Multiple Scripts and Contested Discourse

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Abstract

Disseminating research findings locally, nationally and internationally is complicated and sensitive. International teams of researchers have to navigate and wind their way through multiple agendas, scripts and discourses. This leads to contested discourses concerning the meaning and relevance of findings, often expressed through disputes over the use of language. There is a need to consider local, national and international sensitivities, structures, policies and ideologies and to negotiate a shared awareness and understanding of these differences. The case study presented here is drawn from an international collaborative research project in the area of maternal, reproductive and child health in the Middle East. Issues of difference arose in relation to the nature of the research, the significance of the findings, the terminology to be used when referring to the groups of people being studied or when presenting data. The importance of the political and social context of the research and research teams was as relevant as the research design, data collection and findings.

Keywords

Politics; Research; Collaboration; Dissemination

Introduction

This paper explores verbal and textual communications in international research as performances that occur within interpretive and literal (textual) frames. As performance, these events have a structure including particular settings and ground rules with participants, performers and audiences (Bauman 1978: 9). Literary criticism and reviews of plays are always diverse, with multiple often conflicting interpretations of the meaning, significance and quality of texts and performance and production. Bauman in his essays in the field of sociolinguistics in Verbal Art as Performance writes of how verbal art is a way of speaking:

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Fundamentally, performance as a mode of verbal communication consists in the assumption of responsibility to an audience for a display of communicative competence. This competence rests on the knowledge and ability to speak in socially appropriate ways. (1978: 11)

In research, the questions, data and findings are often understood and interpreted in different ways. These differences can sometimes be issues of differential emphasis and sometimes of contested discourse and meaning. Differences of approach or understanding often reflect the diverse positionality of stakeholders who have different structural positions, accountabilities and sensibilities. There are potential conflicts between service and research agendas, inter-national and national priorities, scientific disciplines and ideological or political affiliations. This diversity is present in all research teams and even more acutely so in multidisciplinary research of the type funded by international agencies at this time. The way in which this diversity is explored is through an actor-oriented analysis of the research process similar to that developed by Long and Long:

we are interested in developing theoretically grounded methods of social research that allow for the elucidation of actors’ interpretations and strategies and of how these interlock through processes of negotiation and accommodation. (1992: 5)

The paper reviews and discusses the multiple understandings of research questions, the process of disseminating research findings verbally and textually in two countries of an EC-funded research project. The case study is being used to highlight broader issues related to the interface between insider and outsider expertise and understandings and the influence of ideologies and politics on scientific research.

**Setting**

The context is a five-year EC-funded study to evaluate and improve maternal and child preventive health care to Palestinians in Gaza (Palestinian Autonomous Territories) and to Bedouin in the Negev (Israel). The institutions involved were a British University, an Israeli University and a Palestinian research centre. There were local researchers and research teams in both countries and a coordinating team in the UK led by the author. This was part of an EC Mediterranean Initiative (Avicenne) whereby the funding required the participation of a European institution with at least two partners in different Mediterranean countries. The definition of the Mediterranean involved both the Mashrak (Middle East) and the Maghreb (North Africa). The research took place between 1994 and 1999. The proposal was submitted at the time of the Oslo accords in September 1993 and the research was undertaken during the ensuing “peace process” which was a time of political transition.

The structure of international collaborative research reflects international political structures and policies. Much funding comes from national and
international organizations or foundations based in the northern and western hemispheres which fund work in the southern hemisphere. The funding for the specific project being used as an example here is no exception. The funds from the European Commission are distributed to countries bordering the Mediterranean in North Africa and the Middle East for research in two areas, water and health. The funding came from Directorate General I (External Affairs) and was administered by Directorate General XII (Science and Research with non-Member Countries). The rationale for this Mediterranean research programme (Avicenne Initiative) was that just as developing trade between the European countries was seen as a means to prevent future wars within Europe, so too would research on water and health (two essential resources) link countries around the Mediterranean in North Africa and the Middle East. The structure is colonial in terms of the flow of money and also by the requirement that a European research institution be involved. More often than not the European researchers in their base institution take on the lead, or in Europe-speak “coordinating”, role since they have a well-resourced infrastructure (Lewando-Hundt 1996). Within this structure, there are issues of external and internal expertise and multiple understandings of the nature of research and its findings.

