

HUMANITARIAN CARE AND THE ENDS OF LIFE: The Politics of Aging and Dying in a Palestinian Refugee Camp

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Burj al Barajneh, a Palestinian refugee camp with a population of around eighteen thousand located in the southern suburbs of Beirut, is one of fifty-eight officially recognized Palestinian camps in the Middle East. Most of these camps have existed for nearly seventy years, since the massive displacement of Palestinians in 1948.¹ Material changes in camp life over this long period were a recurring subject in my conversations there during field research in 2011 and 2012. Concrete shelters have gradually replaced tents, and the buildings have grown vertically over the years. People described increased crowding as the population grew but camp boundaries could not expand. Where once there were open spaces to play, people who had spent their childhood in the camp told me, a neighbor was now pressed right up against you. Most of the camp passageways are only a few feet wide, far too narrow for a car to traverse, but leaving enough space for a motor scooter. The water is salty; the electricity (as in much of Lebanon) is not only unreliable but also often jerry-rigged.

Another frequent topic in these conversations were people who had died untimely deaths, or who had suffered a calamity that brought them close to dying. Aseel told me about a woman who died, young, from a botched tonsillectomy. Ismail described a newly widowed woman whose request for financial support from the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) was denied because the agency deemed her house too nice.

Kamilah recounted how a relative was killed by an electric shock, a persistent threat in the camp. Abu Ahmed put a portion of the blame for wrongful deaths at the feet of UNRWA and its overcrowded, understaffed clinics. In these circumstances, he told me, doctors sometimes became neglectful. He relayed accounts of doctors leaving patients to suffer while they ate their lunch or prescribing the wrong medication. Such stories of death and dying also tell the story of life in the camp. Chronic poverty contributes to ill health. Limits of institutional capacity mean insufficient access to health care. Dangerous infrastructure means a constant exposure to risk when traversing camp alleyways. Crowded conditions exacerbate all these problems and further degrade people's capacities to cope.



Figure 1. Camp alleyway. Photo by Ilana Feldman.

What do the conversations mentioned above suggest about what it is to live as a refugee over the long term? One thing that it can mean—and in the Palestinian

case of decades of displacement, what it necessarily has meant for many people—is to die as a refugee. How do humanitarian actors respond to the inevitability of death? Ordinary deaths are not easily incorporated into a field of intervention whose primary purpose is to save lives: to stop people from dying from “stupid things” (Redfield 2013, 31). This aim helps delimit the activities within the scope of humanitarian concern. Humanitarianism is a “regime of life,” in the sense that Lisa Stevenson (2014, 68) describes, a system “in which keeping people alive has become the primary goal.” Practitioners do not, of course, imagine immortality for aid recipients, but their orientation toward life-saving has limited their attention to servicing dying. A second characteristic of most humanitarian work is that it is intended to be short-term: to respond to crisis and conclude when normal conditions reemerge. In the Palestinian case, and in many other instances around the globe, this intention cannot be realized. Instead, humanitarian work has been compelled to respond to chronic conditions and to confront people’s needs across the whole life cycle. Long-term refugee status means that not only life, but also the end of life must become a humanitarian concern.

This work exposes an array of limits to humanitarian capacity. Of course humanitarian practitioners are concerned about the lives of the elderly, but many see the services that cohort needs as belonging to a different care regime. In addition to such limits of definition, stark constraints exist on humanitarian resources. Providing the full spectrum of medical care that many people require in old age lies beyond the financial ability of many humanitarian organizations. These limits generate confrontations with Palestinian communities, as people demand more services and raise questions about the rights and values embedded in certain choices. Drawing on archival research and ethnographic fieldwork in Burj al Barajneh, this essay explores a variety of interventions that respond to end-of-life concerns.

Humanitarian attention to the end of life, just like humanitarian attention to other moments of life, takes place within a broad landscape of insufficient care, services, and opportunity. Chronic and widespread undercare forms part of the conditions of both living and dying in Burj al Barajneh. Catastrophic illnesses often produce the sharpest confrontations with these conditions of undercare, as they do in many circumstances. The UNRWA health-care system, focused on primary care, takes a life-cycle approach that seeks to address the needs of the population as it moves through these stages. The care available is limited, but it has the explicit aim of promoting “a long and healthy life” (UNRWA 2013, 25). The agency is the largest service provider in the camp, though by no means the only

one. For instance, a local NGO, the Women's Humanitarian Organization (WHO), works to expand access to limited services by sending nurses on home visits to elderly patients unable or unlikely to make it to UNRWA clinics on their own. The Social Support Society (SSS), another local organization, has likewise established a day center for the elderly, the only one in the camp.

An aim of the larger project of which this essay forms a part is to understand the ways in which humanitarianism—especially when extended over the long term—constitutes a social world: with ethical concerns, political claims, and subject positions that are in some sense proper to it, but that are also never wholly contained by it. Humanitarian practice can determine the course of people's lives, and yet the effects of these interventions also travel beyond their direct targets, shaping sensibilities and entire communities. This is a world populated by a multiplicity of subjects, humanitarian providers and aid recipients key among them. These category distinctions often delineate differences of position, rather than of demographics. For instance, Palestinians constitute the overwhelming majority of UNRWA staff, and local NGOs such as WHO and SSS also see themselves as part of the refugee community, rather than just as service providers to it. The categories *provider* and *recipient* contain internal multiplicities and therefore have blurry boundaries.

