed to get him to Gaza Hospital. But on their way back, they were killed in the middle of the road. This was despite their vehicle clearly indicating that it belonged to the Red Cross. It had the red cross sign on it.” (Al-Hout 2002, pp.109-136).

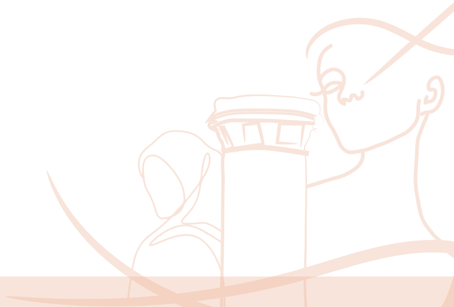
In her novel, Al-Tantouria, Radwa Ashour narrates the life of a family from Tantoura village who were expelled from their land during the Nakba. In the 30th chapter of the novel, the author unfolds events from Akka Hospital. Within that chapter, Abdul-Rahman delves into what had happened to his late father, Dr. Amin, at Akka Hospital on that terrible Friday night. He recounts how the Israelis barged into the hospital several times asking about “some terrorists.” A staff meeting had taken place that morning, between 8 and 9 a.m., for the hospital’s doctors, nurses, and administrative employees. The staff were in a dispute, as some of them stressed that they must leave the hospital while others insisted to remain there. The final decision was to stay. A nurse told Abdul-Rahman that she had pleaded with his father that they must run away, but he laughed off her request and told her he had imagined her to be much braver than that! Only a few minutes afterwards, the hospital was stormed through the emergency gate, and she and her colleagues – along with a child – ran from another gate. From that point on, no one knew what happened to Dr. Amin! (Ashour, 2010, pp. 246-254).

These testimonials show how Israel targets medical spaces by means of attacks and missiles, and help to explain how the settler-colonial structure is aimed at erasing and exterminating Palestinians. In a conversation with Majed Kayyali, we discussed how the Israeli occupation targets Palestinian bodies by attacking health-related structures as primary war targets, meaning that they deliberately inflict pain even after causing injury or during attempts to alleviate injury (Kayyali, USA, May 2021). This has been the orientation of Israel’s continuous attacks against the Palestinian health system, as especially witnessed in the repetitive military shelling on Gaza. For example, during the war on Gaza in May 2021, Israeli warplanes bombarded the city’s Shuhada Al-Daraj Medical Center by launching two missiles from drones. This caused tremendous damage to the health center – to the point that it had to halt its operations. Other health centers – such as one in the north, one east of



Khan Younis, and another one in the middle of the Gaza Strip – had also been targeted. Furthermore, Israeli warplanes destroyed the network of roads linking Gaza's neighborhoods to al-Shifa Hospital, thus impeding the movement of ambulances and delaying the arrival of wounded persons to that hospital. On top of that, the hospitals have been suffering from the stifling electricity crisis. The Gaza Strip in fact lost more than 70% of its energy sources due to the disruption of most electric lines coming from Israel, to the point that there was almost a complete shutdown of the only power station in Gaza. This has forced Gaza's hospitals to constantly run their own generators in light of the scarcity of fuel supplies. (Al-Ayyam Newspaper, May 17, 2021).

After imposing its military rule, Israel applied the policy of linking the health services provided to Palestinians with its own medical structure. Essentially, it has dealt with the "needs" of Palestinians (i.e., resources and budgets) as "grants" bestowed upon the subjects by their master, and not as civil rights (Mustafa, 2016). Researcher Adam Anabosi discusses the role of the Israeli health and medical system in controlling and subjugating Palestinians, as well as isolating them geographically. Among the testimonials he shares is that of an elderly Palestinian woman: When he asked her about how the Israeli Military Governor deals with medical cases that require an exit from one's town for the purpose of receiving treatment, she answered as follows: "My eldest daughter died because she was not given a permit." This happened in 1953, when the girl's father sat all day in front of the Military Governor's bureau, pleading for a travel permit to enable his daughter to access treatment… But to no avail… Leading to her death (Anabosi, 2020). It is worth adding that the Military Government and its civilian wing (which was introduced in 1981, carrying No. 974) aimed to restrict the work of institutions that provided medical services to Palestinians. Among the most important institutions that was severely restricted in this sense, so much so that it was eventually shut down, was the Austrian Hospice. A regular hospital as of 1948, this was one of the most important medical institutions for Palestinians. In a statement issued on January 19, 1984, several institutions and women's associations denounced the Israeli Ministry of Health decision to reduce the number of beds at the Austrian Hospice and to close its Surgery Department. Evidently, such procedures were seen as additional steps towards closing that hospital (hospice), which is precisely what happened. The hospital was shut down by Israel the year after (1985), under the pretext that it was "not up to par" with the required standards of the State of Israel, and that it was not possible for such a small hospital functioning in an old building to provide modern medical treatment at the desired level. Under these pretexts, the claim was that there was no choice but to stop admitting patients or even conducting baby deliveries at this hospital – such decisions were being enforced during a time when this hospital was the main place for treating West Bank and Jerusalemite Palestinians (Society of In'ash al-Usra Archive, 1980-1988).



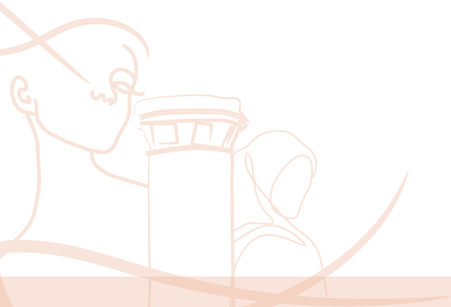
As a result of closures, curfews, and overall marginalization in Palestinian cities and villages, voluntary medical services saw a great resurgence. Researcher Firas Jaber notes that voluntary action "was linked to the development of the Palestinian cause and path towards liberation":

It was in fact quite consistent with it, and this experience reached its peak in the 1970s and 1980s during the First Intifada, when relevant committees recruited tens of thousands of volunteers to perform national and community activities." (Jaber, 2012, p.1).

Such dedicated effort led to the emergence of volunteer-based medical frameworks, such as the Palestinian Red Crescent Society (PRCS), Health Work Committees (HWC), and Patient's Friends Society (PFS). These entities were able to move between different villages, cities, and refugee camps and provided healthcare services to Palestinians. With the outbreak of the First Intifada in 1987, these medical frameworks played a more central role due to the Israeli occupation's excessive forces against Palestinians. Dr. Nufuz Maslamani (a volunteer physician at the Health Work Committees) has spoken up about the horrid incident that took place at the Deir Abu-Masha'al village under siege, where the Israeli forces killed a woman, her husband, and her son just because the woman objected to her son's arrest. Added to that, the occupation forces prevented everyone from reaching the three injured persons to rescue them. Several hours later, all three were found dead in their house. With strong agony and bitterness, Dr. Nufuz describes how she lifted that woman – whose blood was all over the floor –and was unable to save her. (Nufuz Maslamani, Dunya Women's Cancer Center, Ramallah, January 2021).

During that revolutionary period, medical frameworks – both in the homeland and abroad – were constantly targeted with closure and marginalization. Despite the limited resources and capabilities, however, that period was characterized with synergistic health work, and free health services were being provided to Palestinians everywhere. Within the occupied Palestinian territories (OPT), this liberationist approach aimed to break the dependency on and subordination of Israel's health sector, which in turn was being exploited to subjugate, restrict, and punish Palestinian civilians.

In another context, I highlight the subject of health upon the emergence of the Palestinian political regime after the signing of the Oslo Accords in 1993. At the time, the peace talks had adopted the philosophy of "peace in return for security", "economic peace", and so on. As Tariq Dana notes, these accords and their ramifications reinstated colonial structures by "assigning" the Palestinian Authority (PA) the responsibility of providing services (e.g., education, health, and social services)



to the Palestinian population. Meanwhile, Israel tightened its grip on the OPT and maintained full control over every aspect of Palestinian life, including borders, land, water, natural resources, employment, movement, trade, financial administration, industrial zones, and water resources (Dana, 2019, p.69). In turn, the emergence of the PA institutionalized the health and medical spaces under bureaucratic structures, thus leading to the introduction of functional hierarchies, medical policies, and rigid laws and regulations. Consequently, people resorted to privatization to receive quality health services. Notwithstanding that Palestinians in the homeland and diaspora did not, during the revolutionary period, have a private medical sector that provided good health services in return for a fee, yet this sector largely expanded after the establishment of the PA structure. In fact, the private health sector has become most people’s preference for obtaining quality medical services in return for money.

The relation between doctors and patients also saw a transformation: What used to be candid and fraternal during the revolutionary period became, after the PA political structure, more of a “salesperson-client” relationship between doctor and customer, whereas doctors would use their acquired scientific skills under strict regulations. Hence, doctors became more mechanical and “disconnected” in examining patients, dealing with them in a detached manner. In the case that doctors choose to avoid such relations, they will only do so out of sympathy for the patient and nothing more (I do not mean to generalize but this is the general picture).

The Palestinian public has become well-aware of the long queues, waiting lists, and lack of trust dominating the public medical spaces. Although the public health sector has been providing (mostly primary) healthcare services, yet they were nevertheless unable to upgrade their medical system towards providing secondary and tertiary health services. These include tackling malignant tumors, hematology, micro neurosurgery, cardiovascular surgeries, pediatrics, orthopedics, and ophthalmology. This absence constituted a huge problem in the Palestinian health sector, leading to the widespread procurement of the “medical transfer” service. According to a paper issued by the Social and Economic Policies Monitor (Al-Marsad), the Service Procurement item reached approximately 55% of the Total Arrears budget (Abdul-Aziz, 2019, p.29).

In an interview with the Social and Economic Policies Monitor (Al-Marsad), Palestinian doctor and social activist Mamdouh Aker notes that there was a great opportunity to develop the Palestinian health sector after the establishment of the Palestinian political structure. Aker states the following: “It is important to highlight the role of the [Palestinian] Ministry of Health from the very beginning

and the problem related to its orientation. Before the inception of the Palestinian Authority, the main burden of providing [health] services fell upon non-profit hospitals and institutions, such as the Palestinian Red Crescent Society (PRCS), the Arab Women Union Society, and Makassed and Augusta Victoria hospitals. There were no private hospitals at the time. Meanwhile, the Israeli occupation, which dominated the public sector, was not concerned with developing the public health sector. When the Palestinian Authority (PA) came to power after the Oslo Accords, the public health sector became nationalized. This would have required a "quantum leap" in this field, seeing that it was being marginalized for a long time under the Occupation. However, when the PA assumed its authority, they did not show much concern to the health sector in Palestine. Unfortunately, the Ministry of Health sought to provide every single service instead of playing a complementary or partnering role with medical institutions and bodies (these entities were providing services for a long time as medical NGOs and civil society organizations). In this respect, instead of building on previous achievements, the Ministry focused on expanding government hospitals and providing services similar to the aforementioned associations – as if they were competing with them in services that were already present! The public health sector should have used the older medical frameworks as a strong base to leap forward and build upon previous achievements, but this did not happen." (Al-Marsad, Interview with Dr. Mamdouh Aker, May 26, 2018).

This shows that there was a golden opportunity to build upon the achievements of older medical frameworks and to create strong partnership between the existing medical institutions and the public health sector. But (unfortunately) this did not happen. Instead, the new political regime aimed to build public health institutions that monopolized all health services without providing better quality. Their idea was to take over all services instead of cooperating and partnering with other medical frameworks. Consequently, the private medical sector came as an alternative to poor public medical services; it thus became considered an opportunity for receiving accurate diagnoses and good treatments –otherwise unavailable in public frameworks (note that government medical institutions have a low level of public trust).

By and large, a voluntary and synergistic/collective spirit reigned over the health sector during the revolutionary period. After the PA's institutionalization process, however, this sector became materialistic, and staffed mainly "mechanical" employees carrying out administrative regulations. This orientation was greatly encouraged by the superpowers; donor community, World Bank, and International Monetary Fund (IMF), who promoted their vision for building the Palestinian State.

However, this vision was closer to what Toufic Haddad describes as “Palestine Ltd.”, where the harmful philosophy of many Western donors and global financial institutions seems to prevail under the pretext of “development” and “achieving peace” (Bab El-Wad, 2017).

According to author and researcher Iyad al-Riyahi, international donors in the last twenty years played a major role in shaping a new reality and orientation in the local arena. This led to vast changes in the modus operandi of political actors and NGOs in Palestine. Among the greatest transformations was the introduction of the “Good Governance” concept, which was used to advance financial reforms and combat corruption, all the way towards demanding changes in the PA’s security and political system towards unifying and restructuring the security services (al-Riyahi, 2016). Within this context, Raja Khalidi and Sobhi Samour highlight the importance of ensuring public security and the rule of law (Khalidi and Samour, 2011). Added to this has been the significance of establishing a free-market economy, and setting the legal framework to regulate the Palestinian economy and economic relations between Palestine and Israel (Roy, 1999, p.68). These elements generated the “prioritization” philosophy, promoted by Western donors, which gave preference to the security sector and free-market orientation at the expense of other vital sectors (such as education and health). This led to a shortage in health and educational budgets by which to supply good services to the community.

Another point worth considering is that most countries have sought to support Palestine’s health sector out of political considerations. On this note, Sari Hanafi and Linda Tabar indicated that the single medical contribution of the United States Agency for International Development (USAID) pertains to “Family Planning”! As a medical worker sarcastically commented (during an interview): “There are two methods to control population growth in Palestine: One is through Apache warplanes, and the second is through Family Planning programs!” (Hanafi and Tabar, 2004). Hanafi and Tabar quoted another medical worker who said: “U.S. projects are dictated beforehand, and they later make some aesthetic modifications and hold ‘camouflage-style’ meetings and workshops for the purpose of ‘consultation’. Sadly, they admitted to us they there is a ceiling of maximum adjustments that they cannot overrun ‘because some decisions come directly from the U.S. capital.’ Knowing this, we decided to take part in the project only on the design level, to shift the geographic areas of priority.” (Hanafi and Tabar, 2000). In this sense, donor agendas limit the role played by local bodies due to preprepared directives. Consequently, these factors have gone beyond health and medical policies; they included the practice of “social engineering” where the colonizer (with its anxiety about growing Palestinian populations), brings into effect a demographic superiority. Meanwhile, the agendas of

external actors focus on limited programs that disregard intractable diseases, especially tumors – the essence of which cannot be disconnected from colonial structures. It is also not possible to understand donor agendas and their concern about reproductive health and family planning in isolation from colonial structures.

Moreover, most foreign donor states impose funding requirements that stipulate the condemnation of “terrorism”. Nufuz Maslamani elaborately spoke about the problematic requirement of donor countries that a document for “renouncing terrorism” be signed before they provide any funding. Maslamani gave the example of an American doctor who had wanted, for a long time, to donate $10,000 to Dunya Women’s Cancer Center but was not allowed to do so under the pretext of “terrorism”. Ultimately, foreign organizations require that Palestinian beneficiary institutions sign the “renouncing terrorism” document before receiving support, yet reading the details within that document makes one’s rightful national struggle appear as “terrorism”. The cancer center has thus refused to sign such a document, which has substantially decreased the incoming aid even though it is an integral health institution that is in no way politicized. The health center is able and willing to provide donors with all necessary details and medical reports, but it won’t dare fire a staff member for getting arrested by the Israeli occupation forces.

It is also worth adding that international health associations, such as WHO (World Health Organization), have been assessing the health situation in the Palestinian territories without holding accountable the global and colonial structures or considering their own interests or contribution to oppression (Kayyal, 2020). Accordingly, the determinants of illnesses were confined to mere details superficially described in annual health status reports.[22] The 2018 WHO report on “Health Conditions in the Occupied Palestinian Territory, including East Jerusalem and in the Occupied Syrian Golan” clearly shows that the central role of this organization is supervision and follow-up. Meanwhile, its first strategic priority for Palestine was aimed to “contribute to strengthening and building resilience of the Palestinian health system and enhance Ministry of Health leadership to progress towards universal health coverage.”[23] It also highlighted strengthening data collection, improving the level of health services through supporting the family practice approach, and upgrading the quality of healthcare through the implementation of the Patient Safety Friendly Hospital Initiative. Also, regarding the Gaza Strip, the World Health Organization emphasized on enhancing neonatal care

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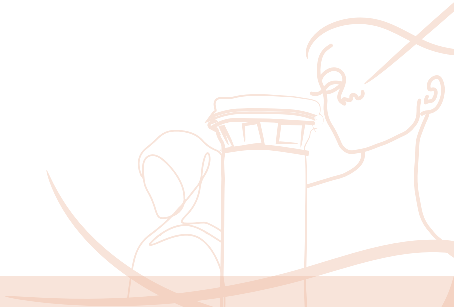
[22] See: “Health Conditions in the Occupied Palestinian Territory, including East Jerusalem and in the Occupied Syrian Golan”, published by World Health Organization (WHO) in 2018.

