Introduction: Public Health and the Promise of Palestine

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This introductory essay contextualizes the special collection of papers on the pandemic and seeks to map the terrain of extant public health research on Palestine and the Palestinians. In addition, it is a contribution in Palestine studies to a nascent yet propulsive conversation that has been accelerated by Covid-19 on the erasure of structures of violence, including those of settler colonialism and racial capitalism, within the discipline of epidemiology. Using public health as an analytic, this essay asks us to consider foundational questions that have long been sidelined in the public health discourse on Palestine, including the implications for health and health research of eliding ongoing settler colonialism. Rather than ignoring and reproducing their violence, this essay seeks to tackle these questions head-on in an attempt to imagine a future public health research agenda that centers health, and not simply survivability, for all Palestinians.

An Epidemiologist's Lament for the Undead

they waited with bated breath for the pandemic to take hold.
they waited for that glorious spectacle to unfold
on that land between the river and the sea,
and in the spaces
with speckles of our people scattered across the globe.
the spectacle
of death
of despair
and of suffering.

of mass funerals bereft of mourners, of burial sites at capacity, of death panels at death beds.

drones overhead.

a rapture before the rapture.
the counters wanted to count
and
the storytellers wanted to tell.

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they awaited tales to regale the world with
afterwards on that glittery stage of palestine exceptionalism,
of palestine pathology, of resilience, of sumud

and of survival "against all odds"

they are still waiting.

we will make them wait.

—May 2020, Baltimore

THE COVID-19 PANDEMIC has accelerated debates in public health and epidemiology on the impact of structures of violence and power on health. Methodologies and policies that have long ignored these structures, in service of allegedly agnostic and objective science, are increasingly being interrogated for their organized neglect of the structural determinants of health.[1] Introducing this issue of the *Journal of Palestine Studies* (*JPS*) devoted to the pandemic, the present essay furthers this interrogation in the context of Palestine. By weaving a thread through this collection of papers, it offers a mapping of public health research in Palestine and of potential future research agendas. Using public health as an analytic, this essay asks us to consider a series of foundational questions that have long been sidelined in the discourse on Palestinian health, including the implications of ongoing settler colonialism.

As an interdisciplinary field of inquiry, public health—unlike clinical medicine—is interested in the prevention of disease and the promotion of health in populations rather than in the treatment of disease in individuals. If we accept here the definition of health articulated by the World Health Organization (WHO) as "a state of complete physical, mental, and social well-being and not merely the absence of disease,"[2] we understand that both individual and public health are determined predominately by the structural and political contexts within which medical care is received. Defined in epidemiology as determinants, these include the environmental, economic, and social contexts within which people work, play, eat, love, struggle, and live.[3] In other words, public health is political inasmuch as our social and economic contexts are political. Health, then, for Palestinians, is inextricable from the ongoing Israeli settler-colonial project of dispossession and erasure and from the capitalist policies and practices that undergird that project in Palestine, in refugee camps, and in diaspora communities. This includes the complicity of the Palestinian Authority (PA) in political repression and security coordination with the State of Israel.[4]

This is not to say that settler colonialism is a social or political determinant of health. Rather, it is to say that settler colonialism precedes and is fundamental to all other determinants of health—be they clinical, economic, social, or political.[5] Settler colonialism is woven, in ways both known and unknown, into these determinants. In its direct attacks on us and on the environments in which we live and seek care, settler colonialism distorts our relationships with our bodies. For example, Israel uproots centuries-old olive groves and relocates to the West Bank toxic, polluting industries that have long been banned by Israeli courts. Such environmental degradation and ecological destruction exact untold physiological and psychological damage on the Palestinian body as evidenced by disproportionately higher cancer mortality rates in the communities surrounding

these industries and the decimation of crop production and yields.[6] Settler colonialism also distorts our body politic by variegating our relationships with each other. In fracturing territory and denying the right of return to refugees, for example, it makes conditions of care impossible, shrinking socialities that sustain mental health, collapsing accessibilities for disabled friends,[7] partitioning land and space to maximize extractive power over natural resources,[8] and hardening the class-determined use of public resources central to health, including water and electricity.

Scholarship on public health in Palestine and for the Palestinian people has not adequately addressed the intimate connections between settler colonialism and health. In order to do so, it cannot only aim to acknowledge, explicate, and unravel the forms of settler-colonial detriments to Palestinian health, or detail the Indigenous response and ameliorations. It cannot continue to be a cyclical exercise in the prodigious use of ever-more sophisticated critical methodologies, theories, or tool kits to unpack the mechanisms of biopower, surveillance, and slow death, while banging at the doors of public health's transnational arbiters and gatekeepers for funding and recognition of that violence.