Humanitarian responses to aging and dying are a setting that brings into view, and into existence, key aspects of this social world. With questions about services for the aging and dying foregrounded, the possibility of the future becomes a site of confrontation among providers and recipients. Often this future appears to be foreclosed. To be sure, there are many sources of constraint on Palestinian lives. In Lebanon, responsibility for the foreclosure of the future lies with many actors—the Lebanese state, other Arab countries, Palestinian leadership, the international community, and Israel among them—and my interlocutors in Burj al Barajneh exposed this full range. Attention to this diversity—to the fact that, as [Rosemary Sayigh \(1994\)](#) puts it, Palestinians have “too many enemies”—does not undermine the centrality of the domain of care in the formation of this constrained world. In the conditions in which refugees live and die, humanitarian limits seep into the Palestinian experience and participate in the foreclosure of the future. This foreclosure is experienced as both an individual matter (*I am being told to die; I will die before my time*) and a collective experience (*we will not be able to provide what we hope for our children; we will not realize our political aims*).² The multiple impossibilities in humanitarian care for the aging and dying

have contributed to circumstances that constrain the political imagination, circumstances in which the future appears lost.

THE HUMANITARIAN LANDSCAPE IN LEBANON

In 1948, approximately 750,000 Palestinians were displaced from their homes, going largely to Jordan, Syria, and Lebanon, and to the parts of Mandate Palestine that became the West Bank and the Gaza Strip.³ These territories constitute the five fields of UNRWA operations. Today, there are five million refugees registered with the agency. Around four hundred thousand live in Lebanon, more than half of them in one of the twelve official camps in the country. The most significant underlying problem confronting Palestinian refugees, and arguably the one from which most others stem, is the ongoing lack of resolution to the problem of 1948. There has been no implementation of most of the many United Nations resolutions on the displacement of Palestinians.⁴ Key among these unfulfilled ideals is the right of return, a central feature of refugee political thought and claims. In recent years the impact of the ongoing failure of the project of Palestinian liberation and statehood has been compounded by an increased loss of hope, of belief in the Palestinian political leadership, and of a personal willingness to make sacrifices for political goals. The tide may yet turn again, but at the moment, the political situation appears rather grim.

Things also look bleak in other arenas. In Lebanon Palestinians suffer from endemic poverty (Allan 2013; Perdigon 2015). They are restricted from working in a range of professions and face widespread discrimination even in fields where they are allowed to work (Knudsen 2009). Since 2001 they have not had the right to purchase property, and they cannot pass on the property they do own to their children. Diminishing work opportunities both in Lebanon and abroad have contributed to a devaluation of education among many youth—this, in sharp contrast to the past, when educational attainment was a central value. As one young man put it, rejecting his father's desire that he stay in school: "They tell you get educated and there are no jobs. You look for work and they tell you it is banned. . . . The story is you waste years for nothing." As in the political field, the economic situation of Palestinians in Lebanon has gotten worse, not better.

Living conditions are also quite difficult (Peteet 2005; Sayigh 1995). Camps near Beirut suffer from the most severe overcrowding. As a denizen of Burj al Barajneh commented to a resident of the Rashadiyya camp, located along the beach in south Lebanon: "Here you have some distance, space. Air might enter. It is suffocation for us." These dire material, economic, and political conditions

contribute to the health problems so widespread in the camp. And the chronic conditions that form part of living as a refugee have a clear impact on the experiences of dying as a refugee. Difficult economic circumstances mean that people have limited resources to confront the increasing medical expenses of old age.⁵ Material in this essay is largely drawn from fieldwork conducted prior to the large influx of refugees fleeing the conflict in Syria. This displacement has put tremendous additional pressure on a humanitarian system already stretched. These latest developments are not part of my analysis here, but they will certainly make the challenges I describe yet more acute.



Figure 2. Shelters in Burj al Barajneh. Photo by Ilana Feldman.

The most important source of humanitarian assistance in the camps, in size and influence, is UNRWA. Since 1950, UNRWA has provided aid to refugees in the five fields of its operations. In the first decades, services were extensive, including rations, clothing, housing, education, and health care. Today the organization provides primarily the last two, along with sanitation and some social services. But UNRWA has never been the only agency working in the camp. Others include international organizations like Doctors Without Borders/MSF, Palestinian national organizations such as the Palestine Red Crescent Society, and

local, sometimes camp-based organizations such as WHO and SSS.⁶ Palestinians view UNRWA as an acknowledgment of international responsibility for the loss of Palestine and the fate of Palestinians (even as they also express concern that humanitarian aid stands in the way of political resolution). Thus they attach obligations to it that they do not ascribe to other humanitarian agencies. With education and health care at the center of its work, UNRWA provides the services a national government might, though it lacks the security and administrative capacities of such governments.⁷ Given UNRWA's profound financial constraints, the presence of other organizations to fill in service gaps has been an important feature of the humanitarian landscape in Lebanon (Khalili 2007).

The humanitarian experience always involves contestation between the structure of the aid system and the desires and demands of recipients. Humanitarian actors explicitly define their politics of life as nonpolitical: both neutral and impartial, concerned with fostering well-being rather than promoting particular agendas (Redfield 2013; Terry 2002). For Palestinians, who view UN humanitarianism as a right, the well-being of the community depends on pursuing a politics of restoration, one in which their national rights and demands are protected and promoted. Palestinians insist on this expansive view of humanitarian responsibility across the spectrum of humanitarian activities, though providers generally respond that this sort of politics lies beyond their mandate and authority. The challenges of servicing old age, as a stage of life marked in part by illness and dying, bring these conflicts into sharp relief. They structure a conversation about humanitarian politics that centers the question of the character and quality of the life that humanitarianism is meant, and may be obligated, to foster. This conversation, which is produced out of encounters with the limits of both humanitarian services and political possibility, shapes how people experience their own lives, including the intrusion of dying into living.

DEATH AS A HUMANITARIAN CONCERN

Death itself, and the burial and mourning processes that go along with it, is largely experienced outside the humanitarian realm in Burj al Barajneh. The camp has a cemetery, and families pay the fees for plots and burials on their own. Even as people frequently complained to me about service inadequacies, no one ever mentioned burials as a matter for which they wanted humanitarian assistance. They did, however, blame humanitarian insufficiency for some of the deaths in their lives.⁸ The end of life thus appears to people as a matter of humanitarian concern, but death and its aftermath largely do not. The lines were not always

drawn in this manner. In the early years after 1948, UNRWA did recognize death as a matter of agency concern: as both a site of service and a mechanism of control.

