

# Fertility treatments under semi/occupation: The case of East Jerusalem

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## Abstract

The state of Israel funds unlimited fertility treatment to any of its female citizens. Palestinian residents of East Jerusalem, whose area has been annexed to Israel after its occupation in the 1967 War, are also entitled to these services. Whereas this occupied population indeed benefits from the state funded treatment, East Jerusalem women face particular difficulties that arise primarily from linguistic and political barriers. The difficulties are especially pronounced when the husband is a resident of the West Bank and as such, requires a special permit to enter the city. The article depicts this mixed picture, in which medical privilege merges with political exclusion.

*Key words:* Israel, Jerusalem, Palestinian, fertility treatments, reproductive policy, IVF.

## Introduction

Israel's public funding of fertility treatments is unparalleled worldwide. Treatment is offered for a modest user contribution – roughly 100 US Dollars per IVF cycle – to practically any Israeli woman, without screening and irrespective of her family status, sexual orientation, education, financial situation or mental wellbeing, to the age of 45 – or 51 if she uses a donor egg – until she has two children with her present partner (where applicable). The number of treatment cycles is not limited and some women indeed undergo as many as twenty five cycles or more (Birenbaum-Carmeli and Dirnfeld, 2008). These exceptional policy and practice have generally been attributed to three major sources: the Biblical prescription, the Holocaust trauma and demography politics. The biblical commandment 'Be fruitful and multiply' (Genesis, 1: 28) has historically identified individual with collective survival, rendering reproduction a collective mission (Swirski, 1976; Haimov-Kochman, 2008). In more recent history, childbearing was constituted as a symbolic response to the Nazi extermination and a rehabilitative act for individual survivors. This pronatalist reaction was

also encouraged by state bodies that aimed to enlarge the local Jewish population, hence defined high fecundity as part of the Zionist nation-building effort (Stoler-Liss, 2003).

These political connotations of fertility charge the entitlement of Palestinians who are Israeli citizens to funded fertility treatment with sensitive meanings and contradictions (Kanaaneh, 2002). Within this category, the case of East Jerusalem is especially pronounced. In order to elucidate the particularity and its practical consequences, we start with an overview of the political and economic circumstances within which East Jerusalem Palestinians receive fertility treatment. We precede the overview with a brief methodological section.

## Methodology

The present paper is based on the participant observations of the second author (R K-H), who is a fertility expert at the Sheikh Jarrah women's health clinic and at the IVF unit at the Mount Scopus Hebrew University Hadassah Medical Center. The observations were supplemented by semi structured interviews with three additional doctors in

the IVF unit, which were conducted by the first author (D B-C).

The description of the political context is based primarily on published reports. The reports are produced mainly by the United Nations Relief and Works Agency (UNRWA) and the United Nations' Office for the Coordination of Humanitarian Affairs (OCHA). Additional sources are reports generated by Israeli bodies: (1) *Btselem*, which is the Israeli Information Center for Human Rights in the Occupied Territories, documenting human rights violations in the Occupied Territories, (2) ACRI, The Association for Civil Rights in Israel, and (3) Jerusalem Institute for Israel Studies. The heavy reliance on reports rather than academic studies encapsulates the scarcity of academic research on occupation-related subjects.

### Jerusalem's Palestinian residents who are not Israeli citizens

Until the 1967 war, the Israeli section of the city of Jerusalem spanned across 38 sq kilometers (Yanay, 2007). Following the occupation of the West Bank in the war, Israel annexed 70 square kilometers. Today, following various changes, the city's jurisdiction is 126 Sq. kilometers (Hoshen and Korach, 2009). Of this territory, one square kilometer comprises the historical Old City of Jerusalem. The rest of the land was a new addition to the city's jurisdiction. Under its rule, the State of Israel has confiscated some 30% of the annexed territory. On this land, it has constructed various government buildings (e.g., the Ministry of Public Security, the Ministry of Housing, the Ministry of Justice, the Jerusalem district court), and supported the construction of 64,870 dwellings for Jewish Israeli settlers. In contrast, the Palestinian residents of the area were allowed to build only 8,890 dwelling units during