Instead, for public health scholars to adequately counter these frames, we must challenge the logics of research itself, the epidemiological models upon which this research is built, and the data upon which policies are enacted and imagined. We must push back against the stubbornly dominant frames of individuated biomedical interventions that attempt to neutralize the political praxis underlying any robust and effective public health response. In contrast to the abundant research mapping prevalence of health outcomes and deploying ostensibly definable and quantifiable explanatory variables, there has been little substantive exploration, if any, of what it would mean to incorporate settler colonialism into our models of health. We must stimulate new ways of integrating understandings of settler colonialism's logics and mechanisms into our public health research and, perhaps to some degree, data—data whose architecture should be set up by, and responsive and accountable to, the Palestinian people. Such a movement toward "data sovereignty" requires us to focus not only on the data inputs and outputs (that is, who collects and owns the data and to what ends it is used and misused)[9] but on transforming and dismantling the power and control structures that prefigure disease and health and how we define and measure them. As a Palestinian public health researcher, epidemiologist, and pharmacist, I conceptualized this issue at the invitation of the *JPS* editors with such a frame in mind.

This special issue also emerges against a backdrop of narratives of despair, passivity, and resignation that homogenize and flatten the lived reality of Palestinians. As a collection, the essays seek to transgress the specter of death, despondency, dying, and de-development.[10] They both address and move beyond the metrics of the Covid-19 pandemic to examine the broader pathogenic role of the structural, political, and social determinants of health in Palestine and among Palestinians. This collection is multiscalar, reading the global, state, and local determinants that the pandemic has exacerbated, further decayed, or reactivated; and while it cites the copious literature on the foreclosures of health due to occupation or settler colonialism, it does not seek to reproduce them.

By featuring scholars, clinicians, and practitioners not abundantly represented in Palestine-centered journals or fora—many of whom are Palestinian and/or work in Palestine—this particular issue brings in new voices and affirms the maturity of scholarship on health in Palestine. It offers

Palestine scholars and organizers an opening to set forth a more robust research agenda that strengthens and coheres the role of public health in social and political transformation. The liberatory possibilities of a public health agenda marking freedom and liberation as central to health live in the spirit of these pages. Though by no means comprehensive, this collection of critical essays aims to situate public health squarely in that space of possibility—of a Palestinian dream that, while for now deferred, is forever at the horizon.

On the Allure of Numbers

We know what makes us ill.
—Bertolt Brecht

The WHO and the United Nations (UN), principally through the Office for the Coordination of Humanitarian Affairs and the United Nations Relief and Works Agency for Palestine Refugees in the Near East, have leveraged substantial resources over the past seventy-plus years for medical care, surveillance, and advocacy around health and human rights in Palestine and for the Palestinians. Beyond direct care provision, these efforts, codified by reports and testimonials, often emphasize the Israeli regime's human rights violations and their preclusion of health.[11] These violations are multifold and include denial of freedom of movement, bantustanization, home demolitions and displacement, and the devastating thirteen-year-long siege against Palestinians in Gaza. Multimillion-dollar studies are commissioned by European aid agencies, the European Union, the UN, and U.S. agencies to investigate the impact of these violations on health outcomes.[12]

Cataloguing human rights violations and accumulating evidentiary data, while critical and necessary as matters of record and as tools for advocacy, do little to end such violations. The cyclical din of knowledge production, now predictable in both its content and tone, has been rendered meaningless by inaction, duplication, and inefficiencies, and ultimately deflects from an urgent reckoning with the underpinnings of disease. For over thirty years, we have understood that geographic fragmentation and the lack of freedom of movement prevents Palestinians from accessing care.[13] The essential medicines shortage that has plagued the Ministry of Health for the better part of a decade is only worsening.[14] By participating in a prolonged performance of epidemiological solidarity, the international community, and those it subcontracts with in Palestine, have disabled, if not foreclosed, possibilities for health. Just as provision of medical care is not justice, data is not justice, and it can in fact be used to obscure and justify further inequities by allowing the foundational and always latent violence to continue unaddressed. It is a politics of enumeration that anticipates disease but does little to prevent it.

The exhaustive tabulating of violations and their attendant health consequences not only ignores the lived and embodied reality of care, it ignores the sociality of health.[15] Health is relational and is informed by dynamic social and political conditions that evolve and metamorphize over time. The Covid-19 pandemic unmasks the complexity of these relationships, as well as the enduring role that racism, racial capitalism, heteropatriarchy, settler colonialism, and white supremacy have played in obstructing clinical medicine and public health globally. Medicine, data, and human rights advocacy

alone cannot fix such structures of violence. In fact, our overemphasis on these tools upholds and further entrenches conditions of deteriorating health.