In the early 1950s, UNRWA officials debated the agency's financial responsibility for refugee burials. The head of the Social Welfare division suggested these expenses as "an appropriate activity" for his division, but also noted that other resources for covering the costs should be explored.⁹ Another official reported staff consensus that the "proper interment of refugees who have died should be a responsibility of the Agency."¹⁰ The question of cost sharing seems to have been a primary concern. As noted in another memo, "It is well known in these countries that there are charitable community organizations that spend on burying the dead who were poor or strangers and had no one to look after them; particularly in the Moslem Communities the Waqf Department takes charge of this work."¹¹ This statement indicates agreement that death and burial were matters of humanitarian concern: the question was which humanitarians should be financially responsible.¹²

These conversations about services for refugee deaths also included discussions about how such contributions might assist in the project of managing refugee communities, specifically in keeping the refugee rolls accurate. Financial constraints posed a problem for UNRWA from the beginning (and are acute today), with the consequence that a ceiling existed on the number of registered refugees permitted in each field. To register infants, and any other eligible nonregistered persons, the ration rolls needed to be regularly cleared of fraudulent registrations, of people who had lost eligibility because of income or movement away from the area, and, crucially, of people who had died. Precisely because reporting deaths would have meant a reduction in rations for remaining family members, people were very reluctant to do so. Reports from the early 1950s indicate that as few as 10 percent of deaths were being reported in some fields.¹³ Paying for burials was proposed as one mechanism to increase reporting. Punitive suggestions also included discontinuing the registration of babies until reporting increased.¹⁴

When the Syrian government asked for UNRWA help in covering burial costs in 1953, it made direct reference to cost recovery. Stating that payment would have a double benefit, the Syrian official argued that "it would on the one hand render a humanitarian service, which is not existing, by providing the family of the deceased with the burial fees which often families are unable to secure. On the other hand this device would ensure a correct [sic] of death cases as they occur."¹⁵ Yet UNRWA officials had by then already tried this approach in other

fields, with limited success. The Jordan field office reported discontinuing the practice after failing to reach the expected level of reporting.¹⁶

Seeking another means to acquire accurate information about deaths, a few years later UNRWA officials in Jordan suggested creating “a list of all the refugees recorded as of sixty years of age and above in a given camp or area” and then having the government check its register of deaths “to ascertain which of the refugees in question were still alive.”¹⁷ This reference to age sixty as a significant threshold between life and death has had lasting relevance, and will reappear in this essay. This naming of sixty as a likely end of life finds echoes in the humanitarian practice of later years, in how Palestinians understand the value humanitarianism attaches to their lives, and in how they experience those lives. The exchange in 1960 makes clear that the Jordanian government had information about deaths that UNRWA did not, indicating that despite its various efforts, the agency had not succeeded in gaining control of the information management around death. This failure became somewhat less troublesome in later years, when presence on the registration rolls conferred fewer benefits to people. If death and burials have largely receded from the humanitarian arena, the end of life now has a place in this field.

LIVING, DYING, AND THE FORECLOSED FUTURE

Long-term humanitarian work (an increasingly common experience) poses both operational and existential difficulties for what Peter Redfield (2005, 329) terms its “minimalist biopolitics,” the use of biopolitical techniques primarily to keep people alive, rather than help them thrive. Redfield (2005, 344) describes minimalist biopolitics as “the temporary administration of survival in circumstances that do not favor it.” The longevity of humanitarian operations in the Palestinian refugee case calls the temporariness so central to its self-definition into question. In this circumstance temporariness has not been replaced by permanence, but rather by an uncertain in-between. Although UNRWA has existed for sixty-five years, its existence needs to be reauthorized every five years. The agency’s finances depend on voluntary contributions from UN member states, which are never guaranteed and are often inadequate, making planning difficult. This problem of the in-between is also experienced by Palestinians in exile, for whom an insistence on the temporariness of their condition forms part of their claims for a political resolution and who also recognize that many will live their whole lives in a “humanitarian condition” (Feldman 2012), therefore making it necessary for the needs of that condition to be addressed.¹⁸

The problems of aging and dying introduce additional challenges into the conundrums of long-term humanitarianism.¹⁹ Palestinians experience the humanitarian inability to provide adequate care for end-of-life conditions as part of a constellation of threats to the population. They understand the continued existence of Palestinians as a people to be their strongest weapon in national struggle, and see undercare as part of a concerted effort to undermine that existence. They believe it to form part of the production of inequalities that [Didier Fassin \(2009, 49\)](#) identifies as central to biopolitics. Fassin argues that biopolitics is not just about fostering or disallowing life but also about “deciding the sort of life people may or may not live.” Palestinians view undercare as such a decision.²⁰ Indeed, some see it as a necropolitical tactic, a direct attack on the life of their community.²¹ Not only does insufficient care contribute to people’s deaths, but the persistent experience of inadequacy contributes to the degradation of expectations and hope for the future.

The elderly now reaching the end of their lives in Palestinian refugee camps are also the last of the so-called Palestine generation: those who were exiled in 1948, who have memories of life in Palestine, and who have lived with acute longing for these places. So their deaths, and the inadequacy of the care they receive in their old age, bring this failure into especially stark relief. No intervention could halt the passage of time, but this generational loss forces a confrontation with the impossibilities baked into long-term humanitarianism. The longer such a situation continues, the harder it becomes for humanitarian practice to effect a meaningful change in the conditions of people’s existence ([Feldman 2015](#)). And the work needed to change the underlying situation lies beyond the jurisdiction and power of humanitarian organizations. Palestinians experience this loss of the Palestine generation as yet another defeat, as a loss of their homeland yet again. The disappearance of the past is also experienced as a foreclosure of the future.