over four decades of Israeli rule. At present, following the erection of the separation barrier that cuts through the Palestinian metropolitan area, about 50,000 Palestinian residents have become isolated behind the barrier, cut off from essential services, including medical care. Many of these residents, who have formerly moved to the city's outskirts, have returned to central city neighborhoods, out of fear of losing their civil status and in order to gain easier access to essential services. Crowding has consequently mounted to 1,054 persons per square kilometer in 2007, the highest figure in the West Bank (UNRWA, 2010). The housing density among the Palestinian residents is also the highest within the city (Table 1). Moreover, owing to Israel's policy of severe restrictions on development and construction in the Palestinian neighbourhoods, East Jerusalem Palestinians are practically unable to obtain formal construction permits from the Israeli authorities. As a result, thousands of Palestinians in the city are under threat of house demolition, eviction or displacement. According to the United Nation Office for the Coordination of Humanitarian Affairs, the figure is roughly 60,000 residents (OCHA 2009), representing just under a quarter of the city's Palestinian residents (Hoshen and Korach, 2009).

In terms of civil status, the majority of East Jerusalem inhabitants – 93% - are defined as permanent residents of the state of Israel. (5 % are citizens and 2% are negotiating their status; Hoshen and Korach, 2007). In this respect they differ from Palestinians who live in the West Bank and the Gaza Strip, who have no civil status in Israel. Being defined as permanent residents, East Jerusalem inhabitants are entitled to most civil rights in Israel, but are denied basic political rights like voting to the Knesseth (Israel's parliament) and eligibility to Israeli passports. As of 2003, an Israeli resident – or

**Table 1.** — The Palestinian vs. Jewish Sector in East Jerusalem.

	Jewish sector	Palestinian sector
<b>Population</b>	495,000 (65%)	269,000 (35%)
<b>Percent of the city's poor</b>	33%	67%
<b>Beneath the poverty line (families)</b>	23%	67%
<b>Beneath the poverty line (children)</b>	48%	74%
<b>Unemployment</b>	9%	13%
<b>Person per room</b>	1.0	2.0
<b>Sq. meter per capita</b>	24	11
<b>Public parks</b>	1,000	45
<b>Swimming pools</b>	34	3
<b>Libraries</b>	26	2
<b>Sport facilities</b>	531	33
<b>Total fertility rate</b>	4.0 (7.7 among orthodox Jewish women)	4.1

Source: Btselem, withholding investments in East Jerusalem, n.d; Hoshen and Korach 2009).

citizen, for that matter – who marries a resident of the occupied territories or a neighboring Arab country, is not allowed to apply for Israeli status for the spouse. This amendment to the Citizenship Law – which has immediate implications on fertility treatments, as will be shown below – has been introduced presumably as a security measure, but was then extended on ‘demographic grounds.’ The problematic stance of the amendment is implied in its yearly revalidation and the continued Supreme Court debate about its legitimacy. The sharp contrast to the Law of Return, which grants every Jewish person and their spouses, full citizenship upon arrival in Israel, is self evident.

Residents of East Jerusalem do have a right to work and travel in Israel. They pay Israeli tax and are eligible to healthcare and social benefits. This entitlement is, however, fragile. As of 1995, East Jerusalem residents who leave their homes and travel abroad for a longer period of time, e.g., to study, lose their residency status (Golan 2009), thereby losing, among other things, their civil rights in Israel. Between 1967 and 2007, the Ministry has revoked the permanent residence status of 8,558 East Jerusalem Palestinians (Btselem, revoking civil status). Notably, in the subsequent year, 2008 alone, it has revoked this status from 4,577 Palestinian residents of East Jerusalem (Hasson, 2009). Generally, East Jerusalem residents, who want to materialize their Israeli civil rights, need to positively prove – unlike any other Israeli – that they have resided in the city continually for years. Investigation is carried out whenever a new claim is being filed (Btselem, revoking social rights).

The reluctance towards East Jerusalem residents manifests in discrimination in other spheres of life as well. In education, approximately 5,500 school-age children, comprising 5.84% of total school-age population, are not registered in any educational institution (ACRI and Ir-Amim, 2009). Of the 645 classrooms that the Israeli Supreme Court has ordered Jerusalem municipality to construct, less than 100 have been built. The gaps in comparison to the Jewish sector are enormous (Table 1). Though they comprise a third of the city’s inhabitants, the Palestinian residents of Jerusalem are allotted a mere 14% of the municipality budget (Golan, 2009). The condition of the Eastern part of the city has been described as ‘general neglect’ (Eldar, 2009).