[23] “Heath Conditions in the Occupied Palestinian Territory . . ..” (WHO), 2018. https://bit.ly/47HZY7c

at hospitals, along with its related policies and guidelines. In other words, the health problems in Palestine were reduced to superficial aspects such as training, preparation, and quality improvement –without holding the colonial structures accountable for harming the local medical institutions by means of military attacks, killing of civilians, and use of prohibited weapons. This shortcoming is largely due to the biased perspective of donor countries which set their priorities under certain considerations and stipulate conditions for funding health sectors.

These kinds of health interventions are customary for external donors that are backed by powerful countries. Take, for example, the quotes of Professor Dr. Howard Waitzkin from the Department of Sociology at the University of New Mexico. In his book, Health Care Under the Knife, Waitzkin explains how the Global South adopted the vertical healthcare approach in the 1990s (as based on certain treatment interventions to address specific diseases) instead of adopting the comprehensive horizontal approach, which focuses on primary health care as defined at the international conference of the Alma-Ata Declaration of 1978 (under the influence of socialist states at the time). According to Waitzkin, the vertical healthcare approach was reinforced after the World Bank infiltrated the World Health Organization (WHO) during the financial crisis that the latter faced in the 1980s. This was especially after the Reagan Administration, when large amounts to be paid from the United States to the United Nations were withheld due to its ideological disagreement with several programs run by UN agencies. Waitzkin added that WHO decided to adopt the vertical healthcare approach in the 1990s, and this was further strengthened with the support of "philanthrocapitalist" organizations, such as the Bill & Melinda Gates Foundation, which remained a main funder and supporter of WHO and its programs in the 21st century. Such examples show how far the World Health Organization can go in its medical directives due to their subjection to what Waitzkin calls "philanthrocapitalism." (Jarrar, 2021).

Global medical frameworks (such as WHO) must hold Israel's colonial structures accountable for their detrimental role, as well as to monitor Israel's perpetrated violence against Palestinians. It is crucial that they move past "developmental" instructions and consider the influences of such colonial structures, and in no way should they look down to Palestinians as people who need "awareness" about how to do things! It is true that the role of WHO is not to solve the aforementioned problems, but it should at least call for upholding certain values and principles, and raise questions beyond asking for investigations or achievements. Does such a goal have a chance under the dominance of capitalistic philanthropy?



In my opinion, the Palestinian political structure could have learned from Cuba’s experience vis-à-vis the health sector after the revolution, whereas health was one of the main demands and gains of the revolution. As researcher Shaker Jarrar clarifies, the Cuban Constitution stipulates that the State must guarantee the right to healthcare by means of providing: free medical care in hospitals, a network of rural medical services and clinics, preventive and specialized treatment centers, and free dental care. This goes along with promoting public health campaigns, raising awareness on health education, conducting regular medical check-ups, providing vaccinations, as well as taking other measures to prevent the spread of diseases… It is thus the State’s responsibility to guarantee access to healthcare for all equally and provided free of charge, unlike the case before the revolution (Jarrar, 2021). With that said, Cuba’s new political structure nevertheless subjugated the health sector to capitalist laws and provided medical services without upholding all persons’ equal right to healthcare. Meanwhile, the private medical sector expanded disproportionately, so much so that it greatly influenced the collective perception in the search for “accurate” diagnoses and treatments. In most cases, the richer groups resort to the private medical sector and get “decent” service, while those who do not have the financial means or need high-cost treatment must stand in long queues and waiting lists. This created a gap between social classes, not only in terms of “rich and poor” as seen in many communities, but also in terms of “proximity” to power (i.e., the new political regime). In this respect, the parties close to the regime became the new elite with substantial influence (e.g., in bureaucracy) and personal interests.

On the Palestinian level, the transformations which accompanied the new political structure created a difficult medical situation, much of which was due to the neoliberal directives of powerful external agents – to say nothing of Israel’s military bombardment, marginalization, closure, and blackmail against Palestinian medical institutions and health facilities. The next chapter describes this poor medical situation as seen in the stories of women suffering from breast cancer.

The testimonies of women participating in this study thus bear witness to the health sector crisis. Our aim has been to deconstruct and analyze this issue by listening to the experiences and accounts of the women themselves, for they, (well beyond the “expert”’ standpoint), are the most capable of explaining the intricate details of their pain and suffering.

Absence of Approved Medical Protocols in Palestine

The statements of women respondents showed that, until now, there are no approved protocols in

Palestine regarding the diagnosis and treatment of breast cancer. In fact, most accounts indicated that the existence of a cancerous lump was discovered by pure chance through self-examination and feelings of suspicion. It was also found that different people had different interpretations regarding these lumps/swelling, not to mention the weak medical system and poor performance of medical teams. The following points were highlighted by the respondents:

Coincidence ("Pure Luck")

Several respondents discovered their cancer infection by pure chance and not through early detection criteria adopted by the Ministry of Health and applied to all women in Palestine. Most breast cancer patients discovered their infection through self-examination. One of the participants, Safiyya "R" from the West Bank, who was diagnosed with breast cancer, stated:

> **"I was forty years old in 2013 when I did a self-exam. To my surprise, I felt a lump in my breast. I went to Dunya Women's Cancer Center, where they performed some examinations. The results showed that I had cancer!" (Ramallah, January 2021)**

Another breast cancer patient from the West Bank, Samar "Q", noted that she discovered the disease by coincidence:

> **"One day, I felt a lump in my breast, but I forgot about it. Two months later, a relative told me that she wanted to do a breast exam, so I decided to go and do it as well. I went to a public health center in al-Bireh, and they were suspicious of a lump. Afterwards, it was proven that I had breast cancer." (Ramallah, February 2021)**

This is consistent with the testimony of Raeda "W" from the West Bank, who was also diagnosed with breast cancer and mentioned the following:

> **I discovered my lump (swelling) by chance. I used to work with elderly people and often felt dizzy and tired. I tried to take care of my health but kept feeling dizzy and had low blood pressure. I took a lot of iron supplements and visited a doctor in 2016. She told me to get a mammogram test, which I did, but it did**

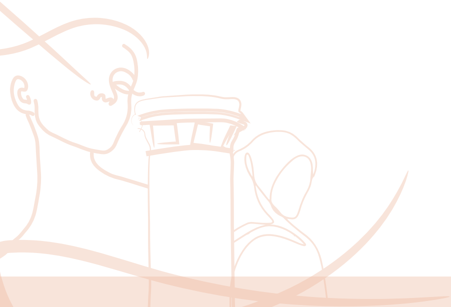
> **not show any lump or tumor. I visited an orthopedic doctor, who asked me to get an x-ray. He told me I have a herniated disk. However, my hair and body started deteriorating and my gynecologist was surprised to see that I have a tumor according to the mammogram test!" (Ramallah, January 2021)**

On the other hand, there were some cases of discovering breast cancer through individual awareness initiatives. Ghada "M" from the Gaza Strip, who was diagnosed with breast cancer in 2016, spoke about an initiative which took place at a mosque. In her words:

> **"I was having intense pain in the chest. During that period, a woman visited us at the mosque and spoke to us about breast diseases. I was encouraged to get an examination in Gaza's government hospital, and then they asked me to get a biopsy at Nasser Hospital." (Gaza, February 2021)**

Meanwhile, there were some cases of early discovery of the disease due to awareness campaigns. Breast cancer patient Aida "A" from the West Bank mentioned early detection campaigns, in which short-term announcements encourage women to take breast examinations. One such campaign, carried out by the UNRWA clinics in the West Bank, related to early detection of breast cancer. The respondent noted that, had it not been for these campaigns, she would have been dead by now. She had not at all suspected that she might have breast cancer, she shared:

> **"I once visited an UNRWA clinic in al-Am'ari refugee camp to get some medications. However, the medicine I was looking for was out of stock. As I was leaving the clinic, I came across a mobile breast cancer clinic, so I went there, and the nurse there performed an examination. The look on her face was quite peculiar! She asked me if I had any problems in my breasts?! I said 'yes,' and mentioned having had problems when breastfeeding my infant five years ago. Intuitively, I felt that the results would be linked to what I experienced before. She asked to do another breast screening, which showed the exact same result (two lumps in the breast). The doctor later told me that I have the most severe form of cancer, and that it has been there for at least three months. He added that if that cancer spread a few more months, I would have been in the grave by now!" (Ramallah, January 2021)**



Such initiatives and campaigns are necessary when the State's role is confined to "medical" organizations and limited to providing treatment vs. early detection. Dr. Nufuz Maslamani noted that breast cancer is no longer considered a fatal disease, seeing that early diagnosis could most likely lead to full recovery. This highlights the importance of diagnosing this disease. After all, a woman might have cancer spread throughout her body before she discovers her infection. Another point to be wary of is that even in cases where a lump is discovered, doctors might provide different interpretations regarding the cause of that swelling, without having agreed-upon standards or medical procedures by which to deal with such indicators.

Differential Diagnosis

In some cases, a woman suspicious of breast cancer might be told by the doctor not to worry and to "go back home". Dr. Maslamani recounts how a woman from a village near Ramallah went to the local doctor after feeling a lump in her breast. She was told that this lump is due to hormonal changes and was reassured by the doctor. However, the disease spread quickly throughout the patient's body, leading to her death. Dr. Maslamani stated the following:

> **"I have seen some cases of cancer where the fault lied completely on the medical staff. We had a 37-year-old patient who said that she went to a doctor telling her that she has a lump, but the doctor said it was too small, and that it is not good to perform a mammogram scan. Shortly afterwards, the woman became pregnant and her hormones changed, leading to the lump's growth. The woman went back to the same doctor, who told her that the lump was due to pregnancy. After two and a half years, the woman came to Dunya Women's Cancer Center, but by that time, the disease had spread throughout her body. She passed away six or seven months later...**
> **When we communicated the result to her, she got worried to pieces about her two-year-old daughter... It was so unsettling that we tried to console her with religion to enhance her patience, telling her that God is the healer... We wanted her to be at peace and comfort... She had a young son who used to accompany her to our center. Whenever she visited us, she would bring gifts of fresh olive oil, thyme, and vegetables. We do not accept gifts, but she used to insist... After**

> **a while, there was no more news from her... Her son visited us a few months later with a bottle of olive oil and thyme in his hands, as well as ten dinars and seventy shekels. He told us that his mother passed away and that she loved us a lot, and that this was a gift upon his mother's request... His mother had asked him to donate that money to the center... I was really affected by this woman's story because she had visited doctors beforehand, but they were the ones who did not diagnose the lump correctly. There must be standard national procedures and a law which obliges all doctors to follow these procedures. All lumps must be properly diagnosed according to approved national protocols."**

Another testimonial about the misdiagnosis of cancer was made by cancer patient Amira "M" from the West Bank. She explained her case as follows:

> **"I was pregnant with my sixth child. During my fifth month of pregnancy, I felt a strange lump in my breast. I immediately went to the doctor who was following my pregnancy and told him about it. He made an examination and confirmed the presence of a lump. He then sent me to a radiology center to perform a test. In that center, they told me that I have a small lump but that it appears to be benign, and since I am pregnant it might stay or disappear after giving birth, so they advised me to wait... I gave birth to my child and breastfed him for two years. However, the lump (tumor) kept growing! After two years, I went again to that center, and they said that there is no tumor. But I kept wondering why I had such terrible pain, which I endured for five years without any help! The tumor kept growing until its size reached 6 cm in two places in my breast! It even reached the lymph glands and the liver... When I discovered the disease, I was already in Stage III Cancer!" (Ramallah, January 2021)**

A similar misdiagnosis was suffered by Khadija "A" from the Gaza Strip:

> **"A year ago, I was suffering from fever and kept shivering. I went to an UNRWA clinic, and they transferred me to the Khan Yunis clinic. I remained in the same condition for a whole year before I got some examinations at Khan Yunis Hospital. I kept complaining about terrible pain, but to no avail. The doctor**

> **there told me that "it is just a small lump; it has no effect" and to "just go home and do not worry". I told him about my fatigue and high temperature, but he confirmed that there is no reason to worry. I kept going to that hospital for a whole month but in vain. A short period afterwards, a woman told me that this lump is very worrying. I went to a different doctor, who said that this lump is serious and must be immediately treated. He transferred me to al-Shifa Hospital in Gaza, which is where they took the first sample. They called me directly after having the results, telling me to come immediately to hospital in order to have the lump removed before it spreads further. This was during the first wave of COVID-19 in Gaza. The hospital did another biopsy and confirmed that I must undergo an operation." (Gaza, February 2021)**

Hana' "S" from the Gaza Strip also mentioned the "misdiagnosis" problem, noting the following:

> **"I sensed a lump in my chest and went to the doctor. I got a biopsy at al-Shifa Hospital in Gaza, but it was not successful. So, I went to a private hospital and got an examination, which cost me 500 shekels. When I felt the presence of a lump, I went again to al-Shifa Hospital. However, the doctor there told me that the tumor is benign and released me. May God forgive him [and may his soul rest in peace]: the lump was not at all benign. It was a malignant cancer!!" (Gaza, February 2021)**

Rana "S" from the West Bank had a similar misdiagnosed breast cancer experience:

> **"I felt the presence of a lump, so I went to the doctor. She told me not to be afraid and that female hormones sometimes cause such lumps. I went back home but didn't feel at ease. Three days later, I went to another doctor, who gave me the same results! He told me that it could be due to the hormones and that I should wait, so I did. Later on, I went to a third doctor, who made a radiological test. The doctor confirmed that I have a lump and gave me its measurements (it was still small at that point). He advised me to see a surgeon who can properly determine the lump's nature. I visited a fourth doctor, who is a surgeon, and he performed an on-site examination. He then asked me to get a mammogram scan, which actually showed something strange…" (Ramallah, January 2021)**

Such misdiagnoses of the nature and condition of the lump, especially in the absence of standard protocols for dealing with breast cancer cases, caused the death of many women. It is vital, therefore, to take into consideration the contexts of cancer patients. As Nufuz Maslamani explains, every woman in Europe above the age of fifty years old will annually undergo a mammogram scan, whereas most breast cancer cases in Palestine are among women aged 40-50 years.