In this project, there were two researchers based at a UK university which had the coordinating role and two research teams in the Middle East. The Palestinian team was based at the Gaza Health Services Research Centre, Gaza City, which at that time was within the Ministry of Health of the Palestinian Authority. The three researchers leading the team had training in epidemiology and public health but also had service responsibilities, two of them within the Ministry of Health and one of them within the United Nations Relief and Works Agency (UNRWA). The Israeli team was located in the Faculty of Health Sciences (a community-oriented medical school) at Ben Gurion University of the Negev, Beersheba. Some of the researchers leading the team had service responsibilities. One was working within the Ministry of Health and there were two family doctors involved, one in the first year and the other in the subsequent four years of the project. They all had part-time university appointments within the medical school.

From the outset of international research collaborations, it is common that there are differences between the various players as to the research questions being studied. These can be accommodated and seen as part of the richness of the multidisciplinary approach and the interface between research, policy and practice but these different interests influence understandings, behaviour and reactions. Reflecting retrospectively on the reasons for the differences can cast light on behaviour which at the time seemed “irrational” or difficult to understand.

In this project, the research design, data collection, analysis and dissemination were influenced by differences in and between disciplinary perspectives, namely anthropology and epidemiology, local, national and international policy agendas, service and research priorities. These differences were played out in the use of language both orally and textually.
Multiple Research Questions

Some differences in multidisciplinary research can be attributed to the formal research training of the participants. The local researchers were almost all epidemiologists by training and the UK team members were anthropologists. There was a consensus that the project was combining anthropology and epidemiology but there was a tension between which was the primary discipline and how they could be combined. Or, to put it another way, which discipline shaped the research questions. Some of the local researchers on both teams had policy and service responsibilities within their respective Ministries of Health that the external social scientists did not. They often had different agendas and priorities owing to their professional positions. The differences in approach were therefore due to external versus internal concerns, as well as interdisciplinary differences.

Understandably, those having responsibility for providing health care and with a background in epidemiology were concerned with the extent of coverage, with understanding why some women were non-attenders, and with taking measures to increase the coverage of care. So the local investigators with responsibilities for policy development and service provision emphasized the behaviour and knowledge of users: Why don’t mothers attend prenatal care? How informed are they? How can we encourage them to attend the clinics and benefit from the care we offer?

The social scientists were not local but members of the UK team, with the exception of one who was only involved in the first year of the study, and they had no local service responsibility. They were more concerned with eliciting and understanding the views and experiences of users of the services and of health personnel in order to see what they wanted improved and developed in the existing provision. The external social scientists were keener to focus on the views and experience of both users and health personnel: What are the views and experiences of attenders and non-attenders? What is the nature of the care they receive? What are the clinic conditions like for the staff in these clinics? What are their views? If women do not attend the clinics, where do they go? What do they gain by attending? How would they like the provision improved?

These differences in emphasis were not incompatible and indeed were part of the group learning and understanding that developed concerning the complexity of provision. The service providers were used to measuring service provision and efficiency in numbers of patients, vaccines, clinic visits. They were interested in identifying what worked and where there were gaps in provision. The differences in approach and discipline were accommodated by the division of the data collection and analysis. The epidemiologists took prime responsibility for the questionnaires and the anthropologists took prime responsibility for the group and in-depth interviews. In addition, since the anthropologists were more focused on capturing experience and events they would identify issues that were “interesting” that seemed of marginal significance to their local colleagues.