In terms of economic status, Jerusalem’s population in general is poorer than that of other main cities in Israel (owing to the high percentage of impoverished Palestinians and orthodox Jewish families in which the man attends biblical institutes and is not gainfully employed). Within this landscape the Palestinians are still the poorest (Table 1).

This disparity is commonly attributed to Israel’s interest in creating and maintaining a Jewish majority in the city. Informally, the concerted effort to drive Palestinian residents outside Jerusalem has sometimes been entitled ‘the silent transfer’. More generally, East Jerusalem residents are perceived as part of the entire Palestinian minority living within the borders of pre-1967 Israel, which is often referred to as ‘the demographic problem’ or ‘threat.’ Noticeably, the birth rate of Jewish Orthodox women in Jerusalem is 7.7 as compared to 4.1 among the city’s Palestinian residents (Hoshen and Korach, 2009). It is this political climate that charges the entitlement of East Jerusalem residents to unlimited state funded fertility treatments with heightened sensitivity.

The clinic at hand is located in Sheikh Jarrah, a residential neighborhood in the Palestinian section of Jerusalem. On account of property dispute regarding houses that had belonged to Jewish owners prior to the 1948 war – namely, before the founding of the state of Israel – some Jewish settlers have reclaimed allegedly Jewish-owned properties and their alleged right to ‘return’ to the neighborhood and gained Court approval to their demand. Since last August (2009), four Palestinian families – 51 people – were evicted from their Sheikh Jarrah homes by Court order, and their emptied houses were captured by Jewish settlers. The motion has stirred loud criticism, mostly from abroad, underscoring the denial of the Palestinians’ respective right to reclaim their own confiscated and abandoned property that is scattered throughout West Jerusalem and the whole of Israel (Medzini and Weiss, 2009). In the context of the present article, we note that Sheikh Jarrah dispute, addressing the locality in which the Palestinian residents meet the mostly Jewish medical staff, features constantly in the media owing to weekly demonstrations in the neighborhood.

### Health and Healthcare in East Jerusalem

In 1995, Israel has ratified the national Health Insurance Law that entitled all Israeli citizens – and permanent residents – to public health care. The payment for the services is collected by the National Insurance Institute, as a progressive tax, in proportion to one’s income. The services are provided by the four HMOs that have been operating in the country in the decades that preceded the Health Insurance Law. Individuals can join or change membership from one HMO to another according to their preference.

The HMOs’ budget is allocated on a per capita basis, according to the insured population’s age. As a result, the competition is especially fierce when the

population at hand is young, i.e., relatively healthy. With a mean age of 19 years, as compared to 25 among the city's Jewish population, East Jerusalem's Palestinian residents, who became eligible to health insurance when the national Health Insurance Law came into effect, make an attractive audience for the HMOs. The competition that evolved among the HMOs brought about a swift improvement in health services in Jerusalem's Palestinian sector.

Consequently, healthcare is a relatively equitable life domain in the underprivileged lives of East Jerusalem Palestinians. An indication, if ambiguous, to this state of affairs can be found in the infant mortality rate. Starting out from 45.2 per 1,000 live births in the 1970's, infant mortality rate among Palestinians in Jerusalem has declined to 6.0 in 2004-2006. Improved as it is, however, this figure is still more than twice higher than the respective figure among the city's Jewish residents: 2.9 per 1,000 births (Hoshen and Korach, 2009). Part of the gap is attributed to the prevalence of congenital malformations due to consanguineous marriage (Amitay, 2005). The remaining difference, however, probably reflects the educational and economic disadvantage of this population.

*Clalit* is Israel's largest HMO, serving over fifty percent of the country's population. The majority of the Palestinians in Israel are also insured in this HMO, so are most East Jerusalem residents. The women's health clinic in Sheikh Jarrah that we will describe below, is *Clalit's* main ob/gyn clinic in East Jerusalem, serving practically only Palestinian women.

In addition to Israeli service providers, the city has nine Palestinian hospitals and 134 UNRWA primary care clinics, providing mother and child healthcare, family planning and preventive medicine services (UNRWA, 2009). These medical centers are not funded by the Israeli system and serve primarily West Bank and some Gaza Palestinians who are not eligible to Israeli health services. We will not go into the details of this subject as it is beyond our present scope.