The vast majority of literature on health and health care in Palestine and of the Palestinians has focused, with some exceptions, on approaches that fixate on the collection of more and more evidence, data (quantitative and qualitative), and numbers. One approach, descriptive in nature, counts or describes health outcomes and health-care access and policy over time and through political spaces. This method may seek to identify factors that lead to (or are associated with) disease and disparities in health outcomes by subgroups of the population, for example, by sex, refugee status, age, gender, income status, or education level.[16] It reads these factors as discrete and definable, both in measurement and in the directionality of their impact on health. A second approach explores popular experiences with health and health care and is often qualitative and anthropological in its methodological design. A third approach examines the impact and feasibility of public health programming and policy interventions in the context of the Israeli occupation.

To be sure, there is indeed a burgeoning literature that is deliberately more critical and sits squarely at the intersection of social epidemiology and social science. It aims to untether measurements and conceptualizations of health in Palestine and of the Palestinians from ostensibly universal models that are neither applicable nor attuned to the particularities of people living under ongoing settler colonialism and chronic, protracted violence. An example of this approach can be found in Rita Giacaman's powerful rumination on the problematic use of "resilience" and the insistence on disentangling political and social suffering from biomedical conceptualizations of disease.[17]

It is helpful here to consider lessons learned in critiques of health disparities research in the United States. Much of the emphasis in the establishment literature has been on quantifying differences between various racial and ethnic groups, ultimately plugging race and/or ethnicity into multivariate regression models to decompose their independent impact on adverse health outcomes. Reemerging critiques of the vast literature using this approach point to the fact that it is not race but racism, settler colonialism, and racial capitalism that overdetermine adverse health outcomes in the U.S. context, especially for Black, Brown, and Indigenous people.[18] These political, economic, and social processes prefigure the allocation of resources necessary to life and health, including, and especially, affordable quality housing, green spaces, health-care access, health insurance, education, safety, and income. Resources are disproportionately allocated and made accessible to white and wealthy communities, rendering Black, Brown, Indigenous, disabled, and low-income communities more vulnerable to adverse health and, by extension, premature death and suffering[19]—a process described by scholar Ruth Wilson Gilmore as "organized abandonment."[20] Critics thus make the case that statistical methods that treat race as a singular explanatory variable and that do not aim to connect the impact of structural and historical legacies of racism to the current conditions of Black communities and other communities of color are problematic, if not in their lack of statistical rigor, then in their implications and (mis)interpretations.[21]

To put a finer point on it: I write this from Baltimore, MD, where there is a fourteen-year life expectancy difference between a Black child born in Sandtown-Winchester (the disinvested-from neighborhood where a young Black man named Freddie Gray lived, was picked up by law enforcement, and eventually killed while in Baltimore City police custody in April 2015, sparking

an uprising), and a white child born in Roland Park, the neighborhood that houses one of the world's elite universities, Johns Hopkins University.[22] Neighborhoods separated by no more than seven miles. This unconscionable life expectancy difference is not due to race or unique pathobiology. Such racist assertions, peddled implicitly in the mainstream public health and legislative discourse, absolve the state of responsibility and reify debunked eugenicist narratives on the vulnerability of certain people to disease and early death. This life expectancy difference—between seventy years in Sandtown-Winchester and eighty-four years in Roland Park—is due to racism and the historic legacies of racial capitalism and settler colonialism mediated by the state, which has rendered certain lives and certain neighborhoods as worthy of investment and others as disposable.[23] This is not a rhetorical distinction. Acknowledging the root causes of the profound inequality in life expectancy and adverse health outcomes is necessary in order to define a meaningful solution and develop effective interventions that address and narrow these health disparities. Ignoring and misrepresenting them simply buys time for policymakers and politicians unwilling to tackle fundamental causes of disease and early death.