In general in research using the deductive positivist paradigm, the research design is prepared to test a hypothesis and answer a question.
Box 1

Addresses in Gaza

In the Gaza study, there was a practical field problem in finding the mothers to interview in the three neighbourhoods. They were a random sample selected from the registration of births held on the Management Information System. The interviewers found that all the addresses were incomplete but that the actual birth information was very accurate. The team developed alternative strategies for finding mothers based on working through clinic staff in each locality who knew the mothers by name (again incomplete addresses on health records) and in particular with well-known figures in these neighbourhoods: the driver who took them out interviewing and the staff nurse of the clinic in Jebalia. This could have been left as a problem in data collection which was resolved but one of the anthropologists saw this as interesting in itself. The accuracy of other information about births—date, sex, place, parents—contrasted starkly with the lack of address. Initially the statisticians and epidemiologists and providers were mystified by her insistence that this was interesting. She saw it as part of the social construction of statistics and persuaded the team to review how information came on to the birth register from the hospital via the clerk to the ministries. Fieldwork identified problems with birthweight in addition to addresses and led to interventions to improve the accuracy of this data. The quantitative members of the team realized that the qualitative approach was able to validate the reliability and validity of the data on the Management Information System (Lewando-Hundt et al. 1999).

In inductive interpretative research, there is more room for developing new directions and being led by the data. The studies managed to do both but this was sometimes disconcerting for those more used to a more purely deductive approach. However, the lead investigators in both teams by the end of the study had developed an appreciation of a multidisciplinary approach.

One of the Israeli epidemiologists interviewed in 1999 felt that she had learnt how to combine qualitative data with epidemiological data. Previously she had perceived qualitative research as a different and separate kind from quantitative research, each with its own merits. This study was the first time she saw how much could be gained by combining them. She is now convinced that one really needs the two for a fuller picture when investigating a research question. Initially she had thought that with qualitative data there was no gold standard to assess its validity as a means of validation and that the two types of methods were measuring different things. But she was now clear that you can measure the same thing with different methods (Interview notes: August 1999). Triangulation—using several different methods to measure or ascertain data on the same topic—is a recognized way of increasing the reliability and validity of qualitative data. It can involve different types of qualitative data or quantitative data or a mixture of the two.

Issues of concern internationally were also of little concern to the local researchers, who were more interested in improving their coverage of the population in the region and nationally. For example, at the time of the
research there was some international debate concerning what is the extent of care for women in terms of their general reproductive health within Maternal and Child Health (MCH) clinics. Are the clinics exclusively focusing on women when they are pregnant, and on babies needing immunization, without considering gynaecological morbidity or family spacing needs? The argument had been presented forcefully in the Lancet in 1985. In a paper by Rosenfield and Maine entitled “Maternal Mortality: a neglected tragedy: Where is the M in MCH?” The international meetings in Cairo and Beijing that occurred during the research focused on women’s rights to choice in reproduction. In addition, there was at that time, in 1994, debate concerning the optimum number of visits needed for antenatal care with some voicing the view that fewer clinic visits during pregnancy would be sufficient in poorly resourced countries.

The EC scientific officer raised these issues on a site visit with the Israeli investigators in early 1994, prior to confirmation of funding, but there was a complete local lack of interest, knowledge or understanding of the ongoing international debate. The concern of the researcher, who was also a service provider, was to encourage non-attending women to attend prenatal care when pregnant and for those who register in the second or third trimester during pregnancy to register earlier so that adequate screening and surveillance could be offered within the preferred number of 6–8 visits during a pregnancy.

Disseminating Findings: International and Local Agendas

The dissemination of findings locally and internationally raised issues of multiple scripts and contested discourse which were specific to this setting but are also pertinent to many research settings. In both Gaza and the Negev, the local investigators would have been content to plan the interventions through reflection on the findings, without further consultation with health personnel or community representatives. This would have been in keeping with the accepted way of doing things in their settings, which is fairly hierarchical. Policy and operational decisions are made in both settings within the Ministry and carried out by health personnel without mechanisms for consultation at the clinic or community level.