Yet defeat is not the only Palestinian response to this condition. The effort of local NGOs to intervene in the landscape of insufficiency, to provide additional care, indicates an intersection between humanitarian practice and Palestinian experience. In offering supplemental care, these organizations make a humanitarian intervention into a humanitarian system. They also confront failures of Palestinian society to provide the kind of elderly care common in the past. These efforts highlight a recursive problem: humanitarian presence is a sign of failure (of states to protect populations, of the international community to push for political resolution, and in this case of a Palestinian state to be realized). Humanitarian prac-

tice always works with and up against the limits of its capacity (to save, improve, transform lives). A humanitarian response to humanitarian incapacities responds to, and reproduces, both these problems. These local organizations cannot solve the problems of humanitarianism and, by working in its terms, they cannot escape its limits.

UNDERCARE AND THE THRESHOLD OF DYING

Conditions of health care in the camp clearly indicate how Palestinians are and feel inadequately cared for.²² UNRWA provides primary health care, generally through clinics located in the camps, to all registered refugees who want these services. Both refugees and humanitarian actors identify this care as insufficient in many ways.²³ The longevity of the Palestinian question has required UNRWA to develop an expansive health-care model, but the services provided are necessarily limited. Refugees complain that medicines are frequently unavailable and that those in stock have often expired. Both refugees and doctors bemoan the overcrowding, which means that patients get only a minute or two with a physician: not enough time for a thorough evaluation. Those refugees with the resources to get their primary care elsewhere often do so. Beyond primary care, the situation proves even more difficult.

In Lebanon, without health insurance, or the independent means to pay, people will not be admitted to a hospital. I often heard about crises engendered by medical emergencies, serious illness, and hospitalization. An UNRWA assessment from 2009 revealed that access to hospitalization for both secondary and tertiary care was deeply inadequate. Reforms to the system led to complete secondary coverage and 40 percent coverage for tertiary care (UNRWA 2012). Given the tremendous poverty among refugees, the remaining costs often proved prohibitive, something UNRWA recognized, but budget restrictions made further coverage impossible. In January 2016, with UNRWA facing a financial crisis, a further policy reform was introduced: refugees will now have to pay up to 20 percent of secondary care costs (depending on where they receive this care). Even as UNRWA (2016) has defended the change as both “in line with international good practice” and as intended to enable more funds to go toward tertiary care, the change caused widespread protests in the camps (Zaatari 2016a).²⁴

Even as health care is meant to manage and maintain life, refugees frequently identify the existing system as both a source of degradation and debasement and as a cause of death. I use the term *undercare* to point precisely to this dual condition. To describe someone as being “under care” means that they *are* being cared

for, being treated by a physician, located within a system of concern. Those who experience undercare are also under care in this broader sense, but the care they receive is systemically inadequate—a fact that both providers and recipients recognize. Refugees also view it as part of a systematic attempt to harm the community.

There are many expressions of undercare: lack of medicine, limited services, and poor-quality care rank among them. My fieldwork in Burj al Barajneh introduced me to others. In UNRWA's life-cycle approach to primary care, the official goal for the elderly is described as "active and healthy aging"—a goal implemented primarily through screening for diabetes and hypertension. When I talked with people in the camp, I learned about other features of these policies toward the elderly. At the beginning of my research I was struck by a phrase heard repeatedly: "Refugees don't have the right to live past sixty." As I probed to find out what people meant by this, I was told by refugees that UNRWA cut off access to more than primary health care after age sixty. As one elderly woman told me: "Now, at my age, I go [to UNRWA], and they do not help me. I am old. I should die." At first I wondered if this was correct, as people can sometimes speak in hyperbole to make a point about inequity, but I soon learned that these words did reflect an UNRWA position.

A 2008 UNRWA report describes the policy: "Rationing of care is the rule, with patients over sixty not reimbursed (and thus often not treated) for end-stage renal disease, cardiac surgery (even stunts [*sic*] or cancer. While the budget constraints are clear, rationing criteria are often inadequate or too stringent" (UNRWA 2008, 31). In the past few years, UNRWA health-care procedures in Lebanon have undergone reform, in part in response to an American University in Beirut–UNRWA survey of health conditions in the camps, which provided a quantitative accounting of their inadequacy. According to a 2011 report by the British NGO Medical Aid for Palestinians, "as part of its restructuring in 2010, UNRWA halted the policy of prioritizing those patients aged under sixty years" (MAP 2011, 11). It remains unclear to me to what extent this policy change has been enacted on the ground. Certainly my informants were unaware of it. The seepage effect of humanitarian practice means that even when a policy changes, its effects linger on: in the lives of people not treated, in the ways people continue to experience this judgment of their value.

So here is another encounter with age sixty being tagged as a kind of threshold in the life cycle. The archival record of information management efforts around death described an expectation that those older sixty might likely die.

This more recent instance concerns a policy decision to offer different life-sustaining services to those over that age. Yet it is not only around services that sixty is a marker. It is also the age of mandatory retirement from UNRWA employment. So age sixty stands for people as the end of both economic productivity and full access to services. This marking suggests that the life cycle is divided in two—the stage of active living and the stage of preparing for death—and that as people cross the threshold, they need to redirect their energies and attentions. The decision to withhold or restore services to parts of the population based on age is clear evidence of [Didier Fassin's](#) (2009, 53) point about the “differences in values attached to lives” that form part of biopolitical practice.