### Fertility treatment in East Jerusalem

Infertility is highly aggravating for affected couples everywhere. In the Middle East, where childbearing is crucial for one's self accomplishment and social standing, the implications are especially pernicious, stigmatizing both men and women (Inhorn 2004, 2009; Haimov-Kochman, 2009; Serour, 2008). The thorough medicalization of the impairment may have somewhat alleviated its stigma (Birenbaum-Carmeli and Inhorn, 2009). Still, childlessness comprises a

major social problem and an injury to individuals' self-perception. The impact on the woman, her dignity, moral identity and psychological wellbeing, is devastating (Inhorn and Van Balen, 2002; Haimov-Kochman, 2009). Often, the woman is blamed for the barren marriage even when its source actually lies in her partner's body (Serour, 2002). The unacceptability of adoption in most Muslim circles rules out this solution to childlessness (Birenbaum-Carmeli and Inhorn, 2009). Equally inconceivable in this setting is the notion of voluntary childlessness, a popular mode of camouflaging infertility in industrialized countries (Inhorn and Van Balen, 2002: 8). Resolving infertility is therefore crucial to the life of infertile couples, and the availability of funded treatment is considered a great relief. Poorer families – and East Jerusalem families largely fall into this category – are especially dependant on public funding. Having said that, we need to remember the state's interest in reducing the city's Palestinian population, which is the broader context of the medical encounter that will be depicted now.

**The community clinics.** *Clalit's* women's clinic in Sheikh Jarrah operates since 1989, serving *Clalit's* Palestinian clientele five days a week. The clinic provides basic obstetric and gynecological services. Fertility treatments are provided mostly by three fertility specialists from the nearby Hadassah Hebrew University Medical Centre on Mount Scopus. The doctors, two men and a woman, are all Jewish. Only one of them speaks Arabic, though in years of work with Palestinian patients, the other two have acquired enough command of the language to enable basic communication. A Palestinian woman has been working at the clinic as a translator for over fifteen years. Her long acquaintanceship with fertility issues, alongside the doctors' knowledge of Arabic, if limited, ensures relatively smooth communication between the Hebrew speaking Jewish doctors and the Arabic speaking Palestinian patients.

At the Sheikh Jarrah clinic only basic tests and treatments can be conducted: Ultrasound follicular follow up and hormonal profiling. For other procedures, still quite elementary, e.g., sperm count or hysteroscopy, the patients are referred to the Jewish part of the city. Historically, the referral to the further laboratory was initiated in order to ensure that the Palestinian patients benefit from the same quality of service that the Jewish population enjoys. Moreover, the distance between Sheikh Jarrah and the West Jerusalem clinic is very short: a ten minute walk. Still, in practice, crossing the path on foot is customary for Palestinian women by themselves, even when walking in pairs. The way thus requires a ride in two buses as there is no direct bus from the

Palestinian part of the city to the Jewish section. Once in the Jewish part of town, the women, identified as 'Arab' by their traditional clothes, are subject to suspecting by-passers' gaze. At the entrance to the clinic, the Palestinian patients, like all others, must undergo a security search, in which they are probably checked more thoroughly. In this clinic, there is no translator and many of the Palestinian patients cannot speak any Hebrew. The linguistic limitation adds to the surrounding tension.

The language-related difficulty requires some elaboration. Arabic is an official state language in Israel. It is the mother tongue of its twenty percent Arab minority. However, Arabic is not a compulsory subject in Jewish schools and only few Jewish Israelis can speak the language. Among Ashkenazi Jews – and most doctors in the IVF unit (and in Israel more generally) are of Ashkenazi descent – Arabic speakers are particularly rare. In Israel's Arab schools, however, Hebrew is mandatory. Palestinians who are Israeli citizens are therefore pretty fluent in Hebrew. This generalization does not apply to East Jerusalem residents, who do not follow the Israeli curriculum and are not required to learn Hebrew. While releasing East Jerusalem residents from a compulsory requirement, this 'freedom' leaves many local Palestinians devoid of communication capacity outside the Arab community. Women, who normally do not work outside their homes – a mere 13% of the Palestinian women in Jerusalem are gainfully employed (Hoshen and Korach, 2009) – have particularly meager Hebrew linguistic skills. Yet, for these underprivileged couples, most of whom make a living off the husband's work as a day laborer, taking a day off in order to accompany one's wife to the clinic and serve as a translator, is a luxury that most patients cannot afford. The woman thus usually arrives in the clinic together with a female relative and depends on the occasional presence of an Arabic speaking staff member.