The push for local dissemination was something which European funding agencies (DFID, EC, ESRC) emphasize. The ESRC has sections on its research forms which require the applicants to elaborate on how the research will be disseminated and how it will be of use. There is also an information booklet on Dissemination (ESRC 1999). In this research project, dissemination was part of the research design and was felt by the European researchers to be an essential stage in the development of local interventions. One of the main components of the research design had been that it was eliciting the views of local users and local health personnel about service provision prior to developing interventions. This concern with consultation and dissemination was an important part of applied anthropological practice and part of the current research ethos in Europe. Carrying this out within two Ministries of Health in the Middle East where dissemination and consultation with users and staff were not a priority was not straightforward for there were
different audiences to address and different types of presentation and performances to be drawn up. The commitment to this part of the research was part of an external agenda.

A first step in this process was to summarize the main findings in an accessible format in the local languages for dissemination and discussion. The Palestinian team was keen to have this report for wide circulation in English and Arabic. The English text was prepared in London and then translated into Arabic by a Palestinian member of the London team with suggestions from a member of the Gaza team who visited London for this purpose. The report was then bound in a single volume using different colour paper for the English and Arabic.

There was some reluctance from a senior member of the Israeli team to have the report available in Arabic and Hebrew. Limited circulation amongst English speakers only was preferred, which was a strategy which would have excluded most of the nurses and Bedouin from perusal and discussion of the findings and their implications. The first draft of the report was prepared in English by the Israeli team and then was shortened and reformatted and translated into Arabic in London. Parts of it were then translated into Hebrew by a member of the Israeli team. The final version had the three languages bound in a single volume with different colour paper for each language.

There were local sensitivities concerning not only the availability of the findings in local languages but also how to present the data in terms of fora and use of words. These sensitivities centred around different understandings of the use of language and terminology, due to political sensitivities as well as different approaches to the data.

One of the first indications of these hidden minefields and multiple understandings was a team meeting held in Gaza when data collection had just been completed. The meeting was informal and involved members of the team and other policy makers and health professionals who had been marginally involved with the study. The audience consisted of members of the research team, the research centre and a few health service managers. In all, approximately 20 people attended. The study findings were presented with the quantitative data on the study sample taking the first 45 minutes. The epidemiologist presented some tables showing the demographic characteristics of the sample in the three neighbourhoods followed by some cross-tabulations showing the utilization of antenatal care (patchy), immunization (near total coverage) and postnatal care (practically non-existent) amidst lively discussion. Some examples of qualitative data on particular topics took up the next 40 minutes, presented by the London team. As a taster to show what qualitative data were like, some quotes from a large number of focus group interviews on drug shortages and waiting times at the clinic were presented. They expressed the views of women who did not like waiting. The issue concerned how some people waiting in line at the clinic used patronage and influence to jump the queue for the nurse or doctor. Some quotes from both staff and patients were presented which showed that people used influence to get care more quickly. Although everyone understood this and would use influence if they could, both users and staff felt this practice disrupted clinic routine.
This presentation was made with the intention of stimulating a discussion about the need to address waiting times in the clinics and to illustrate the fact that the practice of exercising influence to jump the queue was disliked by both patients and health personnel. The effect of the overheads was unexpected for they provoked an explosive and agitated discussion along the lines shown in box 2.

On reflection, the first meeting was planned as a straightforward information-giving exercise. There was little preparation and practitioners of each discipline presented their own type of data. No thought was given to the wider sociopolitical context. The result was that both the methods and the findings were challenged. The second meeting was planned to get results and be taken seriously so that evidence-based interventions could be developed. The report interfaced the different types of data around selected themes relating to possible interventions, the Ministry of Health endorsed it and the findings were framed within an all-day event in a pleasant setting with a substantial meal.

In Gaza, a meeting was held at a local hotel for about 60 participants. The invitations were sent out with the document. The Minister of Health opened the meeting and endorsed the importance of evidence-based health reform. Each section of the findings was presented based around topics using a combination of quantitative and qualitative data, and the possible options for intervention were discussed. There was a lively morning followed by a convivial lunch. The next day a smaller group of policy makers met all day to firm up action plans in different targeted areas. In addition, there were smaller workshops, held in clinics where interventions would be based, to share the research findings and approach to interventions with the staff who had been interviewees during the data collection. This led to the identification of a number of possible interventions and the formation of an intervention committee that met regularly during the next year and a half to monitor the progress of model interventions.

