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Deafness among the Negev Bedouin: an interdisciplinary dialogue on deafness, marginality and context

Kisch, S.

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Chapter 6:

Reproductive Encounters: Negev Bedouin Women's Lay Encounters at Childbirth in an Israeli Hospital¹

Abstract

Though hospital studies have often focused on the vertical relationships between patients and medical staff, the interactions *between* patients have received much less attention. Whereas interaction with staff members is episodic, patients often spend long hours sharing intimate space and daily routines. Such encounters are particularly important when hospitals cater to social groups embedded in socio-political tensions. This paper examines the encounters between women on two sides of a socio-political divide: for several days during and after birth, Israeli Jewish and Arab-Bedouin women, share intimate proximity. Many Negev Bedouin women seldom interact with women outside their own immediate social circles, let alone Jewish-Israelis. Most do not move freely in public space, particularly in spaces that are mixed by gender and ethnicity. I suggest that hospital maternity wards present an unusual encounter zone embodying various contradictions. While birthing is central to the political it also inspires the core metaphors of motherhood and shared humanity. Employing such metaphors can be simultaneously empowering and disempowering. Akin to the de-politicizing potential of medicalization processes, it often conceals the body politics. I analyze the significance of Bedouin women's encounters with unfamiliar women both Jewish and Bedouin, and argue that these encounters are particularly revealing for what they betray of Bedouin women's negotiation of self and other. Bedouin women establish unmediated knowledge about the Other, and refer to these observations to reflect critically on their own society. Additionally, Bedouin women engage in complex deliberations among

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themselves, sharing experiential knowledge and concerns related to childcare and motherhood, and in the process generate a critical debate that reaches far beyond these specific issues. The hospital is thus, not merely a site where health-related values and practices are enacted, but one where they are formulated, negotiated and challenged, *vis-à-vis* others. I thus argue the significance of studying what I here call “lay encounters” for what they betray of the larger social context in which they are embedded.

INTRODUCTION

Inspired by Foucault (1973), anthropologists have approached hospitals as institutional sites of power and surveillance that are inscribed by wider historical and socio-political dynamics. They have also recognized that hospitals differ across ethnographic contexts (van der Geest & Finkler 2004). This has led them to argue that, while hospitals may constitute distinct social worlds, like biomedicine, they are both the product and the producer of specific social arrangements and historical moments. Some early works (Caudill 1958; Goffman 1961; Coser 1962) explored the daily life in hospitals; however, patients’ social worlds have since been abandoned as the primary subject matter of hospital ethnography (Zussman 1993). What is often missing from current otherwise useful analyses, is attention to the fact that interaction in medical settings is not only organized vertically, i.e. between doctors, other staff members and patients. In fact, given the little time available to medical staff to interact with patients, vertically-organized interaction between staff and patients constitutes only a small proportion of everything that takes place in medical settings.

I propose that the social and cultural meaning of medicine is equally-if not more dramatically-constituted horizontally through interaction *among* patients, or what I here call “lay encounters”.² Through these lay encounters, which occur during prolonged waits and between brief encounters with medical staff, people from vastly different walks of life who would otherwise not meet share intimate space and daily routines, construct ideas about: each other, the social positions they represent, and the context of the encounter. While patients may seek privacy in the face of ailment and uncertainly, they

² As opposed to encounters with hospital staff members, these encounters are with fellow patients and visitors. “Lay” is used as opposed to “professional” rather than to “clerical”, as is also the case with the now common use of the term “lay knowledge”

also feel the need to provide and to acquire information about medical procedures, to evaluate services and providers, and do emotional work around anxiety, hope, joy and other kinds of affects. These lay encounters entail far more than the mere exchange of information; for, people observe one another and reveal themselves to each other, often in intimate ways they would hardly- if never-see each other in other life circumstances. It is through these lay encounters that people construct the cultural, social and political meaning of biomedicine, its relevance for their lives, as well as the entire social and political contexts of their lives.

It has long been established that decisions concerning when to seek medical aid, whom to consult, whether to comply, and how to evaluate the efficacy of treatment are made in the popular, non-professional domain (Kleinman 1978). This was established even before the current proliferation of self-help groups, and other patient organizations, which likewise valorize and produce experiential knowledge to challenge and to complement biomedicine (Kelleher 1994). Thus I suggest medical settings—including hospital wards where patients, often subject to medical intervention of the same kind—should be examined as important sites for negotiating such knowledge. The hospital is not merely a site where health-related beliefs are enacted, but a site where they are formulated and negotiated. I would venture so far as to say that, in the ethnographic setting I analyze in this paper, lay encounters render medical staff largely superfluous both as providers of health information and conduits of ideology.

These encounters are particularly important when health institutions cater to social groups that are deeply segregated, in conflict with one another, or embedded in major socio-political tensions and mistrust. My ethnography examines how two groups on each side of a deep social divide negotiate their encounters by evoking the naturalness of bodies, birthing, and motherhood.

Birthing operates in a particularly charged domain of medical intervention- the intersection of medical and reproductive regimes. The encounter between feminist theory and anthropology has produced a substantial body of literature analyzing the cultures and politics of birthing and reproduction (Jordon 1978; Martin 1987; Handwerker 1990; Ginsburg & Rapp 1991, 1995; Strathern 1992; Davis-Floyd & Sargent 1997; Yuval-Davis & Anthias 1997; Lock & Kaufert 1998). Such studies have revealed the many ways in which reproductive practices inscribe the body with particular structures of power.

While population control approaches—with their colonial heritage—often perceive certain women primarily as producers of too many children, the modern project of nation-building further complicates women's status, this time by often promoting increased reproduction. Separate regulations are introduced to incorporate women through their national mission of motherhood; consequently, women's membership in their respective national and ethnic collectivities is often ambiguous (Yuval-Davis & Anthias 1989). Both Jewish-Israeli and Arab-Palestinian women have been shown to be conscripted to “birth the nation” (Berkovitch 1997; Kanaaneh 2002 respectively). Reproductive regimes have always been categorically selective, along lines of class, ethnic and bodily differences; thereby perpetuating “stratified reproduction” by empowering some categories of people to nurture and reproduce (Ginsburg & Rapp 1995). At the same time, Kanaaneh (2002) has convincingly illustrated how women across such ethnic and class divides adhere to similar ideas as to what constitutes “reproductively modern” families. Reproductive health care systems play an important role in endorsing such reproductive regimes. However, the assumptions and ideologies underlying such reproductive regimes are not solely asserted by state agencies or reproductive health care systems. My ethnography examines how lay reproductive encounters convey powerful versions of these ideologies.

While birthing is central to the political, it also serves as a core metaphor for shared humanity. These may seem to be incompatible accounts of birthing: in practice, however, they are deeply intertwined. The history of feminism and anthropology demonstrate how metaphors of shared humanity or womanhood can serve both as a compelling appeal for equity as well as a barrier to acknowledge difference and subordination. Lay hospital encounters illustrate the enactment of both approaches. Moreover, I propose that it is precisely on the basis of such assumed human communalities that the body politics is conveyed and asserted in powerful, albeit implicit ways.

I will investigate these issues using ethnographic materials gathered during visits to hospital maternity wards with Bedouin women, in Beersheba, (the largest city in the Negev region), during a long-term ethnographic engagement, ongoing since 1996. During my initial stay, to improve my local dialect of Arabic and to learn a locally-developed sign language, I resided with the inhabitants of a formally-unrecognized Bedouin settlement around Beersheba. My original concern did not focus on hospital visits or childbirth.

However, living in a household with four co-wives and more than a dozen daughters, visiting with women to their relatives' homes and to clinics, occupied much of my fieldwork time. In the courtyard of my host family alone, more than twenty new children have been born since my initial stay. I was present at the hospital delivery of two of the baby girls, in both cases the mothers planned my presence since early in their pregnancies.

What initially drew my attention to the significance of hospital experiences was Bedouin women's persistent reference to these encounters, occasioned by childbirth, with Jewish-Israeli women of diverse extractions, class and religiosity. Bedouin women often contrasted "the Arabs" and "the Jews" even as they recalled diversity among Jewish-Israelis, and appreciated differences among Bedouin women. Their observations confirmed as well as disturbed existing perceptions and prejudices. Zenab, describing a fair-skinned woman she saw breast-feeding a black baby, proclaimed "This woman actually agreed to marry an Ethiopian!" . She was equally shocked to find out that another Jewish woman chose to become a single mother, remaining unmarried. Sabriya told me that she was amazed that the Jewish-Israeli woman lying next to her was actually a Yemenite, and that her mother—who spoke Arabic—had ten children, "just like Arabs". As to comparisons within their social context, Jamila, for example, was impressed by the fact that some Bedouin women visiting the hospital were more independent, freer to come and go, than women in her own community.