Treatment Problems

Dr. Khaled Sharaf, a specialized surgical oncologist, mentioned the problems of breast cancer treatment as follows:

> **"In Palestine, if a woman sees an oncologist first, s/he may give her chemotherapy. Meanwhile, if she sees a surgeon first, s/he might perform a lumpectomy operation and then ask the oncologist to complete the patient's treatment. This is a wrong approach; the medical staff must collectively determine the overall cancer treatment in order to devise a correct treatment plan for the patient." (Jerusalem, January 2021)**

Dr. Khaled Sharaf added that lumpectomy and mastectomy operations are performed by general surgeons in Palestine instead of surgical oncologists specialized in breast cancer. In his words:

> **"There is no doctor specialized in breast cancer surgery throughout the West Bank. Therefore, the patient goes to the general physician, who will refer her to a surgeon. But the surgeon should in no way be the one to make medical interpretations in this regard! I am a surgical oncologist, specialized in breast cancer, and have been in Palestine since December 2019. Unfortunately, however, I did not get much support from any local institution or ministry. I went to Ramallah Governmental Hospital; I met its director and gave him my professional papers to have them authorized by the Minister of Health's bureau. But when I inquired about that cooperation, the hospital director apologized and told me that there are already two surgeons in that hospital.**

> **This is based on their assumption that any surgeon can perform tumor removal operations, but what about using the most professional mechanisms by which to remove the tumor with the least damage to the breast?! A plastic surgeon only knows about breast tumors in a general, mostly aesthetic, point of view, and might assume that mastectomy is the right treatment. But this person is not a specialized oncologist and does not know there are optimal ways to avoid that. Augusta Victoria Hospital is the only hospital that adopted effective cancer treatment mechanisms. We at the hospital have proceeded to support patients in breast reconstruction, seeing that the Palestinian government does not cover that cost. It is the right of every cancer patient to have her breast repaired, yet, until now, the Ministry of Health has refused to provide that support. This is surprising, especially since the Minister of Health is a woman. One would think she would have been more understanding and supportive of this issue"**

As for applying the correct method to treat breast cancer in the absence of national protocols, Dr. Khaled Sharaf noted:

> **"In the United Kingdom, the order is as follows: The patient goes to the family doctor, and, if something is confirmed, the latter refers the patient to a breast surgery clinic in a public hospital, where the patient immediately undergoes an examination. If the presence of a lump [in the breast] is confirmed, a biopsy is done on the same day. In 90% of cases, these medical procedures are done during the same visit. The result is reached after approximately 10-14 days. However, the patient is not notified (about the result) until after the medical team have a joint meeting and full discussion. After that, the patient returns to the clinic and is informed of the result and the agreed-upon treatment plan. In other words, all decisions are taken collectively and unanimously!"**

This coincides with the statements of Dr. Nufuz Maslamani, director of the Dunya Women's Cancer Center, who pointed out that:

> **"Breast cancer treatment should involve more than one doctor. It must include an entire team: A radiologist to diagnose and determine the place of the lump; an oncologist to prescribe the chemotherapy; a surgeon to remove the lump;**

> **and a histologist to determine the types of tissues. All of them must work together as a team and should collectively formulate a treatment plan. This complementarity is highly needed, and must be followed up with physical therapy and psychiatric support." (Ramallah, January 2021)**

Therefore, the adoption of a Palestinian protocol would be crucial to determine the mechanisms and standards for diagnosing, treating, and checking up on Palestinian women suffering from breast cancer. Such procedures would thus minimize misinterpretations and "sudden" discoveries. The failure to theoretically and practically adopt such protocols has insofar led to major distrust and hesitation among breast cancer patients of public sector services.

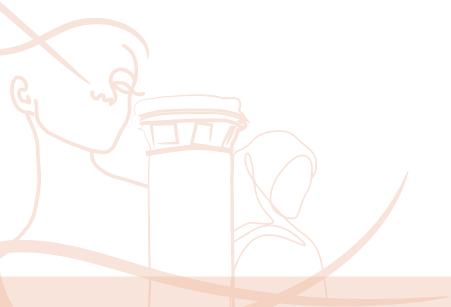
Lack of Trust and its Manifestations

The study statements indicated general skepticism that surfaced among respondents. This was due to several factors, the most prominent of which was the lack of specialized oncologists to tackle their cases. In fact, there were no oncologists, and hardly enough staff members (such as radiologists and surgeons) in public hospitals until early 2020. What further exacerbated the situation were the long and complicated procedures in distant locations: The doctor would be in one building, the lab in another, and radiology department in a third building – all the while the patient moving between far-away buildings. This led to much distrust among cancer patients who found themselves stuck in long queues, waiting times, and poor treatment services.

Long Queues

For Palestinian women, standing in queues has become synonymous with receiving treatment in public hospitals and medical centers. Seeing an oncologist in a public hospital, for example, would require patients to visit the hospital ahead of time and make an appointment (which could take 7-14 days). After booking the appointment, these women must go to the hospital early in the day to re-book the appointment that had been previously reserved by the same persons.

What intensifies the gravity of this situation is the contractual relationship between oncologists and the Ministry of Health, whereas oncologists were hired as part-time employees with only one or two workdays per week. Consequently, oncologists are required to see approximately 50 patients per



day! Dr. Nayef Kasbari, who works as an oncologist at Ramallah Governmental Hospital, stated the following regarding this matter:

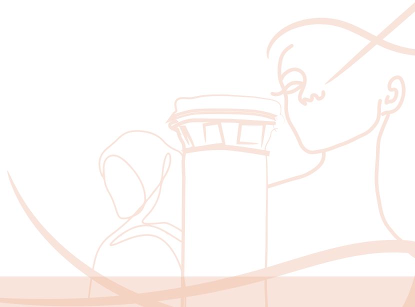
“The number of patients is significantly high. At times, I have to treat approximately 50 patients per day at Ramallah Governmental Hospital! With such a substantial number of patients, it is impossible to effectively treat every patient, not to mention the patients in hospital beds and those receiving consultation. Before 2020, Ramallah Governmental Hospital only had a hematologist and no oncologists. The hematologist’s role was to coordinate the requests for medical examinations. Finally in 2020, the hospital hired an oncologist, but there remains a great shortage of oncologists. There is also a shortage of radiologists, as there are only two radiologists in Ramallah Governmental Hospital.”

Due to the shortage of oncologists and radiologists, cancer patients need to wait about two weeks to visit an oncologist or get an X-ray. Moreover, they need two additional weeks to get the radiograph results. Marah Amro, a psychological support officer and social counsellor at Dunya Women’s Cancer Center, referred to the long queues as follows:

> **“When a woman is diagnosed with cancer after performing a biopsy in our center, she usually goes to a public hospital to receive treatment. In these hospitals, she must wait for about two weeks before undergoing a CT scan. She then must take that scan to a radiologist outside the hospital to have it analyzed, which could cost up to $100. Otherwise, she would have to wait another couple of weeks for the hospital to take more scans and bring a doctor to analyze them.” (Ramallah, January 2021).**

Moreover, breast cancer patient Fida’ “H” from the West Bank stated the following:

> **“We usually go to the Radiology Department and book an appointment, which could entail a two-week waiting period. One time, I had to wait a whole month to undergo a radiological test! After getting a radiograph, one must take yet another appointment and wait for at least two weeks to receive the related report and analysis, whereas the Radiology Department prepares a number of scans and brings a specialist to analyze them altogether.” (Ramallah, January 2021)**



Medical laboratories also entail long queues, as patients have to wait a long time to get a blood sample and must book an appointment to get its results. Breast cancer patient Rula "J" from the West Bank highlighted this point:

> **"Whenever I visit an oncologist, he will ask for further examinations, all of which require booking an appointment to draw a blood sample. There were times when I had to wait in line for six hours to provide a blood sample, and then be asked to come back later to get the results." (Ramallah, January 2021).**

In this respect, the time factor has serious ramifications regarding the spread of cancer in these women's bodies, not to mention the emotional stress of waiting for the test results. Within this context, we must note that, according to the local culture, the word "cancer" is synonymous with "death" [thus intensifying the patient's stressful emotions].

On her part, breast cancer patient Maysar "H" from the West Bank mentioned that, according to people's perceptions, long queues have become an inherent trait of receiving medical treatment – so much so that they cannot imagine getting treatment without standing in queues and waiting for long hours. The public health sector's poor services have thus forced many people to find private sector alternatives. As Maysar "H" pointed out:

> **"People realize that public hospital doctors are overwhelmed and drained by the huge number of daily examinations. They neither have the time nor energy to duly treat every patient. This differs from the private sector, where the patient receives more care and better treatment due to the 'cash.' As a result of long queues and waiting time, I sought a private medical center and underwent the cancer operation at my own expense, thereby paying a substantial amount of money." (Ramallah, January 2021).**

This is similar to the experience of breast cancer patient Hana' "S" from the Gaza Strip, who stated that:

> **"The doctor told me that I had to get a biopsy. I asked him: "Where?!" He said:**

> **"At al-Shifa Hospital… which will take a long time, but if you have enough money, I advise you to go to a private clinic." Since I could not wait a whole month to get examined at al-Shifa Hospital, I decided to go to a private medical center in Gaza to avoid the long waiting time between hospital visits. I was feeling quite sick and mentally exhausted, so my husband asked me to get a CT scan… to feel reassured. The result showed that I have a malignant tumor! I showed the report to a private oncologist, and he confirmed the presence of a malignant tumor that must be treated as soon as possible! My case was quite urgent. My husband refused to have me wait for my turn and had me undergo the needed operation at his own expense so that I could recover. The operation cost us a thousand Jordanian dinars (approximately $1,400), noting that we have financial dues, such as our children's university tuition and house construction expenses. But my husband ignored all the said payments to cover the treatment costs. Unfortunately, cancer patients receive poor medical treatment in public hospitals, where the doctors cannot detect several types of cancer and do not listen to patients (as they are overwhelmed). Private clinics are much better, as public hospitals are also overcrowded and provide poor medical services." (Gaza, February 2021).**

The two above-mentioned cases show the difference between the orientation of the revolutionary era and that of the "institutionalization" era. In the latter, quality health services are not provided to all equally (as per their inherent right) but to those who can afford them. On the other hand, the revolutionary era generated popular medical frameworks to serve all Palestinians without the "good services in return for money" concept. The private sector only emerged as a powerful axis after establishing the PA political structure following the Oslo Accords. Sami Musallam, former General Director of the Office of late President Yasser Arafat, explained how the Palestinian revolution in Lebanon had established six hospitals, providing free health services for all Palestinians, as well as for hundreds of Lebanese citizens who could not afford going to Lebanese hospitals (March 2021).

Also during the revolutionary period, the OPT saw the establishment of new medical organizations (such as the Health Work Committees, Society of In'ash al-Usra, and Red Crescent Society), which successfully operated in various marginalized and remote areas and provided medical services to all Palestinians. However, this feature greatly changed with the emergence of the PA political structure, as the work soon shifted from a collective to an individualistic orientation, thus promoting a "hybrid"

economic approach whereby the international communities' and donors' neoliberal priorities took charge. Such policies circulated around the free market economy, economic liberalization, privatization, and other capitalistic concepts. Considering these changes, the public opinion became in favor of private hospitals and considered them as providers of a better service in return for a fee. In this way, "the capital" emerged as the main element for people's access to medical services. This led to a disparity in the quality of services provided to Palestinians: Basically, the affluent could now receive good health services, and those who are poor will see death around the corner.

Treatment Locations

Among the issues the respondents criticized were the spaces designated for treating cancer. Oftentimes, the oncologist is in one building, the radiologist in another, the cash box in a third one, the laboratory in a fourth building, and the pharmacy in a fifth one... Aside from accessing them, the patients also must wait a long time in each of these locations. In this respect, breast cancer patient Fayha' "S" from the West Bank mentioned:

> **"I went to Ramallah Governmental Hospital one morning. They said I must first get registered. Then they asked me to go and pay at the cash box. They then asked me to draw a blood sample at the lab... they ask you to do everything on your own! When I had chemotherapy sessions at King Hussein Hospital in Jordan, the medical staff there used to come to my room and perform all these activities by themselves. They also explained everything from A to Z with great support and cooperation. Even until this day, they still inquire about my condition; the doctor there keeps checking on me. On the other hand, if you do not do the follow-up on your own in our public hospitals, no one will provide you with any assistance." (Ramallah, January 2021).**

In addition to pointing out the issue of the great distances between relevant locations, the respondents focused on Beit Jala Government Hospital, which is the main hospital providing chemotherapy to women in the West Bank. In that regard, breast cancer patient Rula "J" from the West Bank stated:

> **"The doctor in Beit Jala would write a prescription, so I would have to go to the pharmacy to obtain the chemotherapy medicine, and I would then have to give**

> **it to the nurse to prepare the treatment.” (Ramallah, January 2021).**

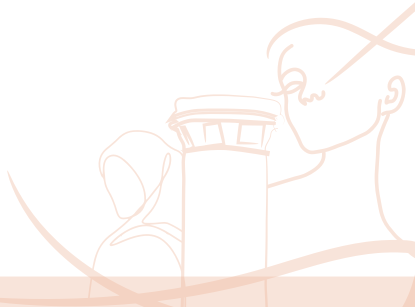
In this respect, Rula had to carry the burden of bringing the chemotherapy medicine from the pharmacy and pass it to the nurse. Meanwhile, Amira “M”, breast cancer patient from the West Bank, expressed her fear and reluctance to receive treatment at the Beit Jala Government Hospital:

> **“I felt so heavy-hearted when they transferred me to Beit Jala Government Hospital. I had heard things about the hospital, and, although I was hesitant, I was so helpless that I gave it a try. Once I saw the situation there, I got so horrified that I decided not to receive any treatment there! For one thing, it is too overcrowded, and the doctor there deals with cancer as if it were a flu. The officer in charge of chemotherapy told me: ‘Come, let me give you chemical therapy now!’ I refused and simply left the hospital.” (Ramallah, January 2021).**

Furthermore, breast cancer patient Rana “S” from the West Bank spoke about her bad experience after the first chemotherapy session at Beit Jala Government Hospital. She attributed the negative feelings to the poor services accompanying that treatment, as follows:

> **“I was devastated when I took the first [chemotherapy] session at Beit Jala Hospital. They do not take the patient’s feelings into consideration. They put you in a department full of cancer patients receiving chemotherapy with great anguish and fatigue... There aren’t even suitable chairs to sit on while waiting for other patients. You must wait for a long time to receive treatment, and you might not find a single chair when your turn comes. Also, the toilets there are horrible and disgusting, and this department is filthy and ignored.” (Ramallah, January 2021).**

Breast cancer patient Fida’ “H” from the West Bank clarifies why the public sees that “those who go to Beit Jala Hospital are considered dead.” According to her, the reason behind that stigma is not due to the provided services but because this place is linked to cancer – which, by the public’s standards, means “death.” For example, when someone says that “a cancer patient was sent to Beit Jala Hospital,” it would insinuate that she was sent there to die. “Ever since I was a child,” Fida’ shares, “the words ‘Beit Jala hospital’ were associated with death. So, when they transferred me there, I unequivocally refused to be treated there.” (Ramallah, January 2021).



On her part, breast cancer patient Rima "S" from the Gaza Strip spoke about the great grief patients endure and the melancholy they suffer in such places:

> **"I did my first chemotherapy session at the Oncology Department in al-Shifa Hospital. That building is depressing and disgusting; it is the oldest building in that hospital! It was constructed ages ago and they turned it into an Oncology Department. All the people there are gloomy... No one talks or smiles; they just sit in total silence for their turn." (Gaza, February 2021).**

Dr. Nayef Kasbari, who works as oncologist at Ramallah Governmental Hospital and Dunya Women's Cancer Center, believes that the medical treatment itself that public hospitals provide to cancer patients is identical to private hospitals and neighboring countries. However, the difference lies in the surrounding environment and accompanying services. For example, private sector patients receive a good level of complementary services that are not available for public sector patients. Dr. Kasbari notes that:

> **"The accommodation services available outside the public sector provide a great level of comfort to patients. However, the actual medical treatment is the same in both private and public hospitals. The main difference between public and private hospitals is in accommodation ("lodging") services: Private hospitals are much better equipped in terms of appearance, cleanliness, and furniture, whereas such quality is not available in public hospitals." (Ramallah, January 2021).**

In this sense, patients suffering from cancer have become reduced to mere "numbers" in long lists. At a time when doctors' attention shifted solely to the disease, patients are left to deal with the physical and emotional ramifications on their own. From being perceived as "numbers" to "clients," patients will need to acquire the needed services from the private sector, depending on their financial means. Ultimately, medical transfers (and service procurement) constitute a major problem that the Palestinian Authority is still struggling to tackle.

Medical Transfers

In this section, I will not delve so much on the cost of medical bills that the Ministry of Health pays for medical services because focusing on how patients deal with transfer-related hurdles in their attempt to receive quality medical services. Getting medical transfers (which is a way to get a good medical service) is, in my opinion, an inherent right of marginalized groups. This is especially the case considering the Ministry's inability to tackle some intractable diseases, such as tumors and heart diseases. The localization of these medical services thus necessitates reviewing this sector. It is crucial, after all, to provide trustworthy treatments and reduce medical expenditures without keeping marginalized persons vulnerable to transfer budget cuts.