Similarly in the Negev the first team retreat to discuss initial findings was difficult—some of the findings were contested and certain terms were considered contentious. The meeting was with the research team, with in addition the supervisor of the nurses in the clinics serving the Bedouin and the head nurse of the Ministry of Health in the region.

There was some nervousness expressed by an investigator with a dual role as researcher and service provider concerning the views of the Bedouin men and women which expressed their dissatisfaction with aspects of care—the lack of staff and clinics, which was generating problems of access, and in particular their requests to be treated with more respect and politeness. These findings at the request of this investigator were not presented at this meeting much to the distress of some of the more junior members of the research team and of the UK team. In addition at lunchtime the head nurse commented that the discussion was too political and we were advised to substitute the word “social” for “political”.

In appeasing the sensitivities of gatekeepers, Bedouin women’s voices were muted as were more junior Arab members of the research team and the integrity of the research findings was felt by some to be at risk. There was some local reluctance to translate the report on interim findings from English
Box 2

Initial presentation of findings and the discussion

Quotes shown on overhead slides

Views of health personnel
“Wasta [using influence or connections] is how I was employed and how many were employed recently. Wasta also plays a role in getting health care quickly.”
“Wasta is a big problem that has exploded in Gaza. It’s a disaster. It also destroys the work system in the clinic.”
“Wasta is called Vitamin W and it is everywhere in the country.”
“I am ready to implement the rules once they are standardized throughout the system.”
“Wasta is widely spread: it’s a disastrous, destructive attitude which should be faced and eradicated.”

Views of female users
“Wasta in the clinic is wrong and must be stopped. If I have an opportunity to use wasta I will use it like other people do. I know this is wrong but what can I do when everybody uses it.”
“I get very disturbed by wasta but if I know someone in the clinic who tells me to ‘come in, go straight in’ I certainly won’t lose this chance because my child is ill and I have left my other children at home alone. What might limit or eliminate wasta is organizing work in the clinic with certain regulations. People will accept this if it is followed and supported by the doctors and staff.”
“I feel upset by wasta; I hate it. Everybody goes to the clinic for the same reasons. It drives me crazy when I see people using it because I believe it is wrong and that my child is not better than other children.”

Resulting discussion amongst managers and researchers

Participant
“This is political talk, incited by foreigners using unscientific methods. No one talks like this. This is dangerous talk.”

Senior members of the research team
“We must accept reality, all of it even if we do not like it.”
“The research was carried out by local interviewers using focus groups which is an established method of enquiry. This is our study and the London team would not publish anything we did not agree with.”
“You are in denial: of course people talk like this.”
“These quotes are discussing the use of influence in the clinic, queue jumping in the clinic. We are not talking about corruption in the Authority. We are talking about favours which disrupt clinic routine.”

Participant
“Favours, acquaintanceship, well that is part of our culture and of many cultures. It is even part of English culture in London.”

into Hebrew and Arabic but this was not the consensus of the research team. This was overcome by doing the Arabic translation in London and one of the investigators based at the University did the Hebrew translation, although this was less extensive than the English or the Arabic. The copies for the teachers’ workshop were prepared in London. Meetings for dissemination
and the planning of interventions were held, but with two separate groups—the nurses in the MoH clinics providing MCH care to the Bedouin and the headmasters and officials in the Ministry of Education in the Bedouin schools. The nurses did not receive copies of the findings in a bound document but the teachers did. Both meetings were low-profile events geared to a targeted limited audience of practitioners and middle managers rather than policy makers or activists.