Negev Bedouin women not participating in the labor market or in higher education seldom have personal interactions with women outside their own immediate social circles, let alone Jewish-Israelis. Most do not move freely in public space, particularly in spaces that are mixed by gender and ethnicity. Hospital maternity wards are one of the few places where encounters with diverse unfamiliar women occur. For a few days during and following childbirth, women share intimate proximity. They are exposed to a very broad array of different reproductive and cultural practices and values, as well as to the social, cultural and bodily practices of complete strangers.

Exploring these encounters leads me to a three-fold argument. The first is that maternity wards provide a *unusual* "encounter zone," placed as it is within the urban and public, yet a stage of the intimate and gendered, embodying diverse tensions and ambiguities about socio-political identities and gendered behavior. The second argument is that Bedouin women establish knowledge of Jewish-Israeli society, its conduct, and its diversity

based on their hospital encounters, which they draw on as a source of authority to confirm and challenge representations of the Other and to develop an “indirect discourse of complaint” (Kelsky 1996:184) to criticize their own society and, often, their own men. Actual exchanges between Jewish and Bedouin women are brief and often entail mere observation rather than more directly-mediated contact, whereas the most sustained exchanges take place *among* Bedouin women, which brings me to my third argument. While Bedouin women use Jewish women as a contrast, they engage in complex deliberations among themselves, sharing views and concerns relating to medical intervention, childcare and motherhood, and generating a critical debate that reaches far beyond these specific issues, including polygamy, breastfeeding, caesarean sections, and family size, indeed, encompassing nearly every aspect of their socio-political positions.

“THE ARABS OF BEERSHEBA”

The native Arab inhabitants of the Negev region are former semi-nomads, commonly referred to as Bedouin. Prior to 1948, they were known as *'Arab an-Naqab* or *'Arab as-Saba*, “the Arabs of Beersheba,” and relied on a combined agricultural and pastoralist economy. Following the establishment of the state of Israel, they have undergone drastic economic, social, and political upheavals. After 1948, only a minority of *'Arab as-Saba* remained within the boundaries of the Negev, confined to an enclosed area where they were kept under military administration until 1966.³ Through the establishment of urban settlements, the Israeli government made a concerted effort to concentrate the Bedouin into state-established townships and to minimize their use of land resources.

The current Negev Bedouin population exceeds 170,000,⁴ half of whom reside in seven such townships. The others inhabit settlements unrecognized by the state, lacking basic infrastructures (e.g., roads, running water, electricity, sewage and waste disposal). Bedouin townships soon became large suburbs with limited employment opportunities; consequently, a

³ Whereas prior to 1948, the estimated number of Negev Arabs was between 65,000-90,000 (Falah 1989), by the beginning of the 1950s it dropped to 11,000 (Marx 1967; Falah 1989; Meir 1997).

⁴ Estimate based on the Statistical Yearbook of the Negev Bedouin 2004.

marginalized, gendered urban proletariat emerged at Beersheba's periphery. Most men, but only a few women, participate in the Israeli labor market, and Bedouin's unemployment rates are among the highest in the country (Marx 2000; Jakubowska 2000; Abu-Rabia 2000). The Bedouin constitute 25 per cent of the Negev population and mostly live apart from the Jewish inhabitants. As citizens of Israel, the Bedouin officially benefit from national health insurance and fall under the compulsory schooling law, but utilizing such services is hampered by discriminatory state priorities, difficult physical access, and language barriers. Supreme Court intervention is repeatedly necessary to compel state authorities to establish health clinics in Bedouin villages or to connect schools to the water system. (e.g Israel High Court of Justice (HCJ) 1997 verdict #7115, HCJ 2000, #4540, HCJ 2001 #3586, HCJ 2004 #786).

Despite considerable diversity in livelihood, lifestyle, political identities, education and gender segregation, the Negev Bedouin can be distinguished from other Arab inhabitants of historical Palestine,⁵ based on their shared nomadic past and distinctive demographic features, including fertility rates that are the highest in the country (50 per cent of the Bedouin population is under the age of twelve), common consanguinity (which reaches 58%, of which two-thirds are marriages among first cousins (Weitzman, 2003)), and common polygyny.

Sedentarization and male proletarianization have produced a sharp decline in women's productive roles and status (Jakubowska 2000; Lewando-Hundt 1984); consequently, for many Bedouin women, motherhood has become central to their very *raison d'être*. Illiteracy rates are still high among women

⁵ The diverse identities of the citizens of Israel are not consistent with either religious or national clarifications. This perceived inconsistency is an effect of the fact that most Israelis relate to their Jewish extraction as belonging to a Jewish nation, rather than a religious affiliation. The major divide in terms of identity is between Israelis who identify themselves as Jews and those who identify themselves as Arabs. The majority of Israel's Arab citizens are Muslim, a minority is Christian. While struggling for their civil rights as equal Israeli citizens, many wish to avoid the label Israeli as they embrace a Palestinian identity. The term "Bedouin" indicates yet another distinction made among Arab, denotes a former nomadic (rather than farming or urban) tradition. The Arabs of the Negev are former nomads, Muslims and citizens of Israel. In the current socio-political reality, the significant divide among Israeli citizens inhabiting the Negev is between Jews and (Muslim) Arab-Bedouin.

and most are monolingual Arabic speakers. Yet, an increasing number of younger women obtain literacy and attend higher education at Beersheba University; some are involved in paid labor that puts them in regular contact with the Israeli majority. Although these women constitute a small, but significant, minority, this paper focuses on the majority of Bedouin women for whom the maternity wards provide what are unusual encounters with a variety of unfamiliar women.

The diverse population make-up of current day Beersheba was largely determined by the fact that after 1948, the Negev became a major destination for Jewish immigrants from the Middle East and North Africa, as well as later immigrants from the former Soviet Union. Today it is Israel's fourth largest metropolis, and its population of over 180,000 also includes Ethiopian immigrants, a small Jewish ultra-orthodox community, Jewish and Arab university students from all over Israel, and, most recently, non-Jewish migrant workers. Nowadays, only a few hundred Arab families reside in Beersheba, mostly middle-class professionals from the north and the center of the country, and some young Bedouin couples employed as teachers, doctors, and other urban occupations. In sharp contrast to its few upper-middle-class neighborhoods and suburbs, Beersheba and the Negev population as a whole score low on national socio-economic measures.⁶

The city provides services for both the Arab and Jewish inhabitants of the southern districts. As elsewhere in Israel, Arabs and Jews mostly live separately and go to different schools, yet all Negev inhabitants use the Soroka Medical Centre in Beersheba, a university teaching hospital and only tertiary health service provider in the area. The wide-ranging clientele of the hospital, therefore, brings together diverse people who normally do not share social space.

⁶ The national socio-economic index evaluates all municipal councils' population, grouping them into 10 clusters. Beersheba itself scores in the fifth cluster, the Bedouin towns score in the lowest cluster (1), the surrounding (Jewish) towns score 3-4, but Beersheba's suburbs score in the tenth and highest cluster (Israel's Central Bureau of Statistics, 2003).

BEDOUIN WOMEN AND REPRODUCTIVE HEALTH CARE

Israel has a resolute pro-natal policy: highly subsidized reproductive health care services, one of the world's highest rates of assisted fertility facilities per population, various direct and indirect welfare incentives to increase family size, and practically absent "family planning" services. Until recently, the allowance per child, from the fourth child onwards, would more than triple. Though child allowances are currently targets of disputed cutbacks⁷, still the accumulated child allowances for a family with 9 children amount to more than the national minimum wage. Under the existing National Insurance Law and the National Health insurance Law, all Israeli citizens (Jews and Arab) are entitled to these reproductive incentives. though these incentives were undoubtedly intended to reduce- rather than to increase - the gap between Jewish and Arab fertility rates, child allowances are one of the more explicit manifestations of Israel's selective pro-natality. Until the mid 90s, military service was one criteria in calculating the sum of allowances, thus denying the vast majority of Arab citizens the full amount of benefits (Frish 2004).