On January 9, 2019, then-Prime Minister Rami Hamdallah declared that the Palestinian government succeeded to reduce the cost of medical transfers to Israeli hospitals by 50%, and that this cost decreased from 40-42 million shekels annually to about 20-22 million shekels annually.[24] However, Hamdallah did not mention how the government succeeded to reduce that cost within a few months only. (Was the cost reduction due to discontinuing medical transfers?) Their idea was to mention the reduction of medical transfer expenditures as "evidence" of the quality of Palestinian health services, without taking the status of Palestinian patients into consideration. In other words, the figures took precedence over human lives!

Breast cancer patient Maysar "H" from the West Bank spoke about how cancer patients are frowned upon when requesting medical transfers, especially in the late stages of cancer, notwithstanding the high levels of tension during the waiting period:

> **"When you request a medical transfer, you might hear comments such as: 'Why should the State pay your expenses? You will die in any case!' When you go to the doctor, he is likely to say: 'Why did you bring her here? Her case is hopeless... Let her die at home.' I received a medical transfer after so much hardship. It took me a whole month to obtain it! Many medical transfers are rejected by the government. This keeps you on your nerves as you wonder whether they will accept or reject. They also claim that this medical treatment is available in public hospitals, but the level of service there is horrid." (Ramallah, January 2021).**

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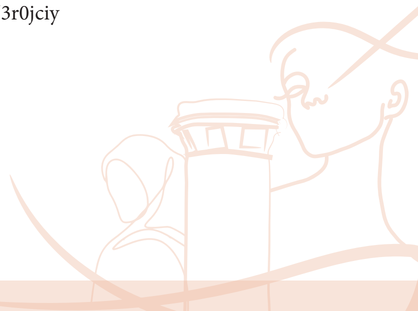
[24] Palestine News and Information Agency WAFA, 9 January 2019: http://bit.ly/3r0jciy



Another interviewee, Aida “A”, who was diagnosed with breast cancer in 2014, spoke about the negative experience of getting a medical transfer to Augusta Victoria Hospital. She had asked for a medical transfer due to being mistreated at public hospitals. Aida explained the procedures and difficulties related to the process. Despite the mistreatment she got at Ramallah Governmental Hospital in 2014, she noted that the level of service in that hospital improved in 2020. According to Aida:

> **“I suffered the greatest difficulty during the beginning of treatment. I used to go every day to the Medical Transfer Department of the Ministry of Health to inquire about my application. This department was located near the headquarters of the Palestinian Presidency (“Muqata’a) in ‘Ein Misbah, Ramallah. The said department is overcrowded with patients waiting for transfer approvals. When it was my turn, I was given a piece of paper and they told me that they will review my application within a week. A committee holds a meeting every Sunday to decide whether to accept or reject requests for medical transfers to Jerusalemite, Israeli, or private hospitals. Unfortunately, they refused to give me a medical transfer the first time, so we had to bring ‘a good connection’ since nothing seems to work here without nepotism. I went to Ramallah Governmental Hospital and told them that I need cancer treatment. I got registered and they gave me a doctor’s appointment for the following week. However, I was quite displeased with that hospital because the nurse there was short-tempered. I told my brother that I will not go back to that hospital, as the nurse was fidgety and asked questions such as: ‘When did you contract cancer? Why didn’t you come at the early stages? Why did you go to Augusta Victoria Hospital?’ and so on. I almost broke down in tears from that unpleasant experience. Many public hospitals used to tell us that ‘instead of paying to Augusta Victoria Hospital, come and receive treatment in public hospitals.’ It should be noted that the Palestinian Authority is hesitant to pay the treatment costs of transferred patients. Nevertheless, when I recently went to Ramallah Governmental Hospital, I saw a progress in the medical treatment they provided. Fortunately, the last year has seen a certain level of improvement in their provided services.” (Ramallah, January 2021).**
>
> **During an interview with breast cancer patient Fida’ “H” from the West Bank, the respondent noted how she got an approval of transfer from a Ministry of**

> **Health clerk, but that transfer was canceled by Augusta Victoria Hospital. She pointed out the following:**
> **"We brought dozens of strong connections (intermediaries) to obtain a medical transfer to Augusta Victoria Hospital. They asked me to bring a paper from my supervising doctor at Ramallah Governmental Hospital. However, the doctor wrote the medical report incorrectly, stating that I needed to undergo an operation instead of getting chemotherapy… Therefore, my name was mistakenly sent to Makassed Hospital [in Jerusalem], where they do not provide chemotherapy. When I went to Augusta Victoria Hospital, I did not see my name among chemotherapy patients. In that moment, I broke down in tears… I said I was no longer interested in getting treated and would rather die … But then I lifted up my head; I imagined my three daughters standing before me and stopped these thoughts. A doctor from Augusta Victoria Hospital (of the Ministry of Health) soon came in and gave me my first chemotherapy session. The Ministry of Health stopped my medical referral/transfer after that. They started to investigate about the person behind the approval of my first and second sessions without signature. Shortly afterwards, Augusta Victoria Hospital asked me to bring a referral or pay the treatment costs. But fortunately, the hospital supported my case, and I was eventually provided with medical treatment through their Aid Department." (Ramallah, January 2021).**

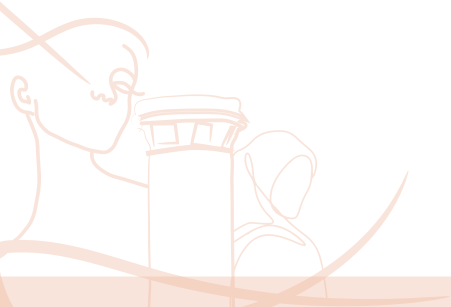
All the interviewees of this study expressed a high level of trust in the treatment provided by Augusta Victoria Hospital in Jerusalem. According to the women respondents, this was due to the hospital's specialized medical staff and great psychological support for patients. On this note, breast cancer patient Rana "S" from the West Bank stated that:

> **"We worked relentlessly for an entire month to obtain a medical transfer to Augusta Victoria Hospital in Jerusalem. That hospital provides good to patients, and they have great teamwork. Their medical staff treats women very well, and whenever a woman suffers from an anxiety attack, a counsellor is brought in immediately." (Ramallah, January 2021).**

Interviewee Raeda "W" from the West Bank agrees with Rana "S", pointing out that:

> **“The treatment at Augusta Victoria Hospital is much better and more precise. They have not only general surgeons but also specialized oncology surgeons. Ramallah Governmental Hospital only has general surgeons, which is why I refused to get chemotherapy there. I also refused to go to Beit Jala Hospital and made sure to get chemotherapy only at Augusta Victoria Hospital.” (Ramallah, January 2021).**

The aforementioned interviews show varying levels of trust regarding different medical spaces. This demonstrates the importance of specialized cancer treatment, which affects the status and viewpoint of patients. Consequently, it is crucial to bridge the gap between trusted and untrusted medical spaces towards reducing the purchase of non-governmental services and minimizing medical expenditures.

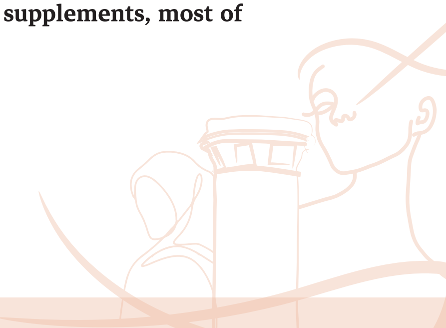


Shortage of Medicines

The problem of medicine shortage was highlighted in participants' statements in varying degrees and per location. The Gaza Strip, where medicine shortage is a recurrent problem due to the Israeli siege and its numerous restrictions and measures against importing different materials, was the most affected. In 2017, the health authorities in Gaza announced that the ongoing Israeli siege therein led to a shortage of 35% in basic and specialized medicines, as well as a shortage of 90% in cancer medicines, and 40% in vital medical consumables (Al-Jazeera, 2017). Moreover, part of the delay in supplying medicines was due to the political discord between Hamas and Fatah, while the ordinary people pay the price for that strife.

Breast cancer patient Lubna "K" from the Gaza Strip experienced a shortage of medicines as follows:

> **"Knowing that Rantisi Hospital does not provide hormonal pills, the Ministry of Health in Ramallah contracted with Al-Hayat private hospital to provide hormonal medicines. Although I received that medication from Al-Hayat Hospital in May 2020, yet that was only for one month. This was because the Ministry of Health did not pay its dues to Al-Hayat Hospital – the latter being a private entity.**
>
> **As a result, this hospital did not manage to give us our much-needed medicines. I go every month to apply for a "financial coverage" at Rantisi Hospital, whereas the doctor fills up Form Number 1 and has me sign it, then the hospital director signs and forwards it to Ramallah for approval. The approval comes after three weeks, and a week later I receive a call from Al-Hayat Hospital to come and take my medicines. The same steps are repeated every month. But sometimes chemotherapy is not available at Rantisi Hospital, so they give me a chemical alternative. However, the alternative comes from other companies and it leads to side effects, such as vomiting and dizziness. In addition, my immunity has deteriorated, so the doctor prescribed a related injection, which was, unfortunately, not available at Rantisi Hospital. The price of each injection is $100! I was waiting for it to be available in order to receive it as soon as possible. But whenever we inquired about that, they always told us that they do not know when it will be available, leading to a delay in treatment. I still constantly wait for that medicine; it is quite tiring… I take nutritional supplements, most of**



> **which are not available at the hospital. When I got my last examination in March 2020, the doctor discovered that the cancer has returned! (I was first diagnosed with cancer in 2014). My doctor told me that I need hormonal treatment and that it is possible to dispense with chemotherapy and only a few hormonal medicines. This comprises of an injection taken once a month, in addition to a pill that you take for five years. However, that pill must be taken at a specific time each day and mistakes can be detrimental… I agreed to go forward with that medication and the doctor supported me. I underwent the related operation in April 2020 and started my hormonal treatment in May 2020. However, the shortage of medicine constituted a problem. Moreover, the price of a pack of Tamoxifen [medicine] is 35 shekels per month, and the price of each injection is 650 shekels. They had this medicine at Rantisi Hospital in only the first two months, but it was not available afterwards. Needless to say, the hormonal medicine must be taken regularly on specific days and times; it does not tolerate any delay. But due to the irregular intake, my treatment became ineffective, and my hormones were messed up. Hence, the cancerous cells are being renewed." (Gaza, February 2021)**

From her end, breast cancer patient Khadija "A" from the Gaza Strip stated the following regarding the shortage of cancer medicines and the subsequent pain:

> **"Femara [a brand name of Letrozole] and many vitamins are rarely available at Rantisi Hospital, leading to terrible pain in the bones. I complained to my doctor about this and went to the PRCS (Palestinian Red Crescent Society). They had me pay a 25-shekel fee and prescribed a bone treatment injection that costs 1,800 shekels! The doctor told me that this injection is a pain reliever, but I did not find it at the Health Department. Also, this medicine is highly expensive. I cannot afford it, as my husband's salary is low." (Gaza, February 2021)**

Cancer patient Ghada "M" from the Gaza Strip also spoke about patients' need to obtain nutritional supplements, which are rarely available:

> **"Gaza receives a lot of aid. Why don't they support cancer patients?! We made**

> **several requests to receive support from the Health Affairs Directorate. When I used to work in the past, I used to buy healthy food for myself and my children. However, we mainly get food supplements now. We only eat one chicken per week and cannot afford fish. And when we find food supplements, we buy them from our own account. Press conferences must be made regarding this matter! The whole world must know! We are not a family of beggars. I am simply a cancer patient who needs support to eat healthy food!" (Gaza, February 2021).**

These stories demonstrate how war and siege have violent ramifications on the bodies of women suffering from breast cancer. In light of the witnessed shortage, certain people decide who deserves to receive treatment and who does not, and they get to identify the kinds of treatment one might receive.

The policies mentioned in the first and second chapter may be non-physical, but they nevertheless have violent implications both physically and figuratively. With that being said, the main policy covered in the next chapter will directly link to the physical state of loss related to this disease, as it affects the whole being of a woman as well as her social surroundings. Consequently, it becomes quite challenging for these women and persons around them to define their gender identity without reminiscing about their physical loss, which is an important component of that identity.

Chapter Three

Engineering of Death: Policies of Controlling Silent Bodies

Gendered Bodies: Dominance in Women’s Daily Lives

In this chapter, I examine how women’s relations to their bodies, themselves, and others, are shaped by gender relations. In essence, cultural traditions, social expectations, and stereotypes are what conceptualize that which is considered “feminine.” The gender perspective, thereby, constructs and legitimizes social differences as per the biological dimensions of “male” and “female.”

Judith Butler, building on Simone de Beauvoir’s view that “woman” is a historical idea and not a natural fact, describes how gender and sexuality are culturally and socially constructed. To be “a woman,” in this sense, does not have an essence. Rather, it is materialized upon conforming to a historical notion that induces the body to become a cultural sign; a sustained and repeated ‘corporeal project’ (Butler 2018, p.131). Such discourse is developed through a set of norms and conventions regarding the notion of “femininity” which formulates gender in a society. Judith Butler also notes that gender does not constitute an identity that is stable but rather one that is constituted over time via repeated acts. Butler also presents the feminist orientation of reviewing the “gendered body” and considering it as “the legacy of sedimented acts rather than a predetermined or foreclosed structure, essence, or fact, whether natural, cultural, or linguistic” (Butler 2018, p.132). In that regard, gender – whether as a construct of identity that is constituted over time or as learned performance of behavior, represents the ways in which “femininity” and “gender norms” are assigned in society.

According to Kholoud Al-Sibai, gender identity dimensions are manifested through the outward appearance, wherein the “body” extends to others through clothing styles and appearances (Al-Sibai, 2007). Moreover, Zahia Ben-Abdallah explains how the female body gets shaped by “beauty” standards, essentially based on social concepts and ideas, which associate femininity with traits like beauty and emotion (Ben-Abdallah, 2005, pp.1-10).

As such, the social construction of feminine gender identity, whether renewed, revised, or consolidated through time, determines its beauty standards through an external set of criteria that relate to ‘body aesthetics.’ The portrayal of ‘woman’ as beautiful, emotional, and an ideal wife – as Zahia Ben-Abdallah describes – is henceforth linked to certain physical criteria. Consequently, any impairment in that body will automatically lead to women’s exclusion and marginalization. As Judith Butler puts it: “Those who fail to do their gender right are regularly punished” (Butler, 2018).[25] Alas,

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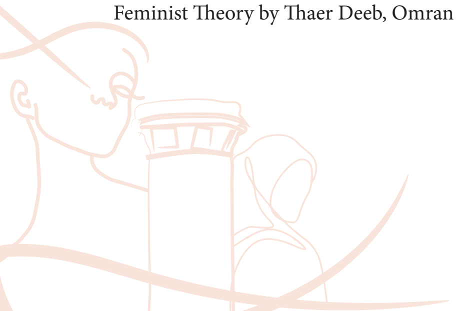
[25] Translation of Judith Butler’s Performative Acts and Gender Constitution: An Essay on Phenomenology and Feminist Theory by Thaer Deeb, Omran for Social Sciences, Issue 7/25. Summer 2018. https://bit.ly/3P5d0Eu



gender identity is one of the most important aspects that define a woman's conception of herself and the society's view towards her. Therefore, a woman who "maintains" the criteria of "femininity" is seen as the ideal woman, yet if there is any deviation from the criteria of "femininity", she will turn from being "fully feminine" to a "sub-feminine" woman".[26]

With regards to women suffering from breast cancer, the realization of losing the two assumed criteria defining 'femininity', namely the loss/potential loss of the breasts and hair, begs the question: How is gender defined in those cases? The mutilating breast cancer treatment, as Joyce McDougall mentions, causes substantial psychological distress, to the point that it undermines (among other things) the patients' sense of subjective identity and self-image. When undergoing mastectomy, many women feel that an essential symbol of their "femininity" has been destroyed. A breast cancer patient who had suffered both mastectomy and hysterectomy expressed this sense of loss when she shared [with McDougall): "I am no longer a real woman. Am I still a person?" (McDougall, 2016, p.135).[27] What is it, exactly, that made the woman think she is no longer a "real woman"?