Thus we learnt painfully that dissemination was not just a matter of the data transmission. The presentation in terms of place, messenger and design was as important as the data. We had to consider the sensitivities of the health system and society we were working within, in order to disseminate effectively. Sometimes local sensitivities prevented or limited the dissemination of information. This was something that none of the team had consciously considered. The culture, ethos and structure of the health service, the wider society and the researchers was as relevant as the research subjects, methods and data. Colleagues who were both researchers and civil servants were in a difficult situation of negotiating sometimes conflicting agendas—those of service and research and the internal versus the external.

**Contested Discourse and Hidden Transcripts**

When we began to disseminate the findings in academic papers a new set of problems needed to be negotiated in terms of the language and terminology to be used in describing the setting and groups undergoing political transition with a history of conflict. History reflects the ideology and politics of the time and we found that this was a contested area when writing reports and papers. Also in the Palestinian setting, criticism of the political situation was not permitted and would make the local researchers vulnerable to unpleasantness. Language was loaded with meanings which were part of the particular history and current politics of the area. What was acceptable had to be negotiated in each setting and each paper depending on the audience and the views of the authors, team members or workshop participants.

In Gaza, ancient history of the port of Gaza was not contentious but any reference to the organization of health care under the Israeli Civil Administration was considered too sensitive and political. A stated preference by the population for Israeli drugs rather than Palestinian products was obscured by calling the Israeli drugs “foreign”. The context of care had to be ahistorical. Recent history was too difficult to write about other than as a general reference to the Intifada. All articles were proofread by the UK and Gaza investigators and the final text was always a composite version that satisfied everyone’s sensitivities. One device used several times was to quote other writers on the recent past so that it was covered but was not an expression of authors’ opinions. An example of this from the Background section of a published paper is as follows:

Indeed the Palestinian National Authority links falling income to the fact that frequent and prolonged border closures during 1995–6 resulted in
increased unemployment. “The majority of the Palestinian labor force still depends for a livelihood on the daily earning of a low wage in Israel due to the lack of enough jobs in Palestine. Recently, there has been a sharp downturn in wage income from Israel which occurs from time to time as a result of frequent, alleged, security closures of the borders between Gaza, West Bank and Israel” (Palestine National Authority 1997: 10). (Beckerleg et al. 1999: 1491)

Even placenames were contentious. Although we referred to Palestine as the place we were working in, in papers this became Palestinian Autonomous Territories as an official address. Hebrew and Arabic refer to the same places differently. In Hebrew one said the “Negev” and “Beersheva”, in Arabic the “Negeb” and “Beersheba”. The difference was not only linguistic but also signified a political affiliation. The way language was used and written was part of expressing postcolonial nationhood in both settings (Thiong’o 1995).

In the Negev there was a central problem about what to call the Bedouin when writing about them. There were contested discourses within the team that reflected the diversity within Israeli society and outside the country. Were the Negev Bedouin to be called simply Bedouin, Bedouin Arabs, Palestinian Israelis, Israeli Arabs, Israeli citizens. There was a lack of agreement within the teams and amongst the Bedouin. The terms were loaded with the way in which they had been used in the past within policies and politics. It was hard to navigate through this at a time of transition.

Palestinians were people who lived in Palestine prior to the establishment of the state of Israel. Subsequently Palestinians living outside Palestine were called Palestinians and those remaining in Israel were called Israeli Arabs in local Israeli political discourse. The Bedouin were referred to by government administrators and researchers as the Negev Bedouin, a subgroup of Israeli Arabs. They called themselves alarab (the Arabs) and only called themselves badoo (Bedouin) when comparing themselves to other groups such as fellaheen (peasants). They also saw themselves as Palestinians but only expressed this in public on rare occasions up to the mid-1970s. The difference between the Bedouin and other Arabs in Israel was emphasized by administrators who saw the Bedouin as less political. The educational infrastructure was weaker and people were more dispersed.