At stake are some of the major paradoxes posed by the Zionist aspiration for a modern, Jewish and democratic state. An anxiety, shared across the Jewish-Israeli mainstream, is that Israel would cease to have a Jewish majority, often denoted as the "demographic problem". In the Negev, this gap is particularly large as the Arab-Bedouin population is characterized by one of the highest fertility rates in the Middle East. According to Israel's Central Bureau of Statistics, in 2003 the Total Fertility Rate (the average number of children a woman is expected to give birth to throughout her lifetime) for Jewish women in the Negev was 2.5 children, compared with 9 children for Muslim women in the Negev. Both the Israeli state and society address its Arab population with a modernist liberal discourse advocating restrained fertility, a population-control discourse deployed because Arab birth rates are perceived as a threat.⁸ In practice, however, and in sharp contrast to the

⁷ Child allowances might maintain many families on the edge of extreme poverty, but it has recently been show that, unlike commonly assumed they do not increase the birthrates among the poor (Frish 2004). The impact of such incentives on actual fertility patterns is thus questionable, even if the intents are unmistakable.

⁸ Concern with declining Jewish fertility rates led to the establishment of a special council in the 1960s, which was to recommend ways to encourage Jewish fertility. In

demographic rhetoric, reproductive patterns are fashioned by reproductive incentives, and the absence “family planning” services.

As a population with high fertility rates, most of Israel's Arab citizens are substantial consumers of reproductive health services. Yet they often encounter attitudes confirming that incentives to reproduce are, for them, merely an unintended consequence of social policy. This commonly results in alienation from the institutions providing health services (Kanaaneh, 1997, 2002). Though Arab doctors and other staff members are no longer unusual, the health care services are primarily staffed with Jewish-Israeli men and women. The obstetric unit at the Beersheba regional hospital has one Bedouin nurse and three other Arab medical staff members: in 2006 they were joined by a new medical resident, the first Bedouin female doctor.

Other factors associated with discriminatory reproductive health care services involve language, physical accessibility, and clinic distribution. Infant mortality among Negev Arabs is the highest in the country: more than three times higher than among its Jewish inhabitants (Weitzman 2003; Almi 2003). Poor living conditions and discriminative provision and accessibility of health services clearly contribute to these alarming disparities. Another prominent factor is a high incidence of congenital malformations⁹, which is associated with intermarriage, limited accessibility to peri-natal care and selective compliance to prenatal testing. National health services in Israel include comprehensive peri-natal care (before and after birth). However, the availability of health care facilities in the Negev is expanding; primary health care facilities and Mother-Child Health clinics (MCH) now exist in all Negev towns, including Bedouin townships. However, these and other health services are inadequate or even absent for many of the residents of the

2002, "The Israel Council for Demography" was reassembled. When it convened for its first meeting, human-right and feminist demonstrators called for the members to resign, claiming a contradiction between their obligations as doctors or as women's representatives and as members of the council (Haaretz, Sep. 3,9; Nov. 28, 2002).

⁹ Infant mortality due to congenital anomalies was 4.4 times higher among the Bedouin (6.6/1000) than among the Jewish population of the Negev (1.5/1000) (Weitzman 2003). Congenital (fatal and non-fatal) anomalies are undoubtedly high among the Negev Bedouin, however it is also the major factor addressed by a range of state interventions; the remaining factors (some closely related to poor living conditions, (Almi 2003)) do not receive any comparable attention in research or actual intervention.

unrecognized settlements (Meir 1997; Almi 2003; see also verdicts by High Court of Justice mentioned in previous section). Despite these obstacles, the vast majority (nearly 90 per cent) of Bedouin women visited MCH clinics for prenatal care (Weitzman 2003)¹⁰.

Among the Negev Bedouin an exceptionally rapid transition from home delivery to full rates of hospital deliveries has taken place, drastically transforming childbirth. Just forty years ago, home deliveries were still the rule and hospital delivery a rare exception. Nowadays, practically all Bedouin women (98 per cent, Weitzman 2003) give birth in the hospital. Hospital deliveries are perceived as desirable, and for elder Bedouin women still largely associated with the reduced rate of infant and maternal mortality. This sharp transition should be understood in the context of four additional factors: fiscal incentive for hospital deliveries, improved access to the hospital, the attractiveness of hospital birth in modern facilities as progressive, and the absence of institutionalized midwifery.

Every woman giving birth in a hospital (or reporting to the hospital immediately after birth) receives a national insurance "delivery reward". For a population generally belonging to the under-classes, such a reward is not economically insignificant¹¹. The reward was introduced as early as 1953, as part of the state's modernizing project, its pro-natal campaign and its demographic-monitoring population registry. In the same year only 5 per cent of non-Jewish women in Israel gave birth in the hospitals (Shuval & Anson 2000). It can be assumed that such rates were even lower in the Negev. Until 1966 However, mobility restrictions were still enforced, and means of transportation and roads were scarce. Walking to the hospital, even riding a donkey, would take over an hour from most encampments, more than three-hours from the more distant locations. However, once the hospital became more accessible, women soon preferred birth there.

In many societies this transition was gradual, and involved a struggle concerning gendered knowledge and authority. It seems that among the

¹⁰ This study among Bedouin women who gave birth at the Soroka Medical Center and found that while 89 per cent visited MCH clinics for prenatal care, most women made their first visit to the clinic late during pregnancy, too late for undergoing early detection of fetal anomalies.

¹¹ In 2004, it was the equivalent in shekels to roughly 280 Euros for the first child and an additional 100 Euros for every additional child.

Negev Bedouin, as possibly among other nomadic societies, there were no local specialized birth attendants¹². Some women were considered more experienced and appropriate to attend birth than were others and so were occasionally called upon. However, under nomadic circumstances, birth was often either unattended or attended by the only kin present. Though there seems to have been no established social institution of midwifery to act as a source of possible resistance to change in practices, still childbirth was drastically transformed from personalized domestic care into the territory of strangers, including unfamiliar men. However, transition to hospital delivery is not perceived as coerced¹³. On the contrary, it is mostly seen as a great improvement.

To understand the encounter between Bedouin women and the Israeli reproductive health care services, it is important to consider that women are often “both subject of and advocates for the medicalization of birth” (Ginsburg & Rapp 1991, p.322): and that medicalization can simultaneously be empowering and disempowering. While, for people in industrial countries, the experience of medicalization has often lead to a sense of disempowerment and a desire for alternatives, for many “economically disadvantaged and rural people ...it is often the obstacles to access medical services that seem to constitute disempowerment” (Gruenbaum 1998, p.58). Rather than merely assert the dichotomy of submission or resistance, it is most useful here to follow Lock and Kaufert (1998) and display the perspectives of Bedouin women as pragmatic actors maneuvering among various networks of power.

Accordingly, the ways Bedouin women selectively utilize the available services is of interest. Bedouin women’s lives are embedded not only in distinct political and (mostly poor) material conditions, but in a social milieu with its own health-related practices and preferences. Such affiliations have been referred to as belonging to “therapeutic communities” such that certain

¹² Also for tasks such as circumcision (normally performed by experts) Negev Arabs commonly used to rely on outsiders who visited the encampment on an irregular basis. Today, many people summon local doctors, and some travel with their infants to the nearest Palestinian town of Dhahariya to have circumcisions performed. The circumcision feasts studied by Marx (1967) were preformed by a Palestinian especially invited from the north.

¹³ This is the case also in Galilee, where traditional midwives commonly attended birth and birthing is more politicized (Kanaaneh 2002).

health and illness-related practices and social roles are accepted or negotiated. Most people adhere to certain horizons of expectation in terms of how they deal with their health (Douglas 1996)¹⁴. Such affiliations are apparent in the way Bedouin women selectively utilize hospital services. For example, Bedouin women reject spinal analgesia (epidurals) though it is hospital-provided; and, while fathers can nowadays be present in the delivery room, only a small minority of Bedouin husbands attend births.

Another feature of Bedouin women's consumption of reproductive health care services is that they also consult West-Bank clinics. Many Negev Bedouin have relatives in the southern West-Bank, and until recently¹⁵, regularly visited there for weekly shopping and other low-cost services, such as dental care. Negev Bedouin women sometimes consult West-Bank clinics for the insertion of intra uterine contraceptive devices (IUD). This procedure is also available at Israeli clinics but, as it does not fit into the generally pro-natal campaign, is not fully reimbursed, and involves various tests and bureaucratic procedures¹⁶. West-Bank clinics are private but low-cost and procedures are performed on the spot. One of the popular doctors visited in the West-Bank is a Russian doctor (married to a local Palestinian); apparently, she often criticizes Bedouin women for destroying their bodies by multiple pregnancies and is a strong supporter of contraceptives. Pregnancy tests and ultrasounds are also occasionally consulted in West-Bank clinics, often in addition to those covered by the Israeli national health care. It is not uncommon for people to draw on a variety of medical systems, seeking the best care available to them.