As noted, the feminine gender identity is reflected on her body through numerous criteria, whether constructed or renewed, revised, or consolidated over time. Clearly, all societies have such criteria – each with its own discrepancies and unique traits. However, I believe that the criteria across the different cultures and societies become eerily similar and band together when it comes to women suffering from breast cancer. This is due to considering breasts and hair as 'aesthetic' symbols defining 'femininity', and upon which the standards across cultures define the beautiful, desired, and ideal woman. Unfortunately, a cancer patient's body is not viewed as a body suffering from cancer as opposed to a healthy body. Rather, it is perceived as an 'unreal' body that is 'devoid' of femininity. Such socially regulated and authority-driven perceptions may define feminine 'beauty' as per the 'outward appearance' of the 'body aesthetic', yet they pay no heed to the actual healing of that body. "Power is everywhere," as Michel Foucault puts it, and disciplinary techniques are institutionalized within families, schools, hospitals, and all private and public spheres. In this respect, Foucault does not confine power to patriarchy or to men's oppression of women, but sees it as widespread and that it is constitutive of that upon which it acts (Foucault, 1975). According to Pierre Bourdieu, such power is practiced through what he coined as 'symbolic violence', whereby a group imposes its social power and moral authority over those it dominates through legitimizing a system of ideas, connotations,

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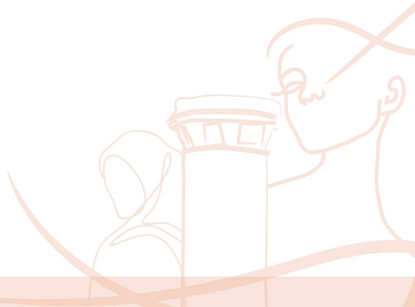
[26] This term was coined by Salam Hamdan during our discussion at Rosa Luxemburg Stiftung (RLS) regarding the society's view towards women who undergo mastectomy after suffering from breast cancer.

[27] Retrieved from translation of Joyce McDougall, The Psychoanalytic Voyage of a Breast-Cancer Patient in "Psychoanalysis and Women" edited by Jerome A. Winer, James William Anderson, and Christine C. Kieffer. Routledge: London and New York, 2004.



semantics, and signs. (As’ad, 2012).

In my attempt to deconstruct the types of prevalent perceptions towards women’s bodies, I consider them from two angles:

First: That these women have subliminally absorbed how to perform their gender-specific identity and internalized stereotypes regarding the physical body. Therefore, they practice “self-censorship”, even when there is a “mismatch” between their perception and the physical reality. Doing this reinforces the power structure and turns cancer patients from victims to “co-enhancers” of the oppressive system that is practiced against them.

Second: That the perceptions of individuals vis-à-vis women’s bodies clearly demonstrate the disciplinary techniques that are used against them (Foucault, 1978). Accordingly, such power is attained through culture and institutions (Connell and Messerschmidt, 2020).

Gender Fullness: Self-Censorship

The study participants’ statements gave us insight into their reaction to the loss or potential loss of their breasts and hair. Their gender identity criterion of their gender identity seemed so intrusive that it became a requisite to their identity. In other words, they could not imagine themselves without these body parts, except with great suffering.

Cancer patient Rania “N” from the West Bank, one of the participants in this study, spoke about breast cancer patients’ awareness of their gender identity criteria as follows:

> **“In our society, a woman’s breasts and hair are a main component of her femininity. I disagree with this, but unfortunately, the people around us look at women in terms of physique and outward appearance. People often ask you whether you applied false eyelashes, drew your eyebrows, or did mastectomy... A woman’s beauty does not lie in her breasts and hair, but we were influenced by certain ideas that were internalized within us. Some people say: ‘This woman does not have breasts; we pity her husband.’ Is it possible that I would no longer be a woman if I had my breasts removed?! (Ramallah, January 2021).**

Several other testimonies mentioned the moments experienced by these women prior to mastectomy. For example, breast cancer patient Hana’ “S” from the Gaza Strip pointed out that:

> **“It is difficult to lose your breasts, as it represents a woman’s femininity and beauty. It is grueling for a woman to undergo mastectomy, so much so that I am embarrassed to get out of the house! If my grandson is to sit on my lap and say: ‘Grandma, why don’t you have anything there [in your chest]?’ he will ultimately feel sad... A main part of beauty would be gone, along with the hair and eyebrows... It is a truly heartbreaking loss.” (Gaza, February 2021).**

Likewise, cancer patient Fida’ “H” from the West Bank talks about the inability to comprehend and accept this loss, especially since these women would probably have anticipated and hoped that they might avoid the mastectomy. Fida’ notes that:
“When the doctor told me I might undergo mastectomy, I told him that I will not accept any breast removal operation. He said my health must come first. I said that’s true, but I could not tolerate the idea of having my breasts removed... The idea shocks me to this very day. I have seen many women whose breasts were removed; it is truly difficult...” (Ramallah, January 2021).

Moreover, breast cancer patient Amneh “T” from the Gaza Strip noted that the fear of losing one’s breasts is stronger than the fear of cancer itself:

> **“Although I underwent many laparotomy operations, I found mastectomy to be the scariest. Having your breasts removed is a very scary thing. I cannot imagine myself without breasts. I used to ask myself: ‘How will I be without breasts?’ That scared me more than the cancer itself.” (Gaza, February 2021).**

Also, breast cancer patient Najah “M” from the Gaza Strip mentioned how cancer was less severe than mastectomy because the idea of breast removal has never been acceptable for her. She added:

> **“I totally rejected the idea of undergoing mastectomy. I accepted my suffering from cancer but could not accept the idea of breast removal! I totally collapsed on the day of the operation. Everyone in the room tried to calm me down. My brother and sister were by my side; they saw me completely shattered. When I got out of the operation, I was totally unconscious. My siblings and their children were trying to fix me to the bed because I tried to run away from the hospital. At that point, I had not yet experienced the pain of the operation**

> **itself." (Gaza, February 2021).**

On her part, breast cancer patient Raeda "w" from the West Bank shared:

> **"I have been suffering from mastectomy for seven years now, and this ghost will keep haunting me for the rest of my life. It is excruciating! When I bathe and look at my body, it's important for to look well. Until now, no one at home (not my husband, children, or daughter-in-law) noticed that I only have one breast! Upon waking up, I always put on my artificial breast. At the beginning of my illness, my daughter was three years old, and my son was five. I did not tell them that I was sick until they grew up and found out. They did not even notice that I have a missing breast... I always avoided answering questions. It is truly difficult. I cannot even look at myself in the mirror now. I always cover my head and have been suffering from depression and insomnia. My husband brought me three kinds of sleeping pills. I take one type each night, but to no avail. They would recite verses from the Holy Quran for me – for healing – but that too was in vain. There has been an entire week when I did not sleep at all. I just kept crying. I dreaded anyone speaking to me. That operation was on a rainy and cloudy day, and I still can't stand winter until now. It terrifies me." (Ramallah, January 2021).**

The above-mentioned cases show that women's fear of mastectomy far exceeded their fear of cancer. This is quite significant, seeing that in the local culture, cancer is such a dreaded disease that the word "cancer" is a synonym of "death". Still, many women find that mastectomy is the utmost catastrophe in any potential treatment plan; a "standard" so deeply ingrained in their psyche. It is also worth noting that many breast cancer patients do not know in the beginning that they might be subjected to breast loss. However, when such a possibility emerges, they become obsessed and apprehensive regarding that "standard". In fact, their strong fear and anxiety could reach a point where it would infiltrate their whole being, and have them start censoring and undermining themselves as per the socially defined and ideologized criteria of "femininity".

Within the same context, different study respondents mentioned the other criterion, namely hair loss. According to the local culture, losing one's hair as a woman is associated with losing the "female beauty". This also related to discovering cancer, meaning that hair loss has often been among the

first indicators of a woman’s suspicion of cancer.

Study respondent Samar “H”, whose mother died of cancer in 2009, expressed how her mother was greatly affected by her hair loss:

> **“I felt that the most painful thing for my late mother was her hair loss. Her hair used to be long, dark, and thick, and she used to be proud it.”**

Moreover, breast cancer patient Insaf “S” from the Gaza Strip said that she was horrified once she noticed her hair thinning. This was after she had separated from her husband due to her illness:

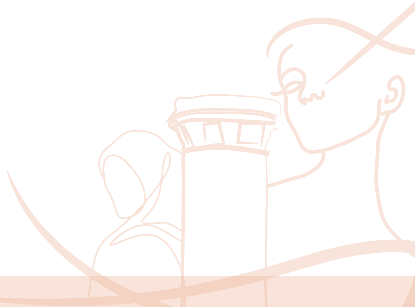
> **“My hair started falling out gradually after the first chemotherapy session. I would find tufts of my hair on the pillow while sleeping. I had mentally prepared myself for this, as I knew my hair will start falling out at some point, yet this experience was very scary, because it has to do with my beauty and femininity.” (Gaza, February 2021).**

Additionally, breast cancer patient Samar “K” from the West Bank talked about her psychological deterioration due to hair loss:

> **“I had dyed my hair shortly before discovering the disease because we had a wedding, and I was very happy and joyful. However, after my two chemotherapy sessions, I noticed that my hair was falling out whenever I washed it. My nieces were very sad and afraid when they saw that. During my cancer illness, I was not affected by anything as much as hair loss; it made me melancholic.” (Ramallah, January 2021)**

Breast cancer patient Amira “M” from the West Bank also described her fear of hair loss:

> **“During my first chemotherapy session, I asked them if my hair will fall out, to which they said: ‘No, that’ll happen after the second session.’ This brought me to tears. My hair was long and beautiful! I loved it. The thought of losing my hair was a catastrophe! They told me that my hair will grow again but that**



> **I must undergo chemotherapy to restore my health. They added that it is just a small period of suffering, and that it'll soon be over... They said my hair will be even prettier when it grows again after the chemotherapy and encouraged me to remain strong for the sake of my children. After my second chemotherapy session, every follicle in my hair caused me pain. It hurt me to tears, and I was afraid... So, I decided to get rid of my hair. My sister is a hairdresser and I asked her to cut my hair. When she started doing that, the hair was falling apart from the roots, which made her cry. When I had my hair cut, I felt relieved because the hair will return and grow again. However, the breast will not be restored." (Ramallah, January 2021).**

In the statement above, we see that the actual pain had more effect than "social standards." This means that despite the significance of social standards, the pain had been so intense that it led to a strong desire to cut the hair altogether. This does not at all suggest that this woman wanted to do away with these "standards," but her aim was to escape that pain, which is often intensified by social standards. Nevertheless, getting rid of the pain could be strongly linked in this case to getting rid of social "standards".

Gender Embodiment: Body Censorship

These testimonies gave us insight to the impact of the two said criteria (loss of breasts, loss of hair) in terms of the husband's opinion. Joyce McDougall speaks about the effect of that loss as follows: "The patient often feels that her sexual life is in jeopardy. The loss of her breast will have inevitable repercussions on her relationship to husband [...]. Bygone fears and inhibitions around sexual and love relationships therefore tend to resurface following a mastectomy. It is understandable that the life partner too will experience considerable anguish when faced with her illness and mutilation – and at the same time the shadow of death tends to be aroused in the partner as well. These combined factors may well mitigate against the sexual pleasure of the couple." (McDougall, 2016, p.135).[28]

Accordingly, the statement of breast cancer patient Aida "A" from the West Bank highlighted the effect of that loss as follows:

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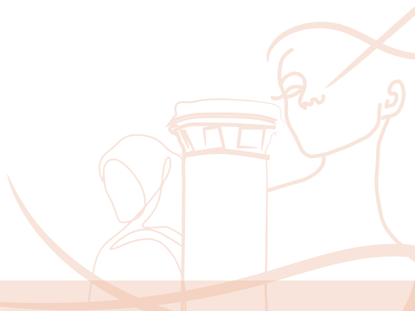
[28] Ibid.

> **"Mastectomy is a major problem. Breasts are an integral part of a woman's femininity. If a woman loses them, she feels something missing in her life. A woman's mastectomy also affects her husband's life. Honestly speaking, breasts are important for a man's sexual arousal. A husband might accept lumpectomy (which leads to certain deformities), but mastectomy will likely cause a problem between the couple. For example, the husband might say that if his wife had her breasts removed before marriage, he wouldn't have married her in the first place... which is exactly what was told to a fellow breast cancer patient who was receiving treatment with me. Sometimes, people ask questions with a good intention but in a hurtful manner. Also, some of them say harmful things in front of the husband like: 'Poor guy, his wife had mastectomy.' And even if he was convinced to stay with her, he might change his mind and start to consider marrying someone else". (Ramallah, January 2021).**

The following testimony shows how breasts are often viewed as an "important object" for the husband, as stated by breast cancer patient Su'ad "A" from the Gaza Strip:

> **"For a man, this (i.e., breast removal) is considered a deformity. It is also seen as a catastrophe – as if the woman became deficient. They do not want a woman with a "missing piece" (so to speak) in her body, a part that is considered important for them." (Gaza, February 2021).**

French sociologist Pierre Bourdieu analyzed individual perceptions and dispositions that are unconsciously created and reproduced within one's self and their surroundings. He explained this under the concept of "Habitus", which has to do with socialized norms or tendencies that guide individual thinking, behaviors, and attitudes (Abdul-'Atheem, 2011). Through the statements of study respondents, it became clear that the perceptions towards the female body had been reduced to her external appearance via stereotypes maintained by these persons and their surroundings. The defect occurs when one of these [stereotypical] "criteria" are lost or potentially lost, such as in the case of breast cancer. In these cases, the said perceptions turn into symbolic violence that these women practice against themselves, and which others exercise against them. Either way, the body



is perceived as “deficient”, “mutilated” and “unreal”; an impairment that ultimately excludes and marginalizes these women.

It is of utmost importance, therefore, to emancipate the women: It is pivotal for a woman to rebel against the socially ascribed binary systems and confined roles that define their gender identity in case of breast cancer infection. In my opinion, this would reduce the violence generated internally within these women and generated by the society against them when viewing them as “unreal” woman. Having said that, I also agree with Melanie Klein on the significance of certain roles in shaping the female identity. Although such stereotypes are most harmful in the case of breast cancer patients, yet it is also crucial to minimize the damage even in the cases of healthy women – who do not expect to lose any “parameters” of gender identity. Essentially, women who suffer from breast cancer must disregard the societal perceptions which confine their bodies and roles to certain daily life tasks.

Dichotomy of “Women and the Mirror”

In the case of study respondent Aida “A”, the pain of losing her “gender identity” was manifested when she stood in front of the mirror and looked at her body: Her hair had fallen out, and she had her breast removed. This led to a kind of “clash” between the woman and her mirror. The mirror’s reflection, which generally makes a woman feel feminine when examining and sensing her physical attributes, has seen a great change as her body transformed into “another form”. According to Aida:

> **“I was shocked when I looked at the mirror! I visited a doctor in Augusta Victoria Hospital. He made an examination and told me to have my hair cut. I said my hair was already short. He said, in a kind voice: ‘No, cut it completely.’ But I did not have it cut all the way. I didn’t listen to the doctor’s advice. The type of chemotherapy that I received, however, made my hair knot and tangle so much it became like a thick block. It became one cluster. I tried to comb my hair, but to no avail. The different hairs held on to each other and it was hard to separate them. I couldn’t look at myself in the mirror at first. Two days later, I touched my hair and found a lot of it in my hand (the hair was falling out). I looked at myself and said: ‘What in the world is happening to me?!’ Then I moved away from the mirror and came back later to look again”. (Ramallah, January 2021).**

What practically happens between a woman and her mirror during the illness is that the woman would be unable to see herself but rather gaze at her "deformed" body through the eyes of her surroundings. And although the cancer patient is the one looking at her body, she will nevertheless be examining it from the perspective of society. French psychoanalyst Jacques Lacan suggests that one can almost own another person by gazing. This is because the presence of the fantasized gaze extends to the consciousness. This makes a woman want to stand up to expectations that identify her [the object] as more "shiny", seductive, influential, and finely dressed, henceforth reflecting worldly representations with its patriarchal, social, and religious values and fantasies. Also, gazing is a masculine strategy to have women represent their historically ascribed symbolism, i.e., to oblige her to become a cultural symbol and identity (Mousa, 2007, p.3).[29] In general, the mirror appears in daily life as the reflection of a healthy body. However, in the case of breast cancer patients, it is the reflection of the body in the eyes of others who consider it as one that is "devoid of femininity", whereas the patient evaluates herself, and others assess her, according to these criteria.