Similarly, it is not uncommon in the sparse literature on social and political determinants of health in Palestine to find multivariate regression tables with effect estimates for each subgroup in an analysis. Such data is neatly parsed out as if it were a simple quantitative matter to disaggregate the health impact of direct exposure to violence from the overriding and ever-present exposure to settler-colonial violence and erasure. For example, in one paper, authors employed multivariate regression models to determine factors associated with the mental health of Palestinian adults in the West Bank, East Jerusalem, and Gaza.[24] The investigators plugged in explanatory variables including family loss, exposure to political violence, and feelings of insecurity to model their impact on the four self-reported health outcomes of interest: limits on functioning due to physical health, feeling broken or destroyed, feelings of depression, and trauma-related stress. Based on the regression models, the authors found little association between the covariates and "feelings of being broken or destroyed," and only insecurity and resource inadequacy were factors related to "feelings of depression." They conclude that it is only resource inadequacy (specifically lack of adequate food, clothing, housing, transportation, entertainment, and capacity to purchase new things) that was associated with all four health outcomes. Notably, they mention, "Multiple dimensions of political violence (hearing bombs, physical harm and humiliation) are related uniquely to trauma-related stress . . . but notably *not with feelings of depression*, *feeling broken or destroyed or functional limitations due to health*."[25] Such a conclusion is difficult to believe, given decades of empirical research that has found exposure to violence to be associated, even causally, with poor health outcomes.[26] Yet, because output from the regression model showed no impact of these experiences on health at a predefined significance value, we accept it to be true.[27] The extant and burgeoning critical public health literature focused on Palestinians is still replete with similar misreadings of cause-and-effect relationships. To read the literature, one might even come to believe that Palestinians are outliers in their pathobiological responses to state-sanctioned violence. The persistent characterization of them as "resilient" is, I would argue, a subsidiary of the global *resilience industry* or, perhaps more pointedly, *Resilience, Inc.*[28]

These public health research approaches are typically, albeit to varying degrees, couched in terms that appeal to broader discourses on human rights. In its most progressive iteration, health is

affirmed as a human right alongside material economic and political rights, and the Palestinians have a right to health, it is argued, by virtue of their humanity. It is concerning then that, taken together, the body of work on the health of Palestinians has not aimed to realize health as the right to thrive but rather as the right to survive, and even then, most minimally. Put more simply, while researchers and advocates are invoking the right to *health*, what they are describing—at least implicitly in their advocacy and operationally in their research—is a right to *live* that sidelines preconditions of self-determination and popular sovereignty necessary for a fully actualized right to health and a just vision for health care. If freedom is a prerequisite to health, and both health and freedom are universal rights, what does it mean to invoke the right to health without accounting for conditions of sustained, persistent, overwhelming, and abiding terror and violence?[29] How can the Palestinians, wherever they may be, realize individual and community health without sovereignty? How can the body be healthy without a healthy body politic? These questions remain the specter haunting any discussion of Palestinian health in the context of a global pandemic.

Pessoptimism beyond Survivability

No sooner had the WHO director-general declared Covid-19 a global pandemic in March of 2020[30] than an avalanche of English-language think pieces and op-eds sounded the alarm about the impending doom that would soon befall Palestine and, specifically, Gaza. Journalists, academics, and activists alike warned that, without immediate intervention and left to their own devices in the context of an ongoing settler-colonial project decimating health systems and people's lives and livelihoods, the Palestinians would be swallowed whole by the pandemic.[31] One particularly ominous piece invoked the UN's statement, declaring Gaza "unlivable" by 2020.[32] Given the context of a decades-long economic blockade and deteriorating environmental and health infrastructure conditions, the author asks, "What happens, then, when you add coronavirus to the whole mix? It seems we're about to find out."[33] Such a buckle-your-seatbelts-as-this-nightmare-unfolds voyeurism was woven into and emblematic of so many public responses. Another piece relayed the story of a Palestinian man, who "staring at the filthy sea on the coast of Gaza City . . . tells [the author] in a whimper, 'Gaza is ready for its burial.'"[34]A recipe for disaster, we were warned of a viral global pandemic thrown atop ongoing occupation and settler colonialism, the ultimate "underlying condition."[35] This grim narrative tack is ubiquitous[36] and advances a longstanding trope characterizing conditions of health in Palestine as horrifyingly intractable and hopeless. These essentializing frames serve dual roles. Mirroring and often informed by abundant human rights reports, they paint Palestine, the Palestinians, and the Palestinian health sector as uniquely vulnerable to the impact of the pandemic; and they depict Palestinians in the global public health imaginary as a people always on the brink of disaster, always on the periphery of death, barely surviving, exceptionally prone to pathology and early death, awaiting the singular event that will be the final straw that propels them to ultimate catastrophe and defeat. A Nakba of Nakbas, as it were—totalizing views rooted in racist notions of biological determinism[37] and inherent Palestinian pathology.