There is some variety in the written and oral discourse. Researchers on the whole write of Negev Bedouin, Negev Bedouin Arabs (Marx 1967). Some increasingly write about Palestinian Israelis (Espanioly 1994; Rabinowitz 1998). Government administrators talked of the Bedouin and in the past have put an emphasis on how different the Bedouin are from other Arabs in Israel—less politicized, less educated. Policies have been different for this group. They may serve voluntarily in the army. State policy could be seen as a policy of divide and rule on the grounds that within the Palestinian Arab minority in Israel only the Druze and Bedouin groups are allowed to serve in the Israeli Defence Forces (IDF). In addition there are local administrative policies in allocation of land and resources which emphasize tribal affiliations and thus perpetuate a lack of unity amongst the Negev Bedouin.
The Palestinian team in Gaza perceived and spoke of the Bedouin as our “sisters and brothers”, Palestinians who had remained in 1948 and who were now Israeli citizens. The Jewish and Arab members of the Israeli research team had differences too in the terms they used in daily language depending on whom they were speaking to. Some Jewish members of the Israeli team referred to the Occupied Territories even when they were Autonomous Territories in a workshop in 1997, four years after the Oslo agreement. Moving from old-speak to new-speak is not simple or automatic and reflects personal understandings of national and international politics.

Box 3

Negev Bedouin—Palestinian Israelis

The Negev, two-thirds of the land area of Israel, contains 7 per cent of the population of Israel. The Bedouin comprise 23 per cent of the population of the Negev. At the time of data collection in 1995 the population of the Negev Bedouin Arabs was officially reported to be 88,300 (Statistical Abstract of Israel 1996) (although this is considered by many to be an underestimate and that the true figure in 1995 was 90,000—95,000). Prior to the establishment of the state of Israel in 1948, there were estimated to be 50—70,000 Bedouin Arabs in the Negev. During the war of 1948, many Bedouin left the area for Egypt and Jordan and became Palestinian refugees. Approximately 11,000 remained and became Israeli citizens (Marx 1967). Bedouin Arabs have been in the Negev since the sixth century, having migrated from the Arabian peninsula. Until recently Negev Bedouin Arabs were a semi-nomadic population living from herding sheep, goats and camels and growing winter barley and wheat. Many Bedouin Arabs in Jordan, Syria, and Egypt are being settled in agricultural villages, whereas in Israel, they are being settled in towns. It has become increasingly difficult to live a semi-nomadic life, as much of the Negev is given over to Jewish agricultural settlements, industrial and urban developments and closed military areas.

The response from one of the Israeli co investigators was as follows:

“I think the terms used to describe the Bedouins are very confusing. I believe that using the terms Palestinians makes one think that they are not Israeli citizens. How about: the Negev Bedouin are Muslim Arab Israeli citizens? If you think Palestinian is essential, I think some extra explanation is needed.” I would say agricultural, industrial and urban development (the word ‘settlement’ makes them sound like Jewish settlements on the West Bank).”

The next draft had the subheading removed, modified the reference to agricultural settlements and added in two sentences at the end of the paragraph which were acceptable to all the authors.

Setting . . . It has become increasingly difficult to live a semi-nomadic life, as much of the Negev is given over to agriculture, industry, towns and areas for military manoeuvres including three airports. The Negev Bedouin are Israeli citizens and form part of the minority Palestinian Arab population of Israel today. They are Sunni Muslims.

This version was acceptable to both the authors and the reviewers and is currently in press.

The Palestinian team in Gaza perceived and spoke of the Bedouin as our “sisters and brothers”, Palestinians who had remained in 1948 and who were now Israeli citizens. The Jewish and Arab members of the Israeli research team had differences too in the terms they used in daily language depending on whom they were speaking to. Some Jewish members of the Israeli team referred to the Occupied Territories even when they were Autonomous Territories in a workshop in 1997, four years after the Oslo agreement. Moving from old-speak to new-speak is not simple or automatic and reflects personal understandings of national and international politics.
So there was a lack of agreement amongst the research teams about how to describe the history of this group, and how to refer to them in papers and reports. All texts were read by members of the team and a compromise accepted for joint papers. The specific terms of this are not the issue. What is important is how ideology and politics affect even the terms in which you refer to or name a group. This is not a neutral issue and it changes over time. These changes at a time of transition are particularly important.