¹⁴ I use this somewhat outdated term here, which was explored by Douglas (1996) following Janzen, in order to revive this useful way to understand partially overlapping therapeutic milieus; however, I recognized the limitations of the term "community".

¹⁵ Movement is increasingly restricted by checkpoints, new bureaucratic procedures, and construction of the southern section of the separation barrier started in 2004. However, many Negev Bedouin still regularly cross the green-line for their weekly shopping, dental treatment and a few other medical consultancies, circumcision of newborn sons, visits of relatives, and importation of cheap labor and commercial goods.

¹⁶ Not only are fees for contraceptive devices not covered by the Israeli National Health Insurance, the procedure requires multiple visits to various clinics for medical examinations and laboratory tests that would prolong the procedure, making it more costly than performing this simple procedure at private West-Bank clinics, that conduct the entire procedure then and there.

It seems Bedouin women are caught up in the tension between much desired services provided by suspect institutions.

ENCOUNTER ZONES

Even when social spaces are shared, Arab and Jews typically socialize separately. In the hospital, this segregation is reinforced by an informal protocol to group Arab and Jewish women in separate rooms. This is seldom openly stated and, due to the considerable turnover, full separation is never achieved. Both Bedouin and Jewish women occasionally request a change of rooms if they find themselves "alone". Most Bedouin women would explain this by pointing to the language barrier: "with the other Bedouin women we gather and chat". Some highly educated or working Bedouin women, for whom the hospital does not provide a unique opportunity for social encounters, would rather not share a room with other Bedouin women. Some express their desire for privacy and complain that Bedouin women receive too many guests, and tend to spend the whole day sitting together, chatting, and "being very noisy". These are also common reasons given by Jewish women for not wanting to share rooms with Bedouin women. Against this context this paper concerns precisely those Bedouin women for whom the hospital does constitute an unusual encounter zone.

From the settlement where I reside during fieldwork, Um-Yusuf is the first woman who gave birth in the hospital. Though Um-Yusuf delivered her first three children at home, in 1963, she delivered this, her fourth child, in the hospital.

"At home" she said "one would grab the tent pole (*"bit'us fil 'amud"*). Women would give birth standing on their feet and squatting in an upright position." "Other women would help". But there would not always be someone around; one of her cousins gave birth while herding the sheep (*"Sarahat ma'al ghanam, uwildet fil ga'"*), with "not even a tree stalk around to hold onto". When Um-Yusuf was ready to deliver her fourth child, she was in terrible pain for many hours, "I wanted to die. And you know, many women did die giving birth then". At last someone was sent by horse to call upon the only man in the neighboring tribes who had a motor vehicle, in order to take her to the hospital. She was afraid and didn't want to go, but realized there was no choice. When I asked what she was afraid of, she smiled and said that she had never been to any hospital, nor even to Beersheba before. "I was afraid of everything,

even from a ventilator [fan] I was afraid! I had never seen one in my life! I don't think I ever saw *the Jews* before". She did not remember much, only that there were several Jews but not even one other Arab around, and that "The Jews took good care of me and the baby, and I slept". Um-Yusuf's granddaughter, who had heard the story many times before, recalled hearing that the Jewish women were impressed with her long beautiful hair and braids. Um-Yusuf confirmed, "they said my hair was beautiful and asked me how I get it so nice". However, Um-Yusuf too was impressed - she called her son Dasa, after the name of the hospital at the time ("Hadasa").

After this extraordinary experience Um-Yusuf gave birth to seven more children, all in the hospital. A great deal has since changed, but the hospital still presents Bedouin women with exciting unmediated encounters, as well as with anxiety and fear.

Childbirth at the Soroka regional hospital inspires both images of coexistence as well as disturbing rumors fed by political and ethnic tensions. For these hospital encounters exist in a time and space marked by the Israeli-Palestinian conflict with all its related discriminations, prejudices, fears, resentments, and suspicions. Contemporary Negev Bedouin experience should be appreciated in this context. The following contrasting accounts illustrate some of the tensions at play.

Having delivered eleven children in the hospital, Um-Salman said, "I would not know how to deliver a child without a doctor. Without a doctor I would die!". Such statements are often as personal as they are political; for Um-Salman, the hospital provides a metaphor of life, peace and co-existence. Telling me of her anxiety every time her son traveled through Tel-Aviv, "while only yesterday another bus was blown up", she sighed and said, "It must be possible to live peacefully". Wanting to illustrate her vision, she then added:

"Look at the people at Soroka, how they all give birth together. And the nurses and doctors-how they help, support and save lives. See their deeds, grand are their deeds! God bless them".

Such reference to hospital delivery as a site of shared humanity—assisting birth and birthing together—are not uncommon. But the hospital also inspires troubling rumors, the most alarming of which involves a general

distrust of cesarean sections owing to fears of un-consented sterilization¹⁷. Other rumors suggest that hospitals “use Bedouin women's placentas for all kinds of experiments and even sell them”. Khaled has several children who suffer from congenital diseases. He shared with me his fear that Jewish doctors cause these defects when pregnant women go for “tests and injections” at the hospital. Thus, the anxieties and uncertainties inherent to childbirth and to medical interventions are enmeshed in a complex political setting—rife with suspicion.

Frequently accompanying Bedouin women in their visits to the hospital, I realized the spatial importance of the maternity wards. Bedouin women often use the expression *'ind al-mwaldaat* (literally meaning: with the women-in-and-after-labor) to refer to the building that houses the delivery hall, obstetrics emergency room, three obstetrics wards, and three maternity wards. Altogether, these are the maternity wards. Following childbirth, women commonly remain hospitalized for 2-3 days. Women also visit this complex for other medical interventions, and frequently visit relatives after birth or when hospitalized.

The manner in which Bedouin women describe and actually move in this space suggests that maternity wards constitute an unusual socio-spatial site. The hospital has two main entrances; the older one, adjacent to the maternity wards, is often preferred by Bedouin women, even when heading to visit a different ward: it is the more familiar one. Women are not merely familiar with the location; it being the site of birthing makes it extra familiar and proper. As one woman put it “this is a women’s place, it is fitting”. Women’s instructions concerning the whereabouts of a sick relative often refer to the maternity and children’s wards as orientation points. Even when at an

¹⁷ Medical staff, often encountering resistance to caesarean sections, were aware of these rumours. *Tubulation*, a surgical procedure to block the fallopian tubes and prevent fertilization, is typically recommended by doctors when a section is performed after multiple pregnancies or repeated c-sections. A c-section might be performed urgently, but *tubulation* requires separate consent. However, one doctor admitted that in some cases doctors may be too keen to perform the procedure, consequently compromising the informed-consent procedure. Bedouin women often refer to *tubulation* as closing or inverting the womb. It is often Bedouin men who suggest that doctors might take the opportunity to 'close her womb'. Interestingly, some of the women say they do trust the doctors, but not their husbands who “might sign to approve such a procedure just so he can then marry a second wife”.

entirely different part of the hospital, women often come to fetch snacks or beverages from the automat or coffee stand located at the entrance to the delivery hall and maternity wards: it is familiar and distinct from the surrounding public space.

Beersheba is a predominantly Jewish urban space, in which most Bedouin women do not move freely. When going into town, Bedouin women are often accompanied by a male kin. More than fear of being “unprotected”, they fear being seen unescorted and thus raising questions among fellow Bedouin as to the appropriateness and legitimacy of their wandering beyond their domestic terrain. Urban space has often been portrayed as alienating and threatening. Simmel’s observation that anonymous urban public space can, nonetheless, grant a “kind of personal freedom” ([1903]1950, p.416) is still relevant here. On one of my visits in town, while joining Hitam for a medical test of her son, she suggested we have lunch there rather than in one of the Bedouin towns on the way;

"Among the Jews we can grab our freedom. Since we are Arab, sitting among the Arabs is not good. Among Arabs we will feel shy, everyone looks and asks. The Jews, they don't know where I'm from, and besides they let their own wives travel alone".