Given the inconvenience and discomfort that these visits entail, many Palestinian patients prefer to approach a private laboratory or clinic in the familiar eastern part of the city, though this means paying out of pocket – if a relatively modest fee (e.g., 70 USD for laparoscopy) – for a service that they can obtain for free in the Jewish part of town. Moreover, the Israeli doctors do not always trust the professional quality of the East Jerusalem procedures and therefore often request a repeating test (e.g., sperm count) in a laboratory with which the doctors are better acquainted, i.e., one that operates in the Jewish part of the city. Problems that cannot be resolved in these clinics, primarily those that require IVF, are referred to the Mount Scopus IVF Unit in Hadassah Hebrew University Medical Center. As mentioned, all these

treatments are provided with just a minimal patient financial contribution.

*The hospital clinic and the predicament of geographically divided couples.* Inside the examination room, in the Mount Scopus IVF clinic, the medical team offers Palestinian women and couples cutting edge fertility care. However, here too, surrounding factors position East Jerusalem residents at a disadvantage vis-à-vis their Jewish counterparts or even their Palestinian counterparts who are Israeli citizens (Palestinians living in those regions that have been included in the state of Israel prior to the 1967 war).

Roughly half the patients in Mount Scopus IVF unit are Palestinians. Nonetheless, linguistic barriers abound here as well. Of the five unit's nurses, only one speaks Arabic. The other nurses and the doctors use a mixture of Hebrew, Arabic and English in order to assure that their instructions are understood properly. Occasionally, however, a woman misunderstands, especially those instructions that are delivered on the telephone, and takes a wrong dose of medication or misses the prescribed time of an injection. Such mistakes may result in cancellation of a whole treatment cycle. Some women solve the problem by requesting a Hebrew speaking relative, in most cases, a man, to receive the instructions over the phone on their behalf, thereby compromising their intimacy and privacy. In the absence of a Hebrew speaking relative, the woman is invited to come back to the clinic, at midday, for the second time on the same day, in order to get the complicated instructions straight. All of these problems become more poignant when the treated spouses live on two sides of the separation barrier, namely, when one partner is an East Jerusalem resident and the other one lives elsewhere, most commonly, in the West Bank.

In 2002, Israel has decided to construct a Separation Barrier that would enable monitoring of all Palestinian movement from the occupied West Bank to Israel. In the Palestinian conurbation around Jerusalem, where life has previously flowed across the municipal boundaries – thereby facilitating the creation of geographically divided couples – the barrier seriously interrupts daily life. People living in neighboring streets and suburbs have been cut off, since entering Jerusalem now entails a long, formal process of permit application, the outcome of which is uncertain. The actual crossing into the city is another obstacle, as only four out of the 14 checkpoints between the city and its surrounding are open to Palestinians. Indeed, in some cases, mobility restrictions may render a couple's meetings – and intercourse – so rare as to prevent conception. A whole year can thus go by without a pregnancy,

making the couple eligible to infertility workup. Ironically, the state that prevents the partners from getting together would provide them with costly, as well as bodily taxing fertility treatments to help them conceive.

As in other Middle Eastern populations, infertility is extremely high among Palestinian men in Israel, implicating 80-85% of the infertile couples seeking medical assistance (Mount Scopus clinic estimates; See also Inhorn 2004, 2009). The common practice of attending to the man's infertility by treating his wife's body is endorsed in the Mount Scopus IVF unit as well. At this point, the question which spouse is an East Jerusalem resident, i.e., which partner is entitled to free treatment, becomes crucial, as the state funds fertility therapy, including IVF, only to the woman, who is the actual clinic patient. This means that if the woman is an East Jerusalem resident, she is entitled to treatment even if the problem is primarily her husband's. However, a West Bank wife of an infertile East Jerusalem resident is not eligible to treatment, even though she would have been treated in order to resolve his impairment. Such couples, in which the wife is not an Israeli resident, have to approach a West Bank fertility clinic and pay for their treatment. The notion that is commonly cited by fertility experts, that in the treatment of infertility, it is the couple – rather than one partner or the other – who is 'the patient', apparently collapses when we look at these Palestinian couples who live on two sides of the barrier.

In the more favorable cases, when the wife is entitled to healthcare, she can start treatment. She needs, however, to resolve the problem of her husband's probable inability to arrive in the clinic at a prescribed day. Both, obtaining an entry permit and crossing the barrier are especially difficult for young men who are perceived as the greatest security threat. The Palestinian men whose wives undergo fertility treatment in the Israeli system belong almost invariably to this category.