Palestinians certainly see these decisions as being about much more than access to services. They view them as reflecting humanitarian decisions about both the right to life, a right they see as denied to the elderly, and their assigned role in society, which, for the elderly, is to prepare to die: “I am old. I should die.” People may not entirely accept this judgment of their value and their role, but they cannot wholly escape its impact. The humanitarian politics of life is defined in part by the tension between the goal of valuing all lives equally and the necessity of differentiating among lives. Like emergency medicine, humanitarian action requires triage ([Nguyen 2010](#)): decisions about whom to help first and, given resource limits, whom not to help at all. The necessity of triage marks an uncomfortable but unavoidable feature of this intervention. In a crisis, the criteria of attention produce hierarchies of need (the more life-threatening conditions receive aid first). But in chronic conditions, where life itself is not the central question, triage produces hierarchies of kind.

UNSETTLING THE LIMITS OF CARE

Even as active aging forms an explicit part of UNRWA's health-care vision, the limits of humanitarian capacity mean that aging remains largely a non-serviced experience. The elderly mostly depend on their families for assistance, and those without family present are particularly vulnerable. When I visited the Rashadiyya camp outside Tyre in southern Lebanon, an employee in a local NGO identified the absence of such assistance as a crucial service gap. In Rashadiyya, Samar told me, most activities were focused on children, and no one paid attention to the elderly. The elderly, she said, sit in their houses without care. There should be a center for them to gather, to spend time, and to talk about Palestine. And, she argued, this would not only be for their benefit but for that of the community, because the elderly “are our memory.” As she talked, she kept returning to the

imbalance of attention: “Yes, children have rights, but the elderly have rights too.” This general question about the correct allocation of care has additional significance in this instance, because the elderly are the final Palestine generation: the last people who can talk about their own memories of Palestine. Failing them, therefore, is to fail the entire community, to disrespect its past and therefore to impede its future.

The limits that Samar described do not describe the whole of the service experience. Two local organizations, WHO and SSS, are trying to respond to the gaps in coverage for the elderly and other vulnerable populations. Their efforts hold both humanitarian and political significance. To a certain extent their work can be viewed as a humanitarian response to system failures: in the Palestinian refugee case, the system is itself a humanitarian organization (UNRWA). As Palestinian organizations, they view their practices as also political: insisting that all Palestinian life has value, that the elderly have a specific value as members of the Palestine generation, and that supporting these people will strengthen the capacity of the entire community to persist and resist.²⁵ This care differs from what [Lisa Stevenson \(2014, 82\)](#) calls “anonymous care,” through which “life becomes an indifferent value [such that] it no longer matters *who* you are, only that you cooperate in the project of staying alive.” The imperative to care for the Palestinian elderly comes not just from their generic status as human beings but also from their position as a link to Palestine.

The Women’s Humanitarian Organization was established in 1993 by Oulfat Mahmoud, a resident of Burj al Barajneh. Oulfat began her career as a nurse and worked during the War of the Camps, a stage of the Lebanese civil war when the camps came under attack and siege. During this period, she told me, “the camp was under siege, no ambulance could enter. . . . I thought people died very cheaply, and that was a turning point in my life, when I decided to quit nursing.” She also could not cope with the work of triage: “That was horrible. Who am I to decide who will live or not?” As difficult as this experience was, Oulfat said it “made me stronger towards my cause and my people’s rights.” And so she started WHO. As the name suggests, its founding purpose was to provide services for women, focused on empowerment and opportunity. This remains a central goal for the organization, but it also has programs (such as those for the elderly) that define constituencies in different terms. Both men and women receive services from the home-visit program, which is a key feature of WHO’s elder care.

During my research, I accompanied nurses on a number of these visits. Almost all the patients had diabetes and high blood pressure, these being the most

common chronic conditions in the camp. The key intervention during these visits was to check blood pressure and insulin levels. Each patient had a notebook in which the nurse recorded their levels. The nurses always asked the patients whether they were taking their medicines (some said they couldn't afford them), whether they were eating right (too much bread and rice in the diet also constitutes a chronic problem), and whether they were getting any exercise. They did not provide medicine, though I was told that that WHO will sometimes help with a delivery from the UNRWA pharmacy if patients cannot get there. Even if patients' numbers were very bad, the nurses did not intervene more aggressively than encouraging them to stay on track with medicine and diet. They chatted a bit with the patients and then moved on. Visits typically lasted not much longer than fifteen minutes (much longer than an appointment with a doctor, however).

Even as the actual services the nurses provide are limited, they seem to amount to something more. In providing another eye on someone's health, they expand the *sense* of care to let patients know that someone is attentive to their condition and will know, and be concerned, if it worsens. They may not be able to change the actual limits of available health care, but they can mitigate the feeling of abandonment, which is not an insignificant effect. No patient we visited seemed anything other than pleased to see the nurses. They might not all have been compliant with their medical recommendations, and they certainly did not feel that they had all the help they needed, but there was no hint of the frustration and resentment often evident in the waiting rooms of UNRWA health clinics. These small interventions push back against and unsettle (see [Murphy 2015](#)) people's experience of the limits of care.

In addition to this sort of health-care outreach, in Burj al Barajneh there is a center of precisely the sort that Samar called for in Rashadiyya. The Social Support Society, established in 2006 by a Turkish woman who has long lived in Lebanon, runs the Active Aging House: a day center for elderly men and women. The criteria for participation in the program (which is free) are the degrees of social isolation, with priority as follows: the never married; the married and widowed with no children; those with only female children; those with male children, but who are out of the country or otherwise absent. On days I visited the center I found fifteen to twenty people there, usually twice as many women as men. A TV was usually on in the corner, tuned either to dubbed Turkish soap operas (popular across the Arab world) or to a station that played Palestinian nationalist songs over a montage of pictures of the *nakba* (catastrophe; the term

used for the Palestinian displacement of 1948). More avid attention was paid to the former.

Activities at the center are oriented around keeping people physically and mentally active. In general they seek to help people endure old age, to remain connected to community, to stay healthy. After one day's art activity—coloring in pictures from elementary-school alphabet worksheets—the center's director told the participants that the goal of the activity was to have them focus, to identify the object in the picture, and color it in correctly. This purpose explained to me why she had been chastising the women when they picked the “wrong” colors for objects. As much as any particular activity, of course, participation in the center gives these elderly a social outlet, a continued presence in society, and an excuse to leave their homes.