Hitam's experience (as well as the following incident) both reveal the complex nature of public space and the contextual nature of social identities and gendered behavior. At the Soroka Hospital, delivery rooms are highly equipped, but wards are still crowded, and both delivery compartments and recovery rooms are partitioned off only by screens. I visited Faiga at the hospital after she gave birth to her third daughter. She had suffered serious bleeding and had to be rushed to the operation room.

"When I woke up in the recovery room, I did not know where I was or what day it was. I realized the husband of the women behind the next curtain had a mobile phone. I asked him if I could make a phone call and called my sister. [As she has often told me she cannot speak any Hebrew, I asked 'did he speak Arabic?' Faiga smiled] "for these things I can speak Hebrew, I said 'sorry, me short phone?' Lying in bed like this, I would be shy to ask an Arab man. This Jewish man was very kind; he saw my pain and effort, and even offered to dial the numbers for me".

As both Faiga's and Hitam's accounts illustrate, Jewish men are not necessarily relevant to their self scrutiny that is alert to social surveillance. Although men do visit, maternity wards are dominated by the presence of women. Among the staff, Bedouin women mostly encounter female nurses and midwives, whom they often refer to as 'doctora's. For many of the Bedouin women, women's space back home is often, by definition, private.

Not only are maternity wards female space, Bedouin women often constitute the majority of patients in maternity wards. Most Bedouin women of childbearing age give birth frequently and regularly visit other women following childbirth. While the Bedouin comprise 25 per cent of the Negev population, the majority of births at the Soroka maternity wards involve Bedouin women¹⁸.

Even in the face of other women, childbirth remains an intimate and private event, while the hospital is a semi-public space. Traditionally, during the forty days following childbirth, a woman is considered *Nafasa*: her grave is said to be open. This custom is documented throughout the Arab Middle East (e.g. Abu-Lughod 1986, Granqvist, 1947) and is known as *Al-arba'in*, the forty days. During this time various restrictions apply to the newborn and mother's bodily practices, such as a postpartum sex taboo and the avoidance of visitors beyond a restricted circle, excluding menstruating women even among those otherwise permitted. In the context of the hospital, however, I have not observed any practice -or even reference to - such customary restrictions, even by those manifestly practicing them at home. When I had asked about this hospital respite, Hajja Za'ila- an elderly and fervent promoter of the *Al-arba'in* restrictions- firmly replied, "In the hospital? They are secure enough!" Thus, maternity wards constitute an exception. While older women often scorn the habits of the younger generation of women and would, at times, cherish and champion various features of their previous lifestyle and conditions, I seldom heard such longing expressed in relation to pre-hospital childbirth. Many older women nostalgically remember earlier days, when an even longer break from household responsibilities was offered, "it was a real treat; we would stay in the maternity ward for nearly a week".

¹⁸ In the year 2002, Bedouin births comprised 56 per cent of all live births at the Soroka Medical Centre.

Birthing provides women with a legitimate manner to venture beyond their households and common networks. It allows them to carve out a intermission in both time and space. An unusual space within the public space, maternity wards are placed within the urban, public and mixed space (by gender and ethnicity), and yet accommodate a familiarized women's sphere. In this setting they observe, and engage with, both Jewish-Israeli and fellow Bedouin women, encounters that both challenge and reaffirm tightly-drawn social boundaries.

ON ASSUMED COMMONALITIES AND OBSERVING THE OTHER

While the exchange between Jewish and Bedouin women in the hospital is hampered by language barriers, political tensions, and attempts to maintain a degree of segregation, it is not uncommon for Jewish and Bedouin women to share rooms or food, to congratulate each other, or to admire each others newborns. Such events are often framed to confirm an assumed commonality and even affinity between women under some universal concept of motherhood. Hamda, a young woman hospitalized in her last weeks of pregnancy, told me:

“Some of them [the Jews] quarrel and some are the best, it is in the personality. Today a very nice Jewish woman was put in the bed opposite me. We chatted a lot, she realized I should lie down and offered to bring me my lunch tray. Yet yesterday the Jewish-woman in the adjacent room with whom we share the bathroom, was very obnoxious. She suggested that I should use another bathroom. I told her ‘this is neither my house nor yours’. We are all just women bearing our children”.

The emotional, vulnerable and intimate moments of birthing, as well as the daily routines of washing, eating, breastfeeding, sleepless nights and healing wounds may kindle the appeal to shared humanity, womanhood and motherhood. However, as Hamda's concluding comment illustrates, evoking commonality is also a way to appeal for equity in the face of discrimination.

As often reflected in the attitude and scrutiny of hospital staff, as well as Jewish women and their guests, the position of Bedouin women as members of a marginal minority is-directly and indirectly-largely determined by the hegemonic perspective of Israeli society. For many Jewish inhabitants of the Negev, the Bedouin -especially Bedouin women- are for the most part invisible or transparent; the exceptions are when Bedouin women are

perceived to be markedly present, i.e., when giving birth or collecting welfare allowances. Thus, while I do not here concentrate on the diverse impressions hospital encounters may have on Jewish women, there are moments when the assumed communalities are in painfully short supply and ethnic boundaries are aggressively enforced. Take the following, rather extreme, case:

Rif'a had given birth to her seventh daughter. On that morning, in a Tel Aviv bus, a Palestinian suicide-bomber had blown himself up along with a dozen other passengers. After the delivery, Rif'a was accompanied by a nurse to a room in the maternity ward. As soon as they appeared in the room's doorway, one of the women in the room said we 'have had enough of Arabs for today', and asked the nurse to find the woman another room. "They were those kind of religious Jewish women," explained Rif'a.

Indeed, it is in the context of such tightly drawn boundaries that events allowing individuals to emerge from fixed categories should be appreciated. Whereas many encounters may reinforce existing prejudices, others may reveal that differences are re-arranged in surprisingly new ways.

Sabriya had just given birth to her first son; she told me about the Bedouin women in her room, about whom she knew quite a lot. In the bed opposite her was an ultraorthodox Jewish woman whose husband had just arrived for a visit. I asked her if she knew where the couple was from. "No, I did not speak to them, they do not like Arabs" she replied. "Who doesn't like Arabs?" I asked. "Those religious people" she clarified. "Why do you think so?" I asked. "That is what the women here say", Sabriya said. Sabriya's husband arrived and suggested that we all go outside, so he could smoke a cigarette. A few minutes later, while we were sitting on a bench outside, the ultraorthodox man appeared and asked Sabriya's husband for a cigarette. While the ultraorthodox man lit his cigarette, he said; "so you must be the fortunate father". Sabriya tried to hide her smile, and the man asks her husband, "Does she understand Hebrew?" This Sabriya understood. Jokingly, her husband said "she doesn't understand anything". Then the man added "I do not speak much Arabic but I can sing some songs", he then sang a line of "'Abdul Wahab¹⁹". Sabriya and her husband looked at each other in surprise and, with some doubt, her husband said, "So sing to us!" The man kept singing.

¹⁹ Abdul Wahab (1910-1991), an Egyptian composer and performer, is one of the most prominent modern classical musicians in the Arab world.

Then Sabriya's husband excitedly joined in and further suggested, "And how about this song?" Later, Sabriya told me that the ultraorthodox man's wife was Tunisian and she could actually speak even better Arabic than he could!"

In response to such stories, women would often offer their comparable experiences. Sabriya's neighbor (present when the incident with the ultraorthodox singer was told) said: "When I gave birth to Thabit [now in his 30s], the woman right next to me was Jewish, but could speak excellent Arabic; she herself was born in Iraq". Women call on their hospital experience to point out that there are some Jews who are actually more like them than are others.

At other moments they recall extraordinary differences, for instance, by conveying with excitement that they observed an unmarried Jewish woman can have an accepted child. While one woman may talk of "the Jews", another may point out that some actually prepare *malfuf* (stuffed vine leaves) "just like we do", and/or speak Arabic. While one woman might be complaining that we Arabs "breed like sheep", another women might knowledgeably remark: "some Jews have many kids, too". Such encounters seem to disturb established categories, producing potentially unsettling but also exciting new experiences. Bedouin women also observe that some (mostly middle class Jewish women) are more obviously keen on their privacy than they, wishing to minimize their hospital stay, shying away from social exchange, and avoiding revealing their bodies when breastfeeding.