In this chapter, I highlighted the pain stemming from the "gender identity" definition of breast cancer patients in terms of two criteria related to loss. The next chapter will delve into another aspect of pain, namely the physical pain emanating in the most extreme stages of the illness.

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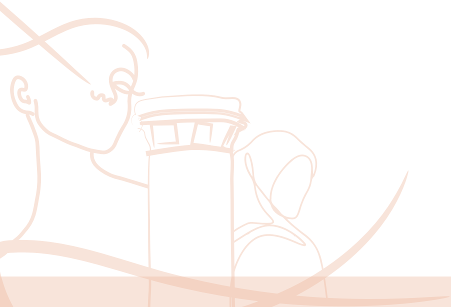
[29] Ibid.



Chapter Four

Engineering of Death: Policies of Controlling Silent Bodies

Pain and Silent Torment: Stories of Pain

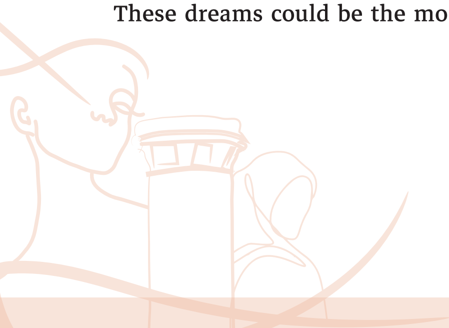
Distinctive stories of pain cannot be caught up in a frenzy. To reclaim one's agency after trauma, one must first humanize the experience of grief. Whether her disposition is one of illness or of hope, a cancer patient construes her narrative from the elements she gathers here and there. Her personal story thus culminates from the details around her, including from the words of doctors, nurses, other patients, as well as observations she gets from reading, listening, and watching. Added to this mix of ingredients in telling her story are the patient's interpretations of her own feelings of remorse, agony, and hopefulness.

If nothing else works, speaking up could be the last resort for a woman's survival during those testing times – as her stubborn resilience in the face of debilitating grief. Giving voice to pain may be the way to call the patient out from the abyss of her misery, while elevating the human condition in a world that is homogenous and predictable (Le Breton, 2017). Telling the stories of pain, therefore, provides the rhythmic composition of women's experiences: It testifies to the suffering of these individuals who are stuck in a cycle of fragility and weakness, and whose accounts are hidden behind their words.

There is no room to escape or hide from the pains and torments of the battles between the ego and the self. Usually, what these women do is to introvertly keep that pain within themselves: They bottle up their grief for so long until they cannot wait anymore. They must do away with conforming to social standards when the pain is so extreme that it becomes part of the self.

In such debilitating moments, no one can empathize with the person's pain, regardless of their level of sympathy. This pain infiltrates the furthest depths of the body to the extent that it is impossible to express it. In these moments of tremendous suffering, silent groaning becomes the only outlet to brace the body. Language and words will be a desolate and tiresome practice, and ears will be too weary to hear the lyrics of even the most cherished songs.

In such debilitating moments of pain, children are led astray, as the "blood bond" absorbs substantial pain. The children's pain goes in line with their loved ones, yet their suffering gets internalized during the hell of waiting. For the patient, the excruciating experience makes it unfeasible for her to perform her daily tasks. In utter helplessness, she might see her unfulfilled dreams flashing before her eyes. These dreams could be the most basic chores, such as doing housework, going outside, preparing



food, tutoring the children, laughing, and playing. All these routines appear to be ‘rewarding’ for the patient who anticipates for their return as soon as the pain subsides.

Within that context, the mirror –for these women– begins to represent something “ugly” they’d rather ignore, because it bears witness to a pale and feeble deterioration. As the body strives to heal itself gradually, it is simultaneously monitored by those fully absorbed in its potential recovery. This includes the patient’s children as they wait impatiently while accumulating intense pain due to their mother’s suffering.

In these agonizing moments, one part of the body colonizes some or most other parts, i.e., a case of internal settlement, as the body becomes eroded. In his anthropological work relating to the body, Le Breton uses the analogy of a toothache to explore a person’s embodiment of the senses. A toothache, as an example, can alter a person’s most cherished activities and hobbies, and can impact her entire mindset and demeanor. It can also change a person’s old habits and oblige her to live in denial, isolation, and self-pity. Therefore, torment in an organ or function can encompass the entire body (Le Breton, 2017).

In such severe moments, neither medications nor doctors can contain the pain that had settled in and infiltrated the body. Only strong sedatives (tranquilizers) may bring some relief for a few hours, but even they most often fail to do so. In the face of torment, the patient can only pray for salvation! Cancer – the King of Diseases… (“Oh Lord, What Days!”)

In the local culture, the word “Cancer” is synonymous with death. In fact, people’s perception of breast cancer is that it is not a temporary illness but an imminent and probable state of death. Many people do not know that it is even possible to heal from cancer; they consider it a permanent health impairment that will inevitably lead to death. Therefore, cancer is often called by other names [in Arabic], such as “the malicious disease” or “that disease”. Most people avoid mentioning that word altogether out of fear!

This fear has even extended to physical places that are in any way associated with cancer. Breast cancer patient Fida’ “H” from the West Bank described people’s reaction when they heard that she was sent to Beit Jala Hospital (specialized in treating cancer patients). She recalls how women were praying for her mercy, and how she had assumed that she was sent there to die.

The only ones who overcame the fear of cancer (and its associated places) were those who experienced it firsthand and recovered from it. Although the fear was present among these women prior to getting ill, yet once they waged that battle, they broke free from that fear. Therefore, the persons who overcame cancer conquered that fear and openly spoke about that disease with all its details.

Breast cancer patient Amira "M" from the West Bank described her perception of cancer prior to her illness, and shared how her view about it changed after she contracted that disease:

> **"Cancer was considered a very frightening word! We didn't even use it as a curse word against an enemy. However, when I personally experienced that disease, I felt that it was more like flu." (Ramallah, January 2021).**

Similarly, breast cancer patient Lubna "K" from the Gaza Strip described her view of cancer before she was diagnosed with it, as follows:

> **"I considered cancer to be a dreadful disease that was far from me. I never imagined for a minute that I would ever get cancer. Whenever I heard the word 'cancer', I would get goosebumps. I didn't know enough about it. We were even afraid of pronouncing that word and would simply call it 'that disease'. However, after I was diagnosed with cancer, I saw that I must confront and overcome it." (Gaza, February 2021).**

That journey entails different layers of pain that range from viewing this disease negatively and struggling fearlessly against it. However, another kind of pain is the debilitating fear for one's children after being diagnosed with cancer, especially because the society links that disease to death and influences one's perceptions. In this respect, mere viewpoints came to be considered as so-called "truth" that took command over one's mind to the impending idea of death. As an example, breast cancer patient Zainab "K" from the Gaza Strip mentioned that:

> **"When the doctor told me that I have cancer, I first thought about my children... My son was in first grade and my daughter in fifth grade. I started staring at my children... Of course, we generally link cancer to death. I had a friend who had breast cancer and passed away, and she crossed my mind. I did not tell my**

> **children about my disease and never showed them my sorrow. I used to think that cancer leads to death. I only discovered the contrary after experiencing it. When I was diagnosed with cancer, I thought that I will die and was wondering about who might raise my children after me... A mother always thinks of her children, so I was thinking about who to pass them to before I am gone." (Gaza, February 2021).**

Also, breast cancer patient Su'ad "A" from the Gaza Strip had to deal with her pain in secret and continued doing what she was doing to avoid causing pain to her household. She noted that:

> **"I did not allow chemotherapy to take over me. I kept standing on my feet and cooked for my children... I did not want them to undergo this suffering with me, so I endured every imaginable pain so that they wouldn't find out. I also had many problems with my husband and wanted a divorce. However, I wondered how I can take care of our eight children on my own (couldn't think of anyone who can help us). Therefore, I decided to endure the pain until the end and never give up." (Gaza, February 2021).**

Another important testimony was that of breast cancer patient Safiyya "R" from the West Bank, who shed light on how her children felt about her illness:

> **"I always asked myself whether the persons around me would understand. I did not know how they will deal with it. I kept wearing a headscarf in front of my children because I didn't want them to see my hair falling out. However, my husband asked me to remove the headscarf at home and he shaved his head bald [in solidarity]. He also encouraged me to participate in social activities. A man can positively affect a woman's personality and make her more open towards life when he supports her." (Ramallah, January 2021)**

Another remarkable interview was conducted with breast cancer patient Rania "N" from the West Bank, who dealt with that pain in an astonishing manner:

> **"During the first session, the doctor told me to prepare myself for hair loss. I took it lightly and laughed it off because my hair was long and it was dyed with**

> **different colors, including blond. I [humorously] told the doctor that my hair was subject to different dyes, so it needs some detox! People often focus on one's hair. So, I asked my eldest son to buy me a shaving machine... This was during the COVID-19 quarantines. He talked to a barber and managed to buy an electric shaver. I am very close to my sister, so I told her to come with her children (her daughters are about the same age as my daughter). I asked my sister to cut my hair in front of the children and that they would help her in doing that. I had already talked to my kids beforehand and told them that my hair will fall out. So, I had the children cut my hair while they filmed it, and we laughed and joked a lot. Afterwards, the children continued using the electric shaver to shave my hair, and we would always be full of giggles and smiles. This made them comprehend the subject in a better way. I didn't want my children to see my hair tufts falling out every day, so this method was much easier for them. I also gave my dear daughter a lock of hair and she has kept it until today. My kids saw that I was strong and were motivated by my determination. I never felt embarrassed when people saw me bald. Our visitors at home always saw me without a headscarf and I would even leave the house sometimes with a bald head." (Ramallah, January 2021).**

Another form of pain highlighted in the interviews was the fear of being forsaken. Several patients saw themselves stuck between the pain of illness and the agony of disappointment and abandonment, as they assessed themselves as something that "expired" or "about to expire". For example, breast cancer patient Insaf "S" from the Gaza Strip recounted how her husband abandoned her, leading to divorce:

> **"I am divorced. Before getting diagnosed with cancer, I had some problems with my husband, so I left his house and stayed in my family's house for a while, but I decided that it's better to go back to my husband's house [back to normal]. Before doing that, however, I felt a lump in my breast which hurt a lot. I wanted to examine the matter, and found out I have cancer... I almost collapsed when I found out about that. When my husband found out, he sympathized with me [at first] and used to call me every two days in the beginning. However, the communication faded away gradually. During the second and third doses of chemotherapy, he did not contact me at all. After my recovery and completion**

> **of chemotherapy, I called him and asked to see him and my daughters [we had split the children between us]. When the girls and I met with him, we asked him if he wants to be with me. He said: ‘Honestly, I do not. I want to leave you!’ I did not ask him why he would do that. I knew him quite well and felt that he didn’t want me anymore. I wanted to ask him that direct question so that I wouldn’t have a guilty conscience. I wanted to hear the answer with my own ears to ensure that I had no misconceptions. I felt that he didn’t want me, and when I heard it from him, I realized that I was right. God didn’t want me to go back to him. Fortunately, God sent this disease so that I wouldn’t return to that man. My ex-husband did not get re-married until now. Perhaps he did not want to pass through that experience with me or to take care of me. He probably didn’t want to pay the expenses either. I am sure that he didn’t want all of that...” (Gaza, February 2021).**

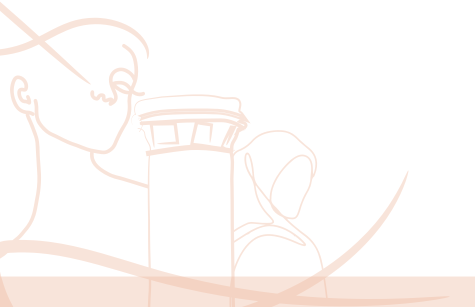
Similarly, breast cancer patient Hana’ “S” from the Gaza Strip expressed a deeply painful story of disappointment during her experience with the disease:

> **“When I asked my husband to pay the cost of transportation so that I would go to the Department of External Treatment in Gaza, he would say: ‘Get that money by yourself.’ So, I had to ask for money from my nephew. I also had to take loans from our neighbor for the transportation fee and financial coverage for my treatment. But despite all of that, my husband used to tell me: ‘You are wrecking me financially!’ I would hear such remarks about 200 times a day! I even thought of committing suicide, but I have a three-year daughter, as well as a daughter in kindergarten, and a sick daughter. They were the reason I didn’t take my own life (my children are very attached to me). Yesterday I took a pill for cancer that has terrible side effects so bad it’s like putting hot coal on your heart and making you feel suffocated in an unbearable manner. I sat on my bed with full tears in my eyes. My daughter came with a sandwich in her hand and exclaimed: ‘Mom, what happened to you?!’” and she threw her sandwich. I often found myself between two fires but decided to internalize my problems so as not to cause pain to my children, although I was totally devastated. I’m a mother who always puts her children first. I would lash out at my husband**

> **if he ever hit the children… However, after my mastectomy operation, it is forbidden for my hand to be subject to any harm, because having no nerves under the armpit will make it swell. Although my husband knows this quite well, yet he hits me on my hand despite that. It is difficult to find a person to hug or embrace (to ease the pain a bit). I often walk in the streets all alone and do not know where to go. When I am outside the house, I feel like my children are too attached to me and that they will come get me, so I decide to go back home although it is mentally relieving to be outside. My husband would assume that I went to the West Bank to have fun, and he would accuse me of betrayal! Imagine that you are on a bed suffering from the pains of radiation therapy while your husband accuses you of "dishonoring" yourself and asks you: 'Who did you meet in the West Bank?!' He accused me of adultery after knowing that a [male] benefactor was providing financial assistance to cancer patients at Augusta Victoria Hospital. He asked me: 'What did you give him in return for that financial assistance?!' For a whole week, he made a huge fuss about that at home. I felt that I was 100 years old and not 38!" (Gaza, February 2021).**

It is also worth noting that mistreatment and pain can sometimes contribute to a woman's cancer infection. For example, cancer patient Amira "M" from the West Bank believes that her husband's marriage to another woman caused her so much pain that it led to her cancer illness:

> **"My husband married another woman about four years before my illness. At the time, I had five children and was in my first year of the bachelor's degree. I almost completely broke down during that period because I never imagined that my husband would marry another woman. I was in a state of shock and grief and kept crying. The day of his marriage was a disaster. I asked that, on his wedding day, I would go to Mecca to perform Umrah [Islamic pilgrimage] because I didn't want to see him. I went and applied for the Umrah papers but, for a certain reason, he got married before I traveled abroad. On the day of his wedding, I wanted to be out of town; to be closer to Allah, and away from my husband. I wanted to forget him. I felt exhausted and told my family to give me a sleep-inducing injection… I just wanted to sleep… I couldn't imagine my husband with another woman. I traveled and did Umrah after he got married.**



> **These were the best 14 days of my life. I forgot him and forgot that he got married. But I was afraid for my children and kept checking on them. I kept suppressing and restraining myself. Five years later, my husband married a third woman, but this time I wasn't that upset. I was really shocked the first time, but now I couldn't care less, even if he leaves me for good." (Ramallah, January 2021).**

Another example of mistreatment and agony was witnessed by breast cancer patient Jumana "S", who noted that:

> **"During that period, I was having problems with my husband. His mistreatment of me greatly contributed to my illness and terrible mental state. I have sons and daughters, some of whom are married. I lived in a state of grief for three years and then decided to give up my rights just to get a divorce. However, I kept feeling tired even after my divorce. If I had not divorced him, he would have married another woman [i.e., a second wife] and he was hinting at that, although his financial condition was not good." (Ramallah, January 2021)**

There is also pain emanating from people's 'curiosity' about what happened with the breast cancer patient. Not less importantly, some people give the impression that this disease was "sent by God" as punishment. According to respondents' statements, many people have the annoying curiosity of trying to find out what happened to the patient by touching her body to see if she got a mastectomy. It is also extremely hurtful when people say that this disease is a "divine punishment" from God and intrusively inquire into what happened to the patient. They also make lamentation statements like "Death is God's affair" [as if she will die and God has decided that].