The challenges of growing old, and especially of growing old alone, are not unique to Palestinians, or to humanitarian situations,²⁶ but they are exacerbated by these conditions. Chronic undertreatment leads to frailty; the material conditions of the camp make it exceptionally hard for those who have mobility problems to get around (this applies equally to the disabled); generally inadequate social services keep people more isolated than they would otherwise be. So the humanitarian condition has a direct effect on the experience of aging, whether or not humanitarian actors provide services for this population. And the impending death of the last Palestine generation, without return or resolution, brings the political failures of both Palestinian political leaders and the international community into sharp relief.

The efforts of organizations like WHO and SSS to provide services to the elderly are meant to disrupt the material circumstances and value ascriptions that are part of living in the humanitarian condition. They aim, of course, to impact the lives of those who receive services, but they also seek to make a different claim about the community. To this extent they not only speak back to perceived humanitarian devaluations of the elderly but also to failures in the Palestinian community to maintain social traditions of respect for the elderly and political recognition of the particular importance of this generation. Social practices of elder care have been degraded by the material difficulties in people's lives. Political recognition is troubled by the fact that the Palestine generation are not just those who know Palestine, but the ones who left Palestine. Following generations have lived with the consequences, and they sometimes blame the elders for having done so. Activities that bring young people to the Active Aging House to hear

stories of Palestine, emphasizing the importance of elder knowledge, are intended to restore traditions of respect.

The efforts of organizations like WHO and SSS to intervene in the conditions of undercare that dominate the refugee service experience are, to be sure, bounded in their effects. They serve a small number of people and they can only help them a little bit. But these efforts are part of a challenge by Palestinians to the circumstances of their life, and a claim to more value and greater rights than they see others ascribing to them. In this way, by pushing at the boundaries of care and value, they are unsettling these limits. Their efforts are also unsettling in another sense, along the line that [Michelle Murphy \(2015\)](#) describes when she talks about “unsettling care” as a critical practice that challenges an easy equation of care and the good. I do not mean that they approach their work as a project of critique, but that their practice reveals the recursive problem at the center of humanitarian care. As a former UN High Commissioner for Refugees put it: “There are no humanitarian solutions to humanitarian problems” ([Tan 2005](#)).

“EVERY DAY WE DIE”: LIVING WITH DYING IN MIND

However difficult their circumstances, the deaths of the elderly are at least age-appropriate. Because of the conditions of pervasive poverty, restricted opportunity, and inadequate health coverage, many younger Palestinians in Lebanon’s refugee camps think about their lives with a shortened horizon, and live with dying in mind. Not only is there the belief that old age is a right not granted to Palestinians but people still relatively young often talk about their lives as being “over.” They may have hope for their kids, but imagine little for themselves. So while age sixty stands as a kind of institutional threshold for life-cycle stages, people’s personal thresholds, and the point at which they tip over into thinking about dying as their proper activity, are often considerably earlier. This condition of living with dying in mind echoes both [Lisa Stevenson’s \(2014, 96\)](#) discussion of the “psychic life of biopolitics” and [Lauren Berlant’s \(2011, 95–119\)](#) account of “slow death.” When refugees describe this experience, they often evaluate it in terms that anthropologists would recognize as necropolitical. They do not view themselves as failing to thrive, or being allowed to fail to thrive, but as being killed.

To consider this condition, I turn to a conversation I had with Faris, a forty-two-year-old father of two. Reflecting on his life and the life of his community, Faris painted a bleak picture of possibility and was damningly critical of nearly every actor on the Palestinian scene: UNRWA, the Palestine Liberation Orga-

nization, the various factions, the Lebanese government, and so on. Just like anywhere and in any condition, of course, camp residents have a range of attitudes, experiences, and emotional states. Life is difficult for almost everybody, but people live with these difficulties in various ways. Faris's very gloomy views tend toward one end of the spectrum, but he is by no means exceptional in his evaluation. His comments underscore that, even as humanitarian care could not restore people's rights, withholding such care is experienced as an attack on both those rights and their lives.

Faris summed up his view of life in the camp by saying: "Every day we die; we are dying slowly. There is no interest in us. No one cares for us." This abandonment of Palestinian life can be understood in biopolitical terms as disallowing life "to the point of death" (Foucault 1990, 138).²⁷ But Palestinians mostly do not feel generically disregarded, but targeted as political subjects.²⁸ They have demands, for both services and sovereignty, and view the abandonment of Palestinian subjects as a project to undermine their capacity to press these claims. Faris thinks this tactic has had some real success, and sees his own views—his own desires for himself and his children—as evidence: "When we were young, we used to say 'we want to return.' There was love for Palestine. We love it; we do not say no. But in the conditions we are experiencing: no. Let them open any European country for us." That so many Palestinians can no longer imagine a future in Palestine is, for Faris, a sign that they are dying "every day." Where undercare for the elderly seems to mark them as being in the stage of dying, in Faris's view that stage now extends across the life cycle.

Faris talked about health care the most in our conversation, but it was not the only threat he, and others, identified. He also viewed the basic infrastructure of the camp as a threat to life. Everywhere in the camps a jumble of electrical wires and water pipes stretches over one's head, a result of the inadequate and ad hoc network in place. I heard many stories of people being electrocuted by loose wires, especially in rainy weather when the camp alleys often flood. As Faris said, "We are scared of the electric cables and . . . the water pipes. This is our fear because in winter, the children cannot walk on the street because it is all . . . the street, the ground is electrified. Most of the time when a child, an elderly person, or anyone, dies, it is from electricity." In these conditions, sources of life can become causes of death.



Figure 3. Electric wires over a camp street. Photo by Ilana Feldman.