Unfamiliar with the etiquette of Jewish women, and often inhibited in approaching strangers in general, many Bedouin women would not make the first attempts to start a conversation. However, it seems that some Jewish women exercise their curiosity more freely and take opportunities to ask Bedouin women about their private lives: how does she cope with having a co-wife or with her many children? Why she was married so young? Or, why does she bears a child every other year? During such investigations, Jewish women often express their conviction that such practices are undesirable:

Jewish women to the women in the bed next to her: "Is it a boy or a girl?"

Bedouin woman: "It is a boy".

Jewish women: congratulates her in Arabic "*Mabruk*" and continues in

Hebrew: "How many children do you have?"

Bedouin woman: "Three girls and four boys".

Jewish women: "And you are so young. Four boys and four girls, isn't that a blessing, isn't that enough? You might want to take some time off now [from birthing] to raise them, it must be a lot of work".

Jewish women seem to feel entitled, if not obliged, to make suggestions that betray their cultural convictions. In many cases, the attitudes of Jewish-Israelis so profoundly reflect state ideology/policy that one does not need to read established policy to know it. Most Jewish women do not, however, necessarily make such comments with a conscious political agenda; indeed they may do so based precisely their sentiments of affinity and assumed commonality.

Such exchanges are also facilitated by the fact that many Jewish-Israeli and Bedouin women share certain perceptions of what constitutes the modern/progressive versus the backward. Indeed, as Kanaaneh (2002) puts it, "reproductive measures are key markers used to negotiate and daily recreate essential categories of identity: the modern, the primitive, the urban, the rural, the Bedouin, the clan, the Muslim, the Christian, the Druze, the local, the foreign, the Jew, the Arab" (2002, p.105). Thus many of the women share what Kanaaneh (2002) has termed "reproductive measures", the perception that certain reproductive practices (such as hospital deliveries) constitute the modern whereas others are markers of backwardness (as in multiple births, boy preference). Jewish women thereby mark themselves as modern by undertaking the task of modernizing their Bedouin neighbors. Various reproductive practices are often denounced, not by labeling them as backwards but, simply for being "unhealthy". Consequently, medical discourses (such as stating that multiple deliveries wear out women's bodies), conflated with implicit and explicit cultural assumptions, have the forceful power seemingly to de-politicize while obscuring the highly politicized realms of reproduction and demography.

Bedouin women's references to differences between Arabs and Jews often feature Jewish-Israeli society as more progressive. Unlike observations that underscore the diversity among Jewish-Israelis, these references refer to a generalized Other. The following conversation unfolded shortly after Jamila returned home from the hospital, having given birth to her fifth son. One of the women present inquired about her hospital stay, wanting to know if Jamila had rested, if she met so and so who had also given birth, and if the wards were crowded with women or visitors.

Jamila: "The Jews are not like us. They work; they are busy, so they mostly visit in the evening. Arab, they come and go in the middle of the day, that is, if they come at all, they [Arab men] beget and then dump ("*bikhalfu ubirmu*".) When I gave birth to Abir, there was a Jewish woman next to me at the ward. While she was resting in the hospital, her husband took care of the household and her two other little kids. Only his cooking was not so good she said".

Amnah, Jamila's co-wife who was also present, added: "Oh, the Arabs. The only thing they know is how to breed, like sheep! They forget something should follow". Amnah was referring to care and attention, but Jamila responded with a smile: "oh no, they don't forget, they collect [the child allowances]. That is the truth. We bear birth and hardship, and they collect!"

Amnah added enthusiastically: "Unlike the Jews they [the Arabs] don't bring their wives flowers or anything that will please her and make her feel nice. They just bring food, snacks and sweets and then eat it up themselves when they come to visit with their many kids".

Though Jamila and Amnah's mocking of Bedouin men was very explicit, I regularly heard Bedouin women praise the conduct of Jews, without making such explicit comparisons- *just mentioning* that some Jewish men change diapers or buy their wife's underwear. These reflections could best be described as instances of an "indirect discourse of complaint" (Kelsky 1996:184). Bedouin women rhetorically use such references to contrast, to negotiate, and to criticize gender relations in their own society. I say "rhetorically", because in the course of contrasting their own society with observations of others, they often praise "Jewish" conduct, not for the sake of praising "the Jews", but in order to denounce forms of conduct to which they are accustomed and the perceived shortcomings of ordinary Bedouin men.

Finally, while women gain knowledge about diversity within Jewish society as well as about similarities between Jews and Arabs, the dualism between Jews and Arabs remains intact. I have, therefore, suggested that Bedouin women employ these insights to draw contrasts between their respective societies, and critically to reflect on self and society. While some women might, long after, recall these significant hospital encounters, such reflections also occur before leaving the hospital. This way, the hospital itself becomes a meeting point, providing many Bedouin women with the opportunity and context within which to discuss their lives and predicaments, to form and share opinions with Bedouin women from all over the Negev.

FROM THE WATER WELLS TO THE MATERNITY WARD

Though Bedouin women often refer to their hospital encounters as a source of knowledge of “the Jews”, in reality such encounters are quite sporadic, consisting of only brief exchanges. Compared to these limited interactions, interaction *among* Bedouin women, who were previously complete strangers, is markedly intense. To my surprise, many of the Bedouin women I visited soon knew of most of the other Bedouin women in their ward, including where they were from (i.e. the settlement or township and family of origin), how many children they had, and whether they had co-wives, or not. In short, Bedouin women bond together in ways that exceed merely assisting each other with translation or polite exchange of information.

In her late twenties, Noha was having a difficult third pregnancy, during which she was often hospitalized for a few days. On one of my visits to the hospital, she told me: “Friendship can come about in half an hour and still remain for a lifetime. There is a woman who gave birth with me when I delivered my first child; she still calls me once in a while and might visit me at the hospital when I give birth. This is an opportunity for us. It is something you do not forget; still today, my mother recalls, ‘when I gave birth to so and so, I came to know so and so’. Once they would meet near the well on the pasture, now it’s the maternity ward”.

Although Noha’s new friend never visited her at home, she was planning to visit her in the hospital after learning (from a relative just released from the hospital) that Noha was once again in the hospital. Even though most hospital relations are not maintained outside of the hospital, I suspect that the water-well metaphor reveals that these encounters are not just about friendship, but about appropriating a legitimate space where strangers meet and exchange news and opinions, exchanges that enact shared cultural terrain and socio-political locations.

Whether in their rooms, at mealtime, or in the evening after visiting hours, one can often see groups of Bedouin women sitting together. On one occasion, I accompanied a woman to visit her niece, Sarah, who had just given birth. When we did not find her in her room, another Bedouin woman directed us to the next room: “they all sit there and chat,” she said. There we found Sarah enjoying the company of a few other women she had not previously known. She got up to welcome us and said it was an opportunity to

talk, "You know, women's talk, about marriage and children and problems"²⁰. Later Sarah told me more about such women's talk:

"Women talk can be not only good things you know. But some time you get some advice. When I was little I heard many things this way, also bad things". With a smile she said, "Do all the guests in a wedding dance? Do all the mourners -gathered at the deceased home- weep?" Then she said, "but for us women there are no better opportunities [to talk] than at the clinic [MCH] or the hospital".

Comparable in many ways to maternity wards, Mother-Child Health (MCH) clinics are meeting places for Bedouin women . Therefore I understand women's decisive and consistent attendance at MCHs to be related not only to the care provided, but also to the lay encounters and knowledge they offer. Though there *are* other opportunities for women to meet and chat, these are mostly special events, and the women encountered there are mostly relatives or other familiar community members. The hospital, then, becomes a place where women-who generally are inexperienced with more public encounters-generate a lively public debate.

For women inexperienced in actively engaging with strangers however, the maternity-ward encounter zones are not without challenges. Though hospital encounters perpetuate new solidarities between women, it is unlike the typically private and protected, gendered familial space. I heard the following "urban legend" from three different women:

The story goes that recently there has been an impostor, dressed in women's clothes; he would join gatherings of Bedouin women at the hospital wards. He wore a black *Jilbab*, and a face veil, of the kind only a few exceptionally religious young women use of late. Occasionally 'she' introduced herself as unmarried, thus looking for a fiancé. Not only would he infiltrate the social world of women's talk, he would also further exploit their trust and steal from their handbags or hospital cupboard.

²⁰ The term "*haki an-niswan*" ("women's talk") is often used in a pejorative manner to imply nonsense or gossip one cannot trust. Back in the village I witnessed a woman confirm her own statement by saying "this is no women's talk, its true". Such informal or lay knowledge is often underestimated , in deference to male, professional or other authoritative discourses.