The husband's absence on the day of ovulation normally results in losing the whole cycle. In one such case, the husband managed to provide the semen in some improvised spot near the checkpoint

and then transferred the sample to a relative who was waiting on the other side. However, this resourceful solution was an exception. In most cases, the cycle was lost.

Losing a cycle was especially painful in the case of IVF. Trying to resolve the problem of having many mature oocytes and no sperm for fertilization, the doctors started exploring the option of oocyte freezing (Table 2). Today, Mount Scopus embryologists are considered Israel's leading team in this technology.

Having realized that the husband's inability to arrive in the clinic on the prescribed day was in fact rather common, the IVF team started requesting a frozen semen sample from every men living behind the barrier. The man thus comes over from the West Bank to the Mount Scopus IVF unit whenever he can and freezes semen for later use. This practice has become a routine component, indeed, a requirement, for treating geographically split couples. If the man cannot obtain a permit to arrive at the sperm bank even once, in order to freeze a semen sample, fertility treatment will not start.

This solution is however, costly, entailing a fee of 700 NIS (nearly 200 USD). In a reality in which the real per capita income is 1,284 USD (Kawach, 2010) this sum amounts to some 15% of one's annual income. The inconvenience and costs drive some geographically divided Palestinian couples to seek treatment in the West Bank, despite the generally lower professional level, as compared to the treatment that the woman can obtain for free as an Israeli resident.

## Discussion

By way of conclusion we can summarize that once inside the clinic, East Jerusalem Palestinians receive high quality fertility treatment, equal to that provided to Jewish Israelis. Yet, the medical encounter is surrounded with formal and informal obstacles and inequality. Palestinian patients suffer more inconvenience due to communication difficulties and restrictions on their movement, which also translate into extra costs. Whereas the doctors do not try

**Table 2.** — Egg freezing-thawing figures.

Time span	1999-2004
Number of women	24 women, of which - 3 Jewish women 21 Palestinian women [the first ten women were all Palestinian]
Numer of frozen-thawed eggs	120
fertilization rate	60%
pregnancy rate	31% per embryo transfer
oocyte survival rate	Rise from 30% to 70%

to alter the political limitations placed on their Palestinian patients, the IVF team does make active and creative efforts to resolve the various problems that individual patients encounter and to maximize the treatment's efficacy under the existing conditions.

A crucial voice that is missing from the depiction above is that of the patients. The doctors interpret the return of Palestinian couples for a second and third child, the gifts and sweets, as well as the babies' photos that they offer the staff as tokens of gratitude. Bringing the babies along is another indication of favorable attitude. Having said that and not necessarily in contradiction, the dialogue between the mostly Jewish staff and the Palestinian patients is carried out with great caution that suggests profound fragility. During decades of work with East Jerusalem Palestinians, both patients and staff consistently refrain – so the doctors testify – from any political comment, even at the height of the Intifada and the Israeli attack on the Gaza strip in the winter of 2009. Even the current struggle over the eviction of Sheikh Jarrah Palestinian families from their homes, and the weekly demonstrations in the neighborhood, which take place near the clinic and the patients' homes, and which are routinely reported in the media, is silenced in the clinic encounter. Another hint towards the underlying tensions is the failure of one doctor in the IVF unit to recruit patients for a qualitative study that aimed to give voice to their travail while undergoing fertility treatments in Israel. The doctor, a (non-Jewish) Russian woman married to a Palestinian man, who lives in East Jerusalem, who is fluent in Arabic and is now an observant Muslim, approached a few Palestinian patients of the unit and invited them to participate in the study. Though she assured the women that the descriptions would be anonymous and that all identifying details would be removed, all but one woman did not even consider participation. Eventually, this woman, too, has decided in the negative. The women's silence leaves us in the dark regarding their experience. Yet, their refusal to talk may represent a sense of insecurity. An interesting, if ironic counterpart to the women's silence can be found in the silence of Hadassah medical center, which intentionally leaves this exemplary Israeli-Palestinian cooperation away from the spotlight.

What does the description above add up to? Possibly, to conclude that owing to the HMOs economic interests in enrolling the Palestinian population, and the doctors' professional conviction, healthcare, and fertility care in particular, are a relatively less discriminatory sphere in the grim picture of Palestinian life under Israeli occupation. Yet, even here, the treatment is imbued with the politics of domination.

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