In Faris's view, the inadequate health care available marked precisely that: something that should be life-sustaining instead becoming both degrading and life-threatening. It is degrading because people need to beg for assistance to access care. It is life-threatening because such begging is not always successful and many people are denied access. As he put it, once you've begged every organization in the camp for money and have come up short (as he argued was inevitable), "What would you do? You would borrow money or sell your house or sell your furniture. There is nothing left, nothing left to sell. So you wait for your death." He directed his ire primarily at UNRWA and the political factions governing the camp. As he put it: "UNRWA is a liar. The revolution is a liar. All of them are liars." As a consequence: "There is no concern. The popular committee doesn't care for us, nor the factions. Nor the Islamic groups. There is no interest, not any. Not for

the old nor the child. They don't see the people's suffering." In his view, the ill and the vulnerable were being directed to simply prepare for death.

Like many people, Faris had not just a general commentary on the problems of access to care in the camp, but a personal story of medical hardship. His account shows both a confrontation with humanitarian limits and the work of claim-making. He told me that his son's leg had been crushed in an accident and required an operation, but that the hospital demanded US\$3,000 ahead of the surgery: "Where am I going to get the \$3,000 from? I started to beg from here and from here until I managed to [gather the money]." UNRWA would cover the hospital stay, but not the operation itself: "How much would the stay cost, \$200? They don't pay anything. They should cover the whole operation. We are people who are known. We are not rich; we are poor." From Faris's perspective, the denial of support was a denial of value, but in insisting that UNRWA *should* pay and that the Palestinians are *known*, he sought to reassert that value and to make a rights claim. So perhaps he is not as utterly defeated as he thinks.²⁹

Faris linked the psychological problems so widespread in the camp to the lack of care and the constant presence of dying as a possibility, and he identified the young as particularly vulnerable to this defeat. As he told me: "Our psyche is tired. And this new generation will have a more tired psyche. The kid of six years: when he turns sixteen, he stops thinking of something called Palestine. He begins to think how he can eat, drink, and live." His generation lived through the suffering of war, he said, but this generation "lives in misery." With little work available, hope is quickly lost. He saw drug abuse as a direct result of these conditions, suggesting that young men started drinking and using drugs "to forget his life and the misery he lives in. All of this is our environment." For Faris, this progressive worsening of the Palestinian psyche, this kind of living, forms part of the death of Palestinian community. The Palestine generation is dying without return. And the young may live without political struggle or political imagination.

HUMANITARIAN LIMITS AND THE POLITICS OF DYING

The passage of time makes dying a new sort of problem for humanitarian practice. And the very necessity for humanitarian services over a person's full life cycle confirms the failure of political actors to address the core problems facing Palestinians. When Palestinians talk about their experience as an ongoing *nakba*, as they increasingly do, they argue that they are not just being left to suffer but are subject to continuing attack. As service sites, aging and dying bring many of the fundamental challenges of the Palestinian humanitarian condition to the fore.

A key challenge is that it goes on and on. Available services can never be adequate to meet people's needs. And no matter how much effort goes into reforming service delivery (removing the age barrier, finding new mechanisms for providing care), humanitarian systems are always partially defined by failure, whose causes often lie outside the humanitarian domain. Because humanitarianism helps define the world in which Palestinians live, they do not only judge or evaluate these problems but also experience their lives, their value, and their community in part through these terms.

When Palestinians declare the constricted service landscape a denial of right—not just the right to generic life but also to full life into old age and to a vibrant Palestinian life at any age—they (using other words) name humanitarian services as both biopolitical and necropolitical. The biopolitical decision about the lives they may live and the sort of dying they might experience is, in many Palestinians' view, matched with a necropolitical determination that this people (even if not any particular Palestinian person) must die.³⁰ Humanitarian actors such as UNRWA certainly do not seek to be part of a necropolitical project (their work must be distinguished from, for instance, the Israeli weaponization of humanitarianism as part of its military strategy). And most Palestinians acknowledge this difference. Even as people offer trenchant critiques of humanitarian operations generally, and of UNRWA's work in particular, many also show genuine appreciation of many of UNRWA's efforts.³¹ In identifying the necropolitical features of the work around dying, they call attention to the impossibility of wholly separating the humanitarian politics of life from other sorts of politics: the international geopolitics that ensures that Palestinian needs and demands never get their due; the politics of siege that makes Palestinian lives repeatedly vulnerable; and the degraded politics of the Palestinian political leadership, which makes it harder to challenge these attacks and inequities.

The view of someone like Faris that the difficulties of Palestinian circumstances in Lebanon have transformed the condition of living into one of dying shows how all of these are brought together in people's experience. In confronting the failures of Palestinian politics and the impotence of international humanitarianism, Faris seems to have moved beyond hoping for a better configuration of life and death: "We have no value," he said. Yet this "anticipation of death" (Stevenson 2014, 96) is not the only Palestinian response to very difficult circumstances. The work of WHO and SSS to change the "sort of life [and death] that people may or may not live [and die]" (Fassin 2009, 4) is another. To understand the politics of living with dying in Palestinian refugee camps, both responses must

be recognized. Neither answer escapes the limits of humanitarian care, but the latter offers an attempt to push back against the impoverishment of the future that has been a consequence of this condition.