Breast cancer patient Maysar "H" from the West Bank pointed out that:

> **"What was most painful is the interference of people. There are people who, upon greeting me, would put their hands on my breasts to check whether I did**

> **mastectomy. In some cases, I would try to get these women embarrassed about asking and I'd tell them: 'If we weren't in the street, I would have shown you my breasts! You know there is nothing wrong with undergoing mastectomy for the sake of your health.' On one occasion, a woman asked me to show her my breasts to make sure that I didn't undergo mastectomy. I told her: 'Not even in your dreams. This is none of your business!" I did not give people the chance to interfere in my private matters. At first, I wasn't paying attention to my chest. But when people kept talking about this, they made me become obsessed with that. I would wake up in the morning and touch my breasts to see if they are still there or not. Many people see this illness as a punishment from God, as if 'the woman committed a grave sin and God is punishing her for it.' However, I see this as a test from God and nothing more. Even some family members used to repeat a popular proverb in reference to my illness: 'We neither stole at night nor committed violations in the morning.' They also would ask: 'Why did God afflict you with this disease?' Also, many people thought that this disease will send me to the grave very soon. An 80-year-old woman once told me: 'There's a chance that I may die before you. Do not be afraid.' She was comparing herself to me, although I am forty years younger than her! She assumed that I would die right away, so she tried to console me by saying that she might die before me!" (Ramallah, January 2021).**

In people's viewpoint, normal diseases –albeit causing physical impairment/sickness– will not necessarily lead to death, for the patient will most likely be cured of it (eventually). However, the society looks at cancer as an inevitable form of death that leads to an "end-of-life monodrama" (so to speak) for the patient. In fact, the society has certain [negative] perceptions on cancer. And although the cancer patient and her direct surroundings might see this disease as a test from God, many others view it as a "divine punishment" which will ultimately lead to death.

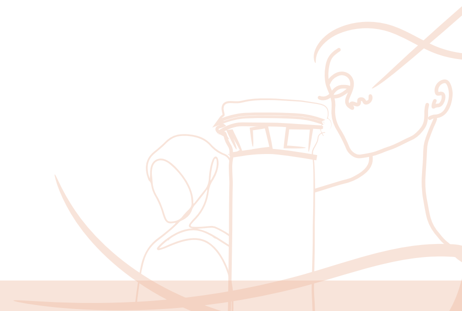
This coincides with the testimony of breast cancer patient Rima "S" from the Gaza Strip, who stated that:

> **"One day, I visited a woman's house, and everyone there kept asking me if I was okay. They made me feel as if I am not like the rest of them, and that I will die**

> **soon. A woman took me by the hand as if to dance with me, but then she put her hand on my breasts to see if there is something there or not. That was highly offensive; it is none of her business!" (Gaza, February 2021).**

Similarly, breast cancer patient Najah "M" from the Gaza Strip stated that:

> **"When I returned from my [medical] travel, I had to take a nap, but I could still hear them telling my daughter: 'It is good that you came to see your mother, because she will die soon.' People think that cancer will inevitably lead to death, but this is not true. Cancer gave me strength and a strong will with the help of God. I loved walking in the morning, so one day, as I was walking from my house in Sheikh Radwan to al-Shifa Hospital, I bumped into a woman I know. She asked how I was doing. I said: 'Thank God.' She added: 'Why is your face yellow?!' I told her that it is not. I went back home and looked at myself in the mirror and started crying, telling my children that my face is yellow. However, my children insisted that my face was not yellow. I decided not to leave the house afterwards. I stayed at home for two weeks despite my love for walking. I didn't even go outside the house to do the laundry because my neighbor once asked me: 'When will you go to "Israel"?' I told her that I had no intention to go there, although, in reality, I had just returned from there four months prior! She told me that she heard from the neighbors that the disease spread all over my body. 'Who told you that?!' I asked. I was deeply affected by what people said, so I focused my time on preparing food and doing housework and forgot about them. I also created a food business to forget my illness and shut the mouths of people who say that cancer is lethal. I want to show them that it is not lethal! This challenge only gives me strength and determination. I started working harder to avoid people and their [poisonous] talk. I also didn't want to be a burden to my children and husband. I did not want to make them feel that I'm sick or cannot prepare food for them. When I finished my radiotherapy sessions, people were looking at me with eyes of pity. Some people call cancer 'that disease' [in avoidance of its name]. When you say that you have cancer, a woman might say: 'Let's change this subject. I'd rather not**



> **listen to that story.' At that point, you can tell her that if she does not want to hear that story, she might as well go out and sit in the sun away from us!" (Gaza, February 2021).**

This statement shows the psychological pain inflicted upon these women by their social environment. Essentially, the society portrays breast cancer patients as persons who have left the scope of life and are approaching death. The said respondent aimed to disregard people's projections by opening a business towards becoming self-reliant. This speaks to the paradox in that the patient was not in denial (she was affected by these confrontations), but that she nevertheless attempted to forget them. Another respondent, breast cancer patient Aida "A" from the West Bank, shared how she tried to conceal her illness as a way to avoid social "projections". She stated that she made this decision so that those who are superstitious about this disease would not find out about it. After all, some people would link the disease to "divine punishment", while others might gloat over someone's suffering. Another reason why she concealed her illness is that she was sure that she will recover one day and did not want people to keep asking about her health in the meantime. Being constantly inquired about the disease, she noted, would bring back the same traumatic incidents and feelings that she struggled to overcome. She noted:

> **"I concealed my illness, but it was a wrong decision. They found out that I have cancer from a person outside our village. But I was hiding my illness for two reasons: First, there could be some people from my area who dislike me, and I did not want them to find out. But the second and more important reason was that I will recover one day and do not want people to keep asking about my illness and reminding me of it. People also found out about my illness from other patients who were with me in hospital." (Ramallah, January 2021).**

Breast cancer patients usually have the liberty to speak in front of the doctor, health professionals, and their family. However, many of them do not express their pain to strangers in the public sphere. Also, the suffering patient sometimes faces the paradox of talking about her pain to some people while concealing it from others. Hence, they swing, so to speak, between disclosure and concealment (Le Breton, 1984, p.373). However, it is tricky to hide one's illness in strongly interconnected environments, which often take the form of an extended family. In these contexts, every individual's behavior and demeanor are closely watched by their surroundings, including their going out and coming in. In such environments, hiding the disease can only happen for a limited time, and any coincidence can lead to exposing one’s illness [to the public].

The Strenuous Battle of Chemotherapy

Chemotherapy is the most strenuous battle in the cancer experience. It takes one to an invisible internal fight between two opposing aspects causing excruciating pain to different body parts. It requires strong resilience, patience, and moments of waiting that are (according to many) “similar to hell”.

Breast cancer patient Aida “A” from the West Bank describes this battle as follows:

> **“In my opinion, my suffering under chemotherapy was worse than a nuclear war. In some cases, a person might sit somewhere and just pass away. But the war between one’s self and chemotherapy is an ongoing internal war that you cannot avoid at any moment”. (Ramallah, January 2021).**

Doctors are aware of the intensity of that battle. Hence, they try to give the cancer patient an idea about what awaits her so that she can confront pain, and not succumb to fear and panic. Le Breton explains that the profession of medicine requires good attendance to patients’ needs and modifying the treatment according to the individual. He also notes that, in order to avoid panic in the minds of patients, the doctor must involve them in the adopted treatment plan and to deal with them as partners. Le Breton adds that when doctors give information about a certain treatment and its effects, patients become actors of their own treatment. This can minimize the impact of the pain, especially because the giving of medical attention decreases the patient’s feeling of helplessness (Le Breton, 2017). The testimonies of study respondents showed that doctors explained to patients what will happen to them in the upcoming period, along with giving them advice and instructions. However, no respondents mentioned that the doctor took their opinion about the chosen treatment plan. Also, doctors neither explained nor clarified the type of treatment or the mechanism of its selection. This means that the medical establishment became somehow disconnected from the people, thus dealing with bodies as “physical materials” on whom they applied their scientific skills along with complex clinical terms and concepts exchanged between doctors. This created two separate groups within the medical realm: 1) The group of doctors using medical discourse and conducting medical practice on bodies, and 2) The group of patients who are alienated from that discourse and who hand over their bodies to doctors that are considered “experts”. What was ironic here was the great level of surrender demonstrated by patients regarding their treatment plans. According to study respondents, that "surrender" emerged from the failure to involve women in their treatment plans and not talking to them in comprehendible language and terms.

Breast cancer patient Rula "J" from the West Bank spoke about not knowing anything about her treatment, as follows:

> **"When the doctor told me that I have breast cancer, I did not grieve at all. I was not sad, I just said: 'Thank God' and remained content. I said to myself 'When Allah loves someone, He afflicts them with trials.' I decided to take the treatments but didn't know anything about them. I didn't know how painful they were. I just knew that I was going to get chemotherapy and will undergo an operation. But I had no idea whatsoever about the details." (Ramallah, January 2021).**

Moreover, breast cancer patient Samar "K" from the West Bank noted that she only received an explanation about the effects of chemotherapy but was not advised about any treatment plan to get rid of the disease. Therefore, chemotherapy was explained to her as "effects" that she must deal with. In her words:

> **"The doctor explained to me the symptoms of the first chemotherapy session, and these symptoms appeared from the first day of taking the dose (such as fever, shivering, body aches, and nausea for a week), after which I went to hospital. Chemotherapy is like a "liquid fire" passing through your body, and to compensate for the good cells, you must have good nutrition. However, I had a problem in eating because food was causing me nausea. The first time I experienced that, I called the doctor in the middle of the night and asked him to give me medication because I was really sick. He told me to take an injection but that was not really helpful. After the third dose of chemotherapy, I told my mother that I cannot continue this treatment, although there was only one more dose left. But my mother insisted that I continue the treatment, saying that I should do this for the sake of my daughters. She finally convinced me, and I took the fourth dose as well." (Ramallah, January 2021).**

This is also in line with the statements of breast cancer patient Rana "S" from the West Bank, who

pointed out that:

> **"I had my first chemotherapy session on January 23, 2017. These sessions were intense and I took the strongest types of chemotherapy, i.e., the red one. Before I took that treatment, they asked me: 'What do you know about chemotherapy?' I replied: 'I know that the hair will fall out, but I do not know anything else.' Then they began explaining to me the types of cancer that can be treated with chemotherapy, along with the negative effects of chemotherapy." (Ramallah, January 2021)**

On her part, breast cancer patient Safiyya "R" from the West Bank shed light on the pain caused by chemotherapy inside her body, not in terms of "visible" or "invisible" effects but, rather, as a stifling pain. She stated that:

> **"The doctor prescribed four chemotherapy sessions. Before my first dose, they gave me a sedative (tranquilizer) and I slept for about half an hour. Afterwards, they told me to eat something (such as a sandwich) and sit under a tree and then come back. I later found out that this was done to relax the body so that it would withstand the treatment. I returned later and sat on a chair. They gave me chemotherapy, and its color was red. I was taking chemotherapy at 9 in the morning and the [intense] pains would begin exactly at the maghrib (sunset) prayer. This happened in all four sessions. However, each of the sessions had a different percentage of concentration. For example, the first session started with less concentration, but the sharpness heightened in the last session. After my last session, I had severe pain for a whole month and thought that I was going to die! You feel like your bones are breaking with substantial pain. I didn't understand what was happening to me! You feel as if there are knives inside your body. I used to scream very loud due to the pangs and would call my mother constantly. I felt that I couldn't hold on… it was unbearable. After the first session, I remained patient and pressed on myself throughout the night. It is also worth noting that the levels of pain change between the sessions. During the morning, I used to scream a lot and couldn't stand it and would ask my mother to come. I felt suffocated and almost stopped breathing. I would get up and walk to take a breath… It felt like choking. Many times, I would**

> **say: ‘Enough is enough, I want to die.’ I could not breathe.” (Ramallah, January 2021).**

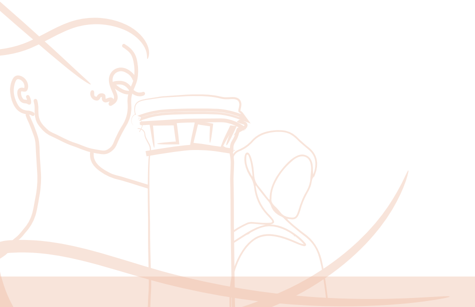
These women were put in situations where they suddenly found themselves overtaken by terror and agony. Alas, the pain of cancer cannot be understood or imagined without knowing the shooting pains of chemotherapy. It is no wonder that chemotherapy became synonymous with cancer, as it is considered the most agonizing internal pain and suffering.

In order to face the torment and fear of that disease, many breast cancer patients decide to embrace it. Le Breton recounts how a prisoner once tried to commit suicide, leading to physical burns and hospitalization (without any risk of death). The prisoner was complaining of pain and the nurse promised to give him an additional dose of painkillers. However, she got preoccupied with something else, whereas the psychiatrist was speaking to him. The warm and spontaneous conversation with the psychiatrist enabled the prisoner to talk about his life and his personal problems. When the nurse finally came with the painkillers, the patient refused them with a huge smile on his face, saying that he does not need them anymore because the pain is gone. Therefore, meaningful conversations, a warm voice, and listening carefully to others without judging them can greatly decrease pain. In some cases of pain or suffering, communication does not even require words because hugging and touching can create rapport between people when words are absent. For example, a hand on one’s forehead or pat on a shoulder can break the patient’s solitude and enhance solidarity and harmony. This can also express friendship and rapprochement during affliction. When words cannot be used to express one’s feelings, a touch can greatly express their emotions. This is quite significant and transcends the traditional rituals of interaction (Le Breton, 2017).

Breast cancer patient Rana “S” from the West Bank talked about how her husband’s embrace helped her overcome her fear of loss due to the disease:

> **“My husband used to warmly touch my bald head and say: ‘I swear to God this is nicer than the bald head of Abu-Wazni!’ [Abu-Wazni is a man known for his big bald head in our village]. He would laugh a lot and pamper me and would talk about me with great confidence. He stood by me in every aspect of my life, and after my illness our relationship only got stronger and more beautiful.” (Ramallah, January 2021).**

By and large, the greatest solidarity and support for these women came from their children. For



example, the children would joke with the mother, apply makeup on her face, and take pictures of the hair growth. The acts seemed worthy of showing the patient how beautiful she is. Breast cancer patient Amira "M" from the West Bank recounts how her daughters applied makeup on her face and painted her nails, while telling her how beautiful she is:

> **"I am blessed to have three daughters, so I did not need anyone else during my illness. My daughters took care of everything at home and stood by me. When they wanted to talk to each other, they would go somewhere else. They always gave me flattering compliments like: 'Mom, you are so beautiful today' or 'Wow, mother, how pretty and luminous is your face today! It's as if you don't take chemotherapy.' When my hair started to grow again, they used to give me great remarks, and whenever a new hair appeared they would take pictures of it. They often brought me juice and received the guests. They arranged the clothes, did my makeup, and drew my eyebrows. They also had me wear a turban and make me laugh. Oh God, how amazing they are!" (Ramallah, January 2021).**

On her part, breast cancer patient Jumana "S" from the West Bank explained how her children took care of her and provided her with nutritious food:

> **"My kids are great. They accompanied me in all my [chemotherapy] sessions. They would compete over who would make healthy food and smoothies, such as carrot juice. The fourth chemotherapy session was different since I took the red one, which burns the body. My children were very worried about that, and my eldest son was greatly affected. My children bathed and dressed me, and my daughter drew my eyebrows. My daughters are constantly buying me new pretty clothes. In short, my children's support was fascinating." (Ramallah, January 2021).**

Another kind of support was observed between patients themselves. In general, the patient suffering from breast cancer unintentionally distances herself from others. However, patients who undergo such ordeals sometimes seek to find other patients who faced similar problems. Sharing their experiences and exchanging tricks and methods can have the power to alleviate the intensity of the pain (Le Breton, 2017).

One cannot fathom that pain without personally experiencing it. Therefore, the people who went through breast cancer, who had to move between different institutions, and who underwent doctors' treatment plans are the only ones who truly understand that pain. The feeling of that pain cannot be expressed with mere words. This shows how language is often limited in articulating emotions. Also, patients oftentimes look for a shared identity with other patients in times when the pain becomes a fundamental aspect of identity. Solid relationships, in this respect, are also empowering in the face of the suffering.