This rumor betrays the peculiar intimacy of this distinct social space and the fears emanating from it. Though these fellow Bedouin women are not personally familiar, the situation and ensuing conversation often stage the very intimate. Such fears of intrusion reveal the value of this, albeit liminal space. For Bedouin women usually confined to the private sphere of the home, this can be a significant though somewhat awkward experience.

Many references to hospital encounters include comparisons to other Bedouin women's conduct and relationships. These are, then, often formulated in collective terms:

"I saw the women from Rahat. They are not like us - their women come and go. The woman in that room, her aunt, mother and sister came to visit her after dark, alone [unescorted by men]. The aunt even has a driving license and a car... Some Arabs, are not closed like us. This family, they have many educated daughters. They are open, they take the new model".

The expression she used "*Mish zai 'arabna*", literally meaning "not like our Arabs", "our Arabs" referring to her own extended descent group and village. Extended families and tribal affiliations still partially inform some collective identities-as well as tensions-within Bedouin society. Whereas interpersonal interactions transcend these affiliations, such classifications inspire various generalization and comparisons. Women commonly rate fellow Bedouin on a scale of open versus closed (progress versus backwardness) corresponding to the reproductive masseurs mentioned earlier. Unlike Jewish women, other Bedouin women allow for closer identification, thereby providing a more valid model for evaluating conduct. Shared circumstances and cultural idioms facilitate drawing analogies to and embracing someone else's experience thus extending individual experiential knowledge²¹. Seeing new options for themselves it also becomes a fertile setting to reflect upon-even question-those largely shared circumstances and cultural idioms.

Childbirth stands central in most Bedouin women's lives; however, this is not to say that women's lives are entirely consumed by reproduction. The reproductive encounters discussed here reveal Bedouin women's concern

²¹ "Experiential knowledge" is a term often used to refer to the construction of intersubjective knowledge, based on communication and reflection on individual experience (e.g Abel and Brown 1998; Kelleher 1994)

with diverse social processes and social relations at large. In their encounters some topics constantly re-occur: polygyny, the burdens of childbirth and raising children, gender roles, and the significance of education. One such example is the debate on breastfeeding and provision of infant formula, which triggers discussions not only on mother and infant health, but also on far more general issues, such as husbands' duties and the standard of living. Several Bedouin women conveyed to me their belief that, the promotion of breastfeeding is merely a result of the overcrowded wards and the need to save on infant milk-formula expenses. (The same financial logic is often assumed to account for the change from newborn nurseries to rooming-in²² arrangements). It seems that the advantages of breastfeeding are sometimes completely overshadowed by women's demand from men to provide- and thus to buy- the best for the baby, which is often perceived as infant-formula.

Sabha's mother sat quietly during most of the visit. It was the afternoon visiting hour, and women were coming and going. Entering the room, they passed Sabha's bed and the open partition curtain and greeted the heavy women, practically blocking the entrance. She generally enjoyed passively listening to the other young mothers sharing Sabha's room. Yet, on one occasion, she excitedly interrupted the conversation: one of Sabha's roommates urged her to breastfeed, instead of having to beg her husband for infant-formula. Upon hearing this, Sabha's mother interrupted, "her husband can perfectly well afford to buy infant-formula. Imagine! If he would refuse to buy food for his child!"

This was in spite of the fact that Sabha's mother raised eleven children and had breastfed all of them. Because providing for one's children is one of men's primary responsibilities, women can gain social support and backing to accuse their husbands if not met. Even when (as is now generally the case) women's claims on material means have decreased, infant formula is an important exception. This shift reflects, in part, the change in women's status from producers to consumers, coupled with reduced household productivity and increased market consumption. Accordingly, the way fellow Bedouin women confront similar structural predicaments becomes a valuable part of

²² "Rooming-in" is a term used when the infant does not stay in the newborn nursery, but in the mother's room during her hospital stay.

one's own experiential knowledge, thereby informing their opinions of what can be demanded and how.

Indeed, much of what is discussed among Bedouin women in the hospital is their perceived shared predicaments- two of the most dominant themes being polygyny, and *kuthrat el awlaad* (literally, multiple children) i.e. family size and high birth-rates. This latter topic often evokes lively debates among Bedouin women, leading to a wide range of debates as diverse as: the rising cost of living, the gendered division of care and nurture-related labor, education, polygyny, and state incentives.

Though they mostly remain dependent on their reproductive role and on the status of their male progeny, Bedouin women often criticize high fertility. To negotiate this contradiction, women may portray themselves as passive agents in managing their fertility. But of course, even when under serious constraint and control, in practice women are seldom merely passive-procreators; to which the presence of these debates well attests. Bedouin women often explain the gap between their desired and actual family size by reference to the discrepancy between men's and women's dispositions. They express discontent with their own reproductive practices, but hold men responsible. Even women of poor economic means criticize the state's policy, specifically its high child allowances, by suggesting that men are wrongly motivated to enlarge family size, some engage in even more extreme rhetoric, expressing contentment with recent welfare payment cutbacks, or suggesting that they be canceled altogether so as to force men to find jobs and to consider the expenses of childbearing. Some of these statements reproduce clichés about Bedouin backwardness or the corruption of Israeli Arabs by state policies, often heard among neo-liberal Israelis, as well as among Palestinians from the West-Bank.

Actual sociological explanations for high fertility rates²³ are beyond the scope of this paper. More significant to this discussion are the actual processes by which Bedouin women form and reform opinions and practices. Within the Arab-Palestine society in Israel, concern is often expressed that

²³ Marx (2000) suggests that economic uncertainty among the Negev Bedouin promotes large families as people put their trust in children. Additionally, segmentary politics, religion, polygyny, deficient family planning services, and child allowances have all been evoked in the debate considering the nature of the pressure on women to maintain high fertility rates.

one of the negative effects of the Israeli demographic rhetoric is that it hampers a more critical internal public debate concerning the repercussions of the high birth rates²⁴. Though seldom shared by men, I suggest it is precisely this debate in which Bedouin women are engaged in gathering in maternity wards.

Thus, Bedouin women engage in complex deliberations among themselves, sharing views and concerns, generating a critical debate that reaches far beyond specific reproductive issues, encompassing nearly every aspect of their socio-political position. These debates, nonetheless, reveal that Bedouin women often juggle between various incompatible power relations (AbuLughod 1990).

In addition to patriarchal gender relations, political discrimination, and changing regimes of production, Bedouin women are also subject to medical regimes that introduce new technologies and dilemmas. Their response to the latter involves selective compliance to medical procedures and medicalised discourses, such that medical options are differently sorted. Whereas most Jewish women consent to the routinely-offered spinal analgesia (epidural), only a minority of Bedouin women do. However, most Bedouin women if any would typically ask for intravenous analgesia (parenteral pethidine). The important thing to recognize is that many Bedouin women first hear about these procedures from other women in the hospital. Intravenous analgesia is provided through an infusion already in place, whereas spinal analgesia is injected near the spinal cord, and is thus perceived to be far more invasive. The dangers of spinal analgesia are well known to many Jewish women, yet for many of them the risk is rendered more acceptable than suffering "unnecessary" labor pain. In contrast, most Bedouin women expect less support from others when they suffer epidural after-effects, however- unlike many Jewish-women- they do obtain compassion with labor pain. This is precisely what belonging to a specific "therapeutic community" entails. At the hospital, women explore and negotiate the constraints defining the horizons of expectation on which they rely; however, new horizons may result from their encounters. In other words, the hospital is not merely a site where

²⁴ In his article "The Demographic Plumb", Shalahat (former editor of two leading Palestinian Arabic newspapers published in Israel) called for such an internal public debate (Haaretz, 25 May 2004).

shared health-related values are enacted, but also a site where they are newly formulated and negotiated.

Bedouin women are subject not only to information from medical staff and mainstream norms of compliance. For their experience also includes networks of relatives who are subject to alternative practices and norms; they are familiar with the West-Bank's practices of birthing where home-delivery and midwifery are common practice, but caesareans and spinal analgesia are not. By contrast, most Jewish-Israeli women barely know anyone their own age that did *not* use spinal analgesia, Unless they are informed by alternative "therapeutic community" such as "back to nature" childbirth movements which are increasingly popular in Israel, but only marginally manifested in common hospital practice. Among Bedouin women, However little or no enthusiasm or interest in such ideas can be found.