An example of the type of comments when writing a joint paper and trying to negotiate and communicate the diversity and commonality is shown in box 3. The initial first draft from London had a cryptic heading in the setting section and then went on to give a general background.

**Discussion**

The performance of international multidisciplinary research is situated in a number of “battlefields of knowledge” (Long and Long 1992). It seems mistaken to consider only disciplinary differences. The social and political context of the research funding, implementation and dissemination is critical. There is a need for sensitive reflection on how ideologies, politics and pragmatic survival strategies impinge on scientific questions and the use of language in text and oral performance. It seems that external researchers working in a local setting as a guest or visitor and colleague need to consider constantly “the importance of treating knowing as a practical, situated activity, constituted by a past, but changing, history of practices” (Hobart 1993: 17).

Cohen, in his fieldwork in the Outer Hebrides, comments: “Modes of knowledge are inextricable from modes of identity. ‘Facts’, ‘knowledge’ are not treated on their inherent merits even if it was possible to establish what these might be. They are assimilated to and evaluated in the light of the social position of the perceiver” (Cohen 1993: 39).

Social scientists tend to remember this when working with informants or subjects rather than bearing this in mind when working with other researchers and policy makers. There may be a tendency to assume that lack of agreement on research design or interventions is about intellectual or interdisciplinary differences rather than being connected to local political and professional constraints. The complexity of our own social worlds is often baffling to ourselves. Negotiating within the constraints of others’ social and political worlds is a hazardous enterprise.

It is clear that local researchers with service or policy responsibilities are often caught between conflicting internal and external agendas. As Hobart writes:

There is an unbridgeable, but largely unappreciated gap between the neat rationality of development agencies’ representations which imagine the world as ordered or manageable and the actualities of situated social practices, an incommensurability tidied away in sociological jargon as “unintended consequences”. The result is that the overlap of developers and local discourses does not lead to improved communication, but to
strain on those locals who are involved in both, and to techniques of evasion, silence and dissimulation. (Hobart 1993: 16)

In these two settings, the local researchers had constraints owing to local political issues and ideologies and there were different positions and opinions within each team that reflected the diversity within each country. I would argue that the analysis and examination of these contested discourses and multiple scripts is an essential aspect of understanding the performance of research in both its oral and written forms. By articulating, negotiating and valuing these differences, the knowledge is situated within both international and local contexts.

The practice of research can only be improved if the politics of research are problematized and considered as part of the research setting. The approach of reflexive anthropology with its consideration of multiple scripts and contested discourses in text and language can only enhance the performance and enterprise of research in a complex, socially constructed world, particularly in international collaborative research, when external and internal expertise and agendas jostle against and inform each other. It is suggested that an explicit recognition and exploration of the diversity and multiple voices and views within research teams as part of research planning and implementation would facilitate and enhance the research process and findings.

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Note

1. There are several reasons for this. Before high schools in the Negev were well established Bedouin boys would go to the Triangle in the middle of the country for their secondary education before returning to the Negev for further study or work. The occupation of the West Bank and Gaza enabled people to re-establish contact with their kin and to see how their lives had developed since 1948. This ended twenty years of isolation from other Arabs and all Palestinians outside Israel. The 1973 war restored some pride also concerning Arab military capabilities and this was followed by the revival of Islam which manifested itself amongst the Bedouin by the establishment of mosques and the growth of the Islamic party. The war in Lebanon was seen as clearly against the Palestinians and resulted in identification with the victims and not the aggressor. The Intifada continued this and the establishment of the Palestinian Authority has given added weight to their shared ethnicity and nationhood with other Palestinians whilst simultaneously being Israeli citizens and Bedouin. Although administrators, researchers and the media may persist in emphasizing the cultural difference of the Bedouin, there
has developed a much greater awareness, identification and activism with other Palestinians in both the Palestinian Autonomous Territories and within Israel.

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