In this context, breast cancer patient Leen "Kh" from the West Bank talked about the friendship that evolved between her and other patients:

> **"A fellow patient and I formed a valuable friendship during a chemotherapy session. We sat next to each other, talked together, and got to know each other well. She told me that her cancer started from the breast and moved to the spine. I became friends with several women there. I wanted to see that woman again and searched for her. Then I heard the voice of a woman crying and screaming, so I entered a small room, and she was there. The nurses did not know where to insert the injection... They tried from her leg, and I went out but couldn't run. I was crying ceaselessly." (Ramallah, February 2021).**

Breast cancer patient Fayha' "S" from the West Bank described her meaningful inter-patient relationships as follows:

> **"I finished my [chemotherapy] treatment six years ago and until today I feel a strong connection and bond with these women. I remember them every day and I think of them and wonder what happened to them. I did not expect to remain this much connected to them!" (Ramallah, January 2021).**

Recently, there was the emergence of several patient groups, especially those suffering from chronic pain, who have the desire to solidify their personal identity through shared networks. Moreover, there is meaningful communication between group members through internet sites and platforms where patients talk together (Le Breton, p.57, 2017). These groups were further enhanced due to having similar hopes and aspirations.

The statements of study respondents showed that they formed social media groups, as breast cancer patient Raeda "W" from the West Bank shared:

> **"When I got sick, I thought it was the end of the world. But when they told me (at Dunya Women's Cancer Center) about a group of women who recovered from cancer, I immediately accepted to join them. This group gave me a good push and they talk about adequate solutions. Also, I met new friends and trainers in that group and my life changed for the better." (Ramallah, January 2021).**

In this regard, Marah Amro – who is a psychological support officer and social counsellor at Dunya Women's Cancer Center, pointed out that:

> **"After the recovery phase, we start integrating women into supportive groups. We tell them that this disease is not the end of one's life. We conduct supportive activities, and train them on project management to enhance their effectiveness. This convinced many women that this disease is not the end of the world. Also, we keep listening to their requests and wishes. For example, many of them expressed the desire to go to the beach, so we organized two trips for them to the seaside." (Ramallah, January 2021).**

But did we ever stop and ask ourselves: "What are the dreams of breast cancer patients?" According to study respondents, their dream is to return to normal life with its basic daily routines, such as taking care of their kids, cleaning the house, preparing food, and so on. These normal daily chores, which many consider "tedious", are the biggest dream for cancer patients who struggle for that purpose! Breast cancer patient Aida "A" from the West Bank explained this as follows:

> **"I was eager to return and clean my house and go back to my children. I yearned to sit at home with them, cook for them, and teach and take care of them. My youngest daughter was in the third grade [about 8 years old] when I was diagnosed with breast cancer. She kept crying and telling me: 'Mom, I don't want you to die!' She would add that cancer leads to death and that she hoped to see me more at home because I was often being hospitalized. She cried all**

> **the time during my chemotherapy treatment. My dream was to just go back home and take care of my children." (Ramallah, January 2021)**

Likewise, respondent Rima "R" from the Gaza Strip spoke about her dream as follows:

> **"My dream was to return to normal life. This was my main concern. I dreamt of recovery in order to help my husband go to work in the morning and prepare my children for school. I also hoped to clean the house and prepare food for my children so that there would be food on the table when they come back. I really missed these things. My dream was to recover quickly and compensate them for these [difficult] days." (Gaza, February 2021).**

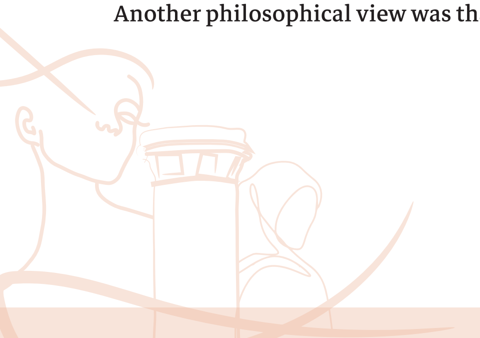
These things, which connect the participant to her surroundings and to those who need her, reminded her of the normal life. In her direst moments, she realized their need for her to be healthy and her desire to be around them and embrace them. She now dreams of the small details which seemed "boring" in the past, especially because they are linked to normal life with the "hustle and bustle" of her loved ones.

Philosophy of Life ("Spiritual Realm")

The statements of respondents showed that their experience with cancer led to a new outlook towards life that enhanced their spiritual life. For example, breast cancer patient Ghada "M" from the Gaza Strip noted that: "My whole view of life changed. I started taking things more gracefully. I no longer give too much attention to my worries. Everything became trivial compared to that disease." (Gaza, February 2021).

Moreover, respondent Fayha' "S" [breast cancer patient] from the West Bank explained how the disease completely changed her as a person, and that it transformed her way of dealing with life's concerns. When someone defeats this disease, she clarifies, it transforms the self into an inner warrior. In her words: "After cancer, I became a new person and learned to love myself. I love everyone, but my self-love takes precedence over my love for others." (Ramallah, January 2021).

Another philosophical view was that this disease came in the form of trials and tribulations, and that



Allah tests those who are righteous and faithful. According to this view, patients must withstand the affliction by becoming closer to God through worship and spiritual practice. For example, respondent Samar “K” from the Gaza Strip stated that: “Everything is trivial compared to the disease. You feel that you must thank God. I personally saw my faith grow a lot because of that. You feel as if you are in another world, a spiritual one.” (Ramallah, January 2021).

Furthermore, respondent Fida’ “H” from the West Bank explained how her empathy towards other people’s pains increased after her experience with cancer. This also made her more active and involved in social events. She noted that: “I became more empathetic with people. For example, if someone is sick, I feel that I am sick as well. I always make sure to visit ill persons around me. The disease made me stronger, and I became more involved in social activities.” (Ramallah, January 2021). Additionally, respondent Safiyya “R” from the West Bank stated that her experience with cancer revealed true friendships: “This experience was difficult, but I loved it. It showed how true friends stand with you through rough times. These experiences reveal many things to you.” (Ramallah, January 2021).

Also, respondent Rania “N” from the West Bank explained how the disease can make a person capable of confronting challenges and persevering in the face of the disease:

> **“Cancer taught me a lot of things. This difficult experience made me a strong person. I used to be oppressed by my family members. They would impose all the rules and I used to obey them. However, when I got cancer, I stood courageously in front of everyone. I learned to say ‘no’ when I disagreed with something. Today, I do whatever I deem suitable. Through the cancer, I also discovered the people around me. I never imagined that my husband would cheat on me. Shortly after my illness, I found pictures, messages, and other things which indicated that. Cancer taught me that nothing is unusual, but that one must never give in to despair. You must be strong!” (Ramallah, January 2021).**

Therefore, this disease leads to a new perspective and philosophy of life. It also raises questions about the way in which this disease spreads within the body and gets “engineered” in a silent and unnoticeable manner.

Conclusion

Engineering of Death: Policies of Controlling Silent Bodies

Conclusion

In general, breast cancer has been viewed as a strictly physical disease. This book, however, proves that actions pertaining to the disease do not occur in a vacuum, as certain devised policies go together with it. To get a good grasp of what this disease and the violence it inflicts upon human bodies entails, one must examine the different aspects, concepts, and standards related it. In sovereign countries, one may unravel this issue by considering the political, economic, and social dimensions. The case of Palestine, however, requires an extra critical analytical lens, namely the colonial context and its structural target to eliminate Palestinian bodies. It becomes apparent how such a context gets ill bodies trapped amid hostile policies. It leaves patients no chance to escape the subjugation and punishes them for any attempt to do so by denying them access to treatment.

The book demonstrates how the prevailing Palestinian discourse – focusing primarily on military and political struggles, catchy slogans, and huge aspirations – has always overlooked ordinary individuals' experiences, daily suffering, and life concerns. In this sense, the dominant discourse has either disregarded personal narratives or tried to use them for political gains.

Irrespective of the dominant discourse that has often neglected individual suffering, this book puts forward a narrative for breast cancer patients. It offers the space to reflect upon these women's voices, adversities, and unrecorded history. This is vital because the narratives of these women and their sharing of 'biological deficiencies,' as per the lens of violent colonial structures and negative social stereotypes, are closest to reality.

The research may enhance public awareness of the structural violence perpetrated against the bodies of women suffering from breast cancer. Amplifying the voices of women themselves and hearing their perceptions in the face of the oppressive structures is ultimately more suited in the creation of knowledge than relying on the viewpoints of "experts."

The book thus recontextualized the angle of knowledge production: It did so by steering away from the "structure/ego" representations of the "expert voice" and turned, instead, to the lived experiences of women with breast cancer (whether stated explicitly or implicitly). In essence, this redirection of knowledge production shifts the discourse from the 'margin' to the 'center', as it provides the opportunity for these women to recount their stories and speak out about the violent policies and practices perpetrated against them.

Among other things, this book attempted to scrutinize colonial policies pertaining to radiotherapy, especially because this treatment is not available in the Gaza Strip or the West Bank. Within this context, Palestinian breast cancer patients are subjected to a set of intertwined, integrated, and institutionalized colonial policies – all of which must be examined in an all-inclusive and comprehensive manner. As Raef Zreik points out, every detail paves the way for discovering other important details. For example, a settlement indicates a special road that leads to it, and the road points out to the [apartheid] wall, and the wall is linked to permanent military patrols (Zreik, 2014).

The book also captured how colonial policies are influenced by Zionist political ideology that legitimizes punishment under the pretext of “Israeli/State security.” The “Shin Bet” security agency (also called “Shabak”) serves this purpose: This agency is tied to institutionalized surveillance structures and probes into the lives of Palestinians. In fact, it monitors every detail of human bodies to determine, as per the colonial viewpoint, whether a Palestinian is “disciplined/good” or “non-disciplined/bad”. The Palestinian bodies that the Shin Beit considers “bad” will ultimately get punished: They will be denied entry to the 1948 areas (i.e., within the Green Zone) and part of the territories occupied in 1967.

Also highlighted in this book is Israel’s discriminatory categorization of “life rescue” vs. “quality of life” policies. In distinguishing between the two, it denies medical travel for cancer patients who are subjected to such classification in the Gaza Strip without specifying the criteria for “quality of life”. This policy made it extremely difficult for patients to prove their right to treatment as a “rescue of life” and not a “quality of life” issue.

The book also shed light on the numerous cases of violence perpetrated against breast cancer patients and their accompaniers in the public space. The assumed ‘security policies’ have subjected cancer patients to exaggerated physical searches, including undressing them at times and taking away their food and drinks. Also, these bodies were forced to be “disciplined” during inspections, strip searches, and violent actions. In the context of torture and humiliation, Palestinian bodies are forced to “adhere” and “comply.” Otherwise, they will get punished: The colonial structure will deny them access to medical treatment and deprive them of the right to recovery.

The book also demonstrated the Israeli attacks against the health sector in Palestine by means of shelling, incursions, marginalization, and closures, alongside the neoliberal methods going simultaneously with Israeli assaults (especially in the Gaza Strip). These acts intend to destroy health sites that might rescue or restore a Palestinian body after getting attacked by the military.

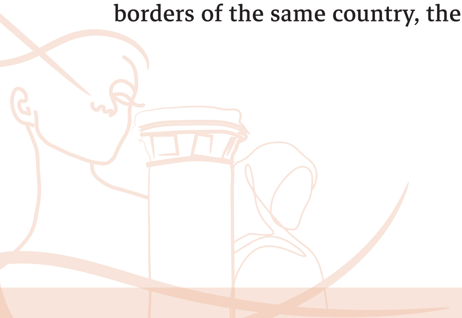
The book also deliberated over the revolutionary period when people had worked in solidarity and with synergy. Back then, doctors were not isolated from patients but were on the front lines of the battle to save lives. However, after the establishment of the Palestinian political regime following the

Oslo Accords, this sector became institutionalized within largely bureaucratic hierarchies and rigid administrative systems. After Oslo, receiving good health services became reliant on market laws and capitalism, thus turning the medical profession from a potentially liberating tool into a mere job. Within this framework, powerful states, donors, the World Bank, and International Monetary Fund (IMF) played a major role in designing their global "recipe" for Palestinian state-building and set priorities which did not hold colonial structures liable. Consequently, the newly established political system started competing with the existing medical frameworks in providing primary healthcare services instead of investing in and developing their capacities in treating incurable diseases. By and large, the Palestinian health regime was unable to provide sufficient human resources, equipment, and treatments for such diseases. This led to serious problems (particularly the substantial "medical transfer" purchases), that successive Palestinian governments failed to address.

Furthermore, the book highlighted the lack of approved medical protocols/procedures in Palestine vis-à-vis the examination, diagnosis, and treatment of breast cancer. As a result, most cases of cancer were either discovered by chance or by the spread of the disease in one's body, and there were medical errors in patients' treatment plans. The findings revealed that most women did not have a certain place in mind for undergoing cancer-related examinations. As a result, each respondent would get her cancerous lump examined in a different place that she heard about by word of mouth or through a friend/relative advice.

Among the issues discussed was the lack of trust between cancer patients and public sector services due to the absence of specialized oncologists in public hospitals until the beginning of 2020. This was aggravated by the insufficient number of medical staff (e.g., oncologists, radiologists, surgeons), and the far distances between health departments and buildings. Several patients mentioned the inconvenience of having to move between far-away locations, seeing that the doctor would be in one building, laboratory in another, and radiology department in a third building. This contributed to long queues, waiting time, and poor cancer treatment services in cases where women sought treatment in the public sector.

The book also discussed women's relationship with themselves and the relationship of others with these women. This gender-specific identity is influenced by cultural ideals and systems, images/stereotypes, and social expectations regarding "femininity". Within this context, I argue that, although the "gender standards" might differ according to place and time even within the geographic borders of the same country, these constructs are quite similar when it comes to women diagnosed



with breast cancer, who are viewed as different from other women. A cancer patient's body is not perceived as an ill body versus a healthy one but, rather, as a body 'devoid of femininity' due to linking femininity with two criteria related to loss and physical condition during sickness, namely the breasts and hair

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Through the testimonies of patients, the book examined how certain perceptions were so deeply ingrained in the minds of these women that they became a basic component of their gender identity. This transformed the gender identity of cancer patients from being victims into "co-enhancers" of the same power structures defining 'femininity' that are practiced against them. Through the patients' statements, the book considered the social perceptions towards women's bodies after their loss of organs, where stereotypes enforce certain physical criteria regarding these women's gender identity. Such disciplinary techniques are also promoted within families, schools, and different institutions.

The book included several painful stories expressing the torment of suffering individuals who are oftentimes weak and fragile. These stories are filled with 'suffocating' feelings as found between the lines of patients' statements, such as the sense of 'choking' that ripples strongly inside these women who live in an atmosphere that directly links cancer with death. The society does not consider this disease as a temporary illness but, rather, as an imminent state of death. Therefore, many people –in fear or superstition– choose to avoid the mere mention of the disease and refer to cancer by something along the lines of 'the malignant disease' or 'that disease'.

The testimonies in the book revealed the painful and invisible battle between the opposing forces of 'body' and 'pain' in those struggling against cancer. This battle requires strong resilience, patience, and moments of waiting which, according to many, are "similar to hell".

By and large, this book was produced to deconstruct the discourse pertaining to cancer and shift it from the margin to the center. This is a natural, normal, genetic, or hereditary illness, and it should not be restricted, manipulated, or engineered in any way that oppresses against the bodies suffering from it. It is thus vital to re-examine societal views, as well as to transform victims' negative perceptions of their reality. This could make room for several marginalized narratives in the face of elitist discourses which use human suffering mainly for promoting political goals or conducting research studies.

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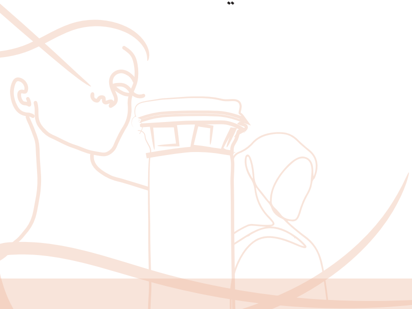

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