While such selective practices are obviously beyond individual decision-making, they can also not be reduced to mere acts of distrust or withdrawal predetermined by social categories. Shared experience and knowledge, as well as social networks and conditions, encourage Bedouin women to relate and to learn from each other's experience. This enables them to maintain critical distance not only from medical authority, but also from the implicit authority of the dominant society. Thus, while lay encounters at maternity wards provide fertile ground for the sharing of experiential knowledge, it also marks the boundaries of such shared knowledge. Bedouin women draw contrasts with Jewish women to evoke and provoke critical reflection and differentiate their experiences. In contract, fellow Bedouin women provide more valid models. Among Bedouin women -despite internal diversity - they extend their identification to select from among contested practices.

Finally, without serious consideration of those incompatible power relations in which Bedouin women are enmeshed, much of their deliberation is rendered incomprehensible. I am here informed by Abu-Lughod's (1990) analysis of the changing network of power in which the *Awlad 'Ali* Bedouin women are enmeshed. More specifically, I follow her compelling illustration of how young women resist their elders' coarseness while becoming involved in new forms of sexualized femininity by purchasing cosmetics and lingerie. In turn, argues Abu-Lughod, these practices bind these young women both to local and global consumerism and to their husband's power to buy things. One of their few legitimate domains for insisting upon their husband's investment is in childcare by having a say in his expenditures. Most pointedly, Negev-

Bedouin women's principal demand often is to be provided with infant milk formulas. However, in this attempt to tackle the changing gender and production relations, they render themselves increasingly dependent on their husbands and on costly consumption goods (often, finally, having to settle for cheap powdered milk).

That challenging one axis of power might involve embracing another, should also be kept in mind when considering the Bedouin women's praise of Jewish-Israeli society, the reiteration of various clichés and prejudices concerning their (men's) reproductive patterns, and abuse of child allowances, or portraying themselves as passive-procreators. In the process of challenging internal gendered power relations and reproduction regimes, women submit themselves to stereotypes that are more commonly used in their disadvantage.

CONCLUSION: REPRODUCTIVE ENCOUNTERS

In hospital maternity wards, Bedouin women—who are largely confined to their household and kin network—encounter diverse unfamiliar women: both Jewish and Bedouin women from different classes, ethnicities and religious backgrounds. I have argued for the significance of studying such lay encounters for what they betray of the larger social context in which they are embedded.

Despite the limited interaction between Arab-Bedouin and Jewish women, Bedouin women's frequent reference to these encounters attest to their significance. Given the brief direct interactions Bedouin women otherwise have with members of Jewish-Israeli society, the intimate proximity offered by adjacent hospital beds, provide them with a lively glance into the lifeworld of the culturally- and politically- dominant Other. Bedouin women often evoke their hospital encounters with Jewish women to establish their unmediated knowledge of Jewish-Israeli society, its social conduct, and cultural diversity. Furthermore, Bedouin women rhetorically use such references to draw contrasts with their own society. In fact, based on this pattern I venture that the brevity of such contacts—coupled with the need to establish first-hand knowledge of the Other—conspire to provide the gravitas of these brief encounters not only for Bedouin women, but for any underclass or subaltern.

Among themselves Bedouin women engage in elaborate discussions sharing knowledge and concerns, as they consider and negotiate the horizons of their expectations regarding health and childcare in terms of their social locations and relations. But, as Bedouin women generate critical reflection concerning gender relations even challenging the internal gendered power relations and reproduction regimes within Bedouin society, they also often reproduce common prejudices and clichés. That is, immersed as they are in incompatible power relations, in the course of challenging one power relation, Bedouin women may submit themselves to discourses that in another context are used to subjugate them to other power relations. However, by establishing their shared experiential knowledge that inform their selective practices, Bedouin women also maintain critical distance from medical authority and, indirectly, from the authority of the culturally and politically dominant.

Thus my threefold argument, I have argued that maternity wards present an unusual encounter zone embodying various contradictions. For many Bedouin women it constitutes an exception both in time and space, a familiar women's space within the predominantly Jewish urban public space. This is a space in which the private and intimate is transformed and reversed to encompass nearly every aspect of the socio-political and the public; setting a stage upon which tensions regarding the body physical, the body social and the body political are played out.

Birthing, central to both the political as well as to what is perceived to be most essentially human, is deeply implicated in these tensions. Many women conceive of the maternity ward as a female space, a space where women share the commonality of birthing, womanhood and motherhood. This assumed commonality is then confronted with considerable differences in practices and values related to reproduction as well as with the divisive politics of reproduction and its selective reproach of high fertility. In Israel, reproductive politics are partially masked by universal health and welfare services. However, demographic ideologies and fears are so profoundly ingrained in mainstream dispositions that they are frequently reproduced in seemingly benevolent lay encounters. I have proposed that, by way of disregarding the wider context, this assumed communality can simultaneously be empowering and disempowering. Employing such metaphors can also serve as appeals for equity and attempts to defeat the constructed dualism between Jews and Arabs, or simply to overcome the awkwardness of intimate exposure in the face of strangers. Women often evoke and centralize metaphors of shared

humanity and womanhood to bridge difference and dissonance. But comparable with the workings of medicalization, the de-politicizing and de-contextualizing force of such appeal to shared humanity makes some women especially vulnerable to the power relations embedded in a supposedly neutral context.

In short, the reproductive activity of birthing not only sets the stage for the lay encounters examined here, but are themselves pregnant with social and political tensions. In the extraordinary context of bearing new life, these encounters potentially disturb existing divides and enable individuals to emerge from fixed categories. Amongst themselves, not alienated by political tensions Bedouin women's lay hospital encounters provide a valuable context to share experiential knowledge and to reflect on the wide range of themes related to their reproductive roles and health. However, as long as the forces that construct certain people (and their babies) as a threat remain unchallenged, these encounters may largely re-produce the social boundaries and conditions that make them so extraordinary. Fortunately, Bedouin women do challenge these forces- albeit mostly among themselves- even as they also appropriate certain elements of the dominant culture's imposed critique for their own purposes.

Hospitals mirror biomedicine's efforts to remove patients from their social context. However, hospitals hardly mask the social realities in which they are situated: to the contrary, they reflect them in multiple and, at times, amplified ways (van der Geest & Finkler 2004). Still, I maintain that hospitals do generate an exceptional social space. Precisely because hospitals are not isolated social enclaves, the intimacy they impose on strangers provokes lay encounters that are loaded with social and tensions, as well as social potentials for negotiating these tensions.

Particularly when catering to a universal health care system, public hospitals, bring together people that would otherwise not meet. People whose social worlds do not ordinarily intersect- some utterly invisible to each other, others who might meet as masters and servants, political rivals or even enemies - share intimate space and daily routines. It has been suggested that the decline in hospital ethnographies is related to the continuing decrease in length of hospital stays (Zussman 1993). Yet the present study focuses on the significance of information gleaned from *brief* encounters that nonetheless generate social experiences that women recall and share for years after. Upon hospitalization, even for brief and simple interventions, people find

themselves in an extremely awkward public space: sharing rooms with strangers, mostly lying in beds wearing nightwear, often overhearing groans, snores, and private information on bodily functions and personal life. While, for some, this might prompt a more zealous seeking of privacy than ever, it still remains that such encounters impose intimate observations of both social and bodily practices. Moreover, such encounters often involve portentous moments in life and anxieties of death. In the face of uncertainty and complicated medical procedures, people often feel a need to compare and share information and doubts. Such moments, along with the focal concern with the body, often evoke a sense of what is perceived to be fundamentally shared and human.,

I would, in fact, venture to say that significant lay encounters occur in other medical settings as well where patients spend hours resting or waiting for often extremely short medical interventions; medical knowledge is translated, questioned and health-related practices are thereby negotiated in lay encounters. For example, the waiting rooms of pediatricians- where mothers perform nurturing tasks while waiting, connecting through their children with other mothers- provide a promising site to explore how knowledge is shared and produced through lay encounters. As illustrated by the intensive interaction amongst Bedouin women, the hospital is not merely a site where health-related values and practices are manifested and enacted, but also a site where they are formulated, negotiated, and contested. In this way the Negev-Bedouin women negotiate their selective use of medical interventions by relying on encounters that are facilitated by the very medicalization of reproduction. Thus, as social arenas, medical settings function as sites where people are subjugated to medical routines and logic as well as where reflective responses to these forces are negotiated. Paradoxically, the increased medicalization of life generates settings where people share experience and knowledge, which allows them to maintain and develop critical distance from medical and culturally dominating authority.