ABSTRACT

What is it to live as a refugee over the long term? One thing that it can mean—and in the Palestinian case of nearly seventy years of displacement, what it necessarily has meant for many people—is to die as a refugee. This essay explores the consequences of the ways in which humanitarian work has been compelled to take up the end of life as a humanitarian concern. Drawing on fieldwork in the Burj al Barajneh Palestinian refugee camp in Lebanon, it explores care for the aging and dying as a setting in which key aspects of the social world produced through humanitarianism are brought into existence and view. The problems of the end of life introduce additional challenges into the conundrums of long-term humanitarianism, occurring at the intersection of humanitarian practice and Palestinian experience. With the questions of services for the aging and dying foregrounded, the possibility of the future becomes a site of confrontation among, and within, providers and recipients. Often, this future appears to be foreclosed. [humanitarianism; dying; refugees; Palestinians; Lebanon; biopolitics]

NOTES

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1. Ten camps were established after the 1967 June War in which Israel occupied the West Bank and Gaza Strip. Lebanon's twelve camps all date to 1948.
2. The Palestinian experience suggests this emphasis on foreclosure, in distinction from much of the literature on futurity, which focuses on things like aspirations ([Appadurai 2013](#)), anticipation ([Adams, Murphy, and Clarke 2009](#)), preparation ([Lakoff 2007](#)), and accessibility ([Ginsburg and Rapp 2015](#)).
3. This displacement was a consequence of the conflict over the end of the British Mandate and the proposed partition of Palestine into two states (Jewish and Arab). Palestinians left as fighting came to their villages, when they learned about atrocities committed in other towns (such as Deir Yassin), and when they were expelled by Zionist, and then Israeli, military forces.
4. An exception to this general rule of inaction is the fact that UNRWA was established as a result of a UN resolution, in keeping with a broader trend in which international responses to the Palestine problem have been dominated by the humanitarian.
5. Palestinians are not alone in these problems. Access to health care is a problem for

- many in Lebanon, and elderly Lebanese are also relatively underserved ([Abdulrahim, Ajrouch, and Antonucci 2015](#)).
6. I have written about both Doctors without Borders and the Palestine Red Crescent Society elsewhere ([Feldman 2015](#), n.d.).
 7. In describing its role, UNRWA insists that it does not administer the camps but provides services in them.
 8. These judgments are what [Sherine Hamdy \(2012, 179\)](#) calls *political etiologies*: the linking of disease causation to political-economic structures that determine resource distribution.
 9. Chief, Social Welfare Division to Deputy Director, memorandum, 11 February 1952, UNRWA Archives, Amman, Jordan.
 10. Reports Officer to Deputy Director, memorandum, 31 January 1952, UNRWA Archives, Amman, Jordan.
 11. Assistant Chief, Social Welfare Division to Reports Officer, memorandum, 15 January 1953, UNRWA Archives, Amman, Jordan.
 12. Comptroller to Acting Director, memorandum 7 April 1953, UNRWA Archives, Amman, Jordan.
 13. Reports Officer to Director, memorandum, 3 October 1952, UNRWA Archives, Amman, Jordan.
 14. "Relations between the Jordan Government and the UNRWA," n.d., UNRWA Archives, Amman, Jordan.
 15. Director of PARI to UNRWA Representative, Syria, letter, 30 May 1953, UNRWA Archives, Amman, Jordan.
 16. Acting Director to Syria Representative, memorandum, 15 June 1953, UNRWA Archives, Amman, Jordan.
 17. Note for the Record, 6 July 1960, UNRWA Archives, Amman, Jordan.
 18. By "humanitarian condition," I mean both how humanitarian practice shifts over the long term from crisis response to addressing more chronic needs and also how living with humanitarianism moves from the shock of catastrophe to a condition of life.
 19. These challenges also raise the more general question of the place of death in biopolitics. [Foucault \(2003, 248\)](#) argues that as power is expressed less as "the power of the right to take life, and increasingly the right to intervene to make live," death is privatized. Under these conditions, "death is beyond the reach of power, and power has a grip on it only in general, overall, or statistical terms." [Giorgio Agamben's \(1998, 160\)](#) attention to brain death as a site of "politicizing death" suggests that the grip power has on death may not always be as statistical as Foucault suggested.
 20. When it confronts the limits to its capacity, UNRWA often evaluates the problems in technical terms, focusing on the management of resource scarcity and on structural and financial constraints on organizational capacity, but its officials are also aware that Palestinian death in exile stands as a stark reminder of the utter failure to achieve a political resolution.
 21. Scholars have also noted the necropolitical (see [Mbembe 2003](#)) features of, especially, weaponized humanitarianism. Israel's relationship to Palestinian populations under occupation is often highlighted as a key case in point ([Weizman 2011](#); [Bhungaliala 2010, 2012](#)).
 22. In distinguishing between "are" and "feel" here, I do not intend to introduce a gap between reality and meaning (though such gaps always exist), but to underscore that a key effect of undercare is to shape how people experience their lives.
 23. [Liisa Malkki \(2015, 59\)](#) notes the pain and frustration "technical insufficiency" can cause humanitarian workers. Such responses are evident in the Palestinian case as well.
 24. Protests were also fueled by reports that a refugee with thalassemia from Burj Al Shemali camp, near Tyre, set himself on fire after being faced with increased costs for treatment ([Zaatari 2016b](#)).
 25. The work of the Palestine Red Crescent Society is a significant instance of how Pales-

- inian politics and humanitarian principles can be enacted by single organizations (Feldman n.d.).
26. For anthropological accounts of aging in other contexts, see Cohen 1998; Lamb 1997, 2009; Lock 1994.
 27. On forms of abandonment, see Biehl 2013 and Povinelli 2011.
 28. This is why I suggest that they evaluate this practice as necropolitical. They see themselves identified as those “who must die” (Mbembe 2003, 11), as persons and as a people.
 29. Although Faris’s story did not end with the death of his son, I heard similar accounts that did.
 30. Mbembe (2003, 29) cites the Palestinian case when he writes that “late-modern colonial occupation is a concatenation of multiple powers: disciplinary, biopolitical, and necropolitical.”
 31. Palestinian attitudes toward UNRWA are deeply conflicted, both across the population and within individuals. People recognize UNRWA as a crucial service provider and source of recognition, even as they critique it for shortcomings in both these areas. There are also significant differences across the fields of operation in prevailing opinion about UNRWA. Relations have been most strained in Lebanon.

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