In fact, the predicament of the Palestinians is not *entirely* exceptional and is shared by other colonized peoples living under the yoke of settler colonialism, empire, and global racial

capitalism[38]—be they in the working-class boroughs of New York City[39] or the Indigenous lands of the Navajo Nation.[40] The response to such attempts at elimination are also not exceptional. The Indigenous have always prepared for and anticipated pandemics. First, because pandemics and disease have long been weaponized as biological warfare deployed in service of conquest, containment, and genocide;[41] and second, because they already live amid the ever-present threat of annihilation—experienced in the settler-inflicted rupture between the land and the Indigenous that "represents a profound epistemic, ontological, cosmological violence."[42]

We know from evidence in the United States and elsewhere that allostatic load, the real pathobiological response of our bodies to accumulated stress and ruptures over years, decades, and centuries of oppression, is one of the primary drivers of premature death.[43] By the numbers, the health system in Gaza, under assault on all fronts for at least the past thirteen years, is indeed extremely vulnerable to the spread of infectious disease and the rapid increase in the incidence of any disease: only one in ten households in Gaza has access to clean and safe water;[44] electricity provision is at best intermittent and at worst inexistent;[45] importation of essential medical equipment and supplies is severely restricted, if not denied, by Israel, and their procurement in any case underfunded by both Israel and the PA.

Yet, acknowledging this and noting the worsening disparities in health outcomes engendered by the settler-colonial project, we must also accept the reality that people are alive in Gaza. They are trying to live despite a blockade that has held them hostage in forced isolation from the entirety of the planet for the past thirteen years, and they still aspire to live healthy lives. What then are the implications for the health of a people—1.8 million in Gaza to be exact—to be constantly reminded by a world that has abandoned them that the expiry date for the livability of their home has long passed? And then to be told that in this afterlife of unlivability, a global pandemic that has led to the early deaths of more than half a million people worldwide[46] is knocking on the doors of the Erez (apartheid) crossing a few miles away? How do these narratives that insist Palestinians in Gaza—bravely resisting in the Great March of Return protests—are not just dying, but that they are already dead, exacerbate and compound allostatic load? To broaden the scope of this question to all Palestinians: how do a people reject this pessimistic narrative and imagine a life that is livable and worth living when all metrics, policies, donors, infrastructures, and health advocates have rendered them disposable and prescribed for them premature death? While "we were never meant to survive,"[47] we were also never meant to live under the perpetual shadow of mortality.

There is a special dissonance to the doom-and-gloom media narratives in light of a public health approach both in Gaza and the West Bank that was comparatively successful in public health terms in initially mitigating and containing the spread of Covid-19. With proactive measures taken early on to stem the tide of infection, the West Bank and Gaza saw lower Covid-19 cases and fatality counts in the first few months after the pandemic was declared than many better-resourced health systems, including those of the United States and Israel.[48] There is much to say here about how this initial success in managing Covid-19 may have been predicated, in part, on settler-colonial tools, namely increased PA cooperation and securitization with Israel.[49] Yet even these entrenched power entanglements were eventually overrun by the vagaries of the settler project itself, as we eventually witnessed a rapid rise in cases across the West Bank.[50] Public health scholars could read the PA response as a success story. And in many ways, it was. To do so, however, they

would have to ignore the political conditions that enabled that success in the first place. Alternatively, they could adopt the opposite approach, the one of despair and defeat described earlier. What are the consequences for the Palestinians of this narrative that de facto strips us of agency and health? How do we make sense of the understandable fear of utter loss of control, literally and figuratively, when millions and millions of dollars have been spilled over the past two decades, especially post-Oslo, into reclaiming and restoring a notoriously fragmented Palestinian health-care system that is somehow magically resilient to the insults of settler-colonial violence?[51]

These are complex questions and their answers are fraught with contradictions. The engagement on the question of health in Palestine under the shadow of Covid-19 was more nuanced and self-reflexive in the Arabic-language press.[52] Ubai Aboudi, director of Bisan Center for Research and Development,[53] who remained under Israeli administrative detention at the time of writing, expounded in a piece published on 23 April 2020 on the ways that global neoliberalism and the commodification of health and health care put low-wage Black, Brown, and Indigenous communities most at risk for the disease.[54] This reality has played out as foretold in the United States, where Black and Latino people are twice as likely to die of Covid-19 than white people.[55] Indigenous communities such as the Diné (Navajo Nation), on whom data is often invisibilized or never collected at all, are in fact concerned by the existential threat Covid-19 might pose to their people.[56] Aboudi also critiqued the PA, whose budgets prioritize policing and security coordination over public health.

This too, then, is the problem with the homogenizing narratives of impending disaster. Not only are Palestine and the Palestinians not altogether exceptional, they are also not a monolith, even in their vulnerability to viral pandemics under the unifying condition of settler colonialism. When the PA enforced a quarantine that forced businesses to close and required workers—except for essential medical workers and those who labored inside Israel—to stay home, it both cut off financial support to the most economically precarious and forced extended families into conditions where social distancing, the recommended measure for containment along with masking, was nearly impossible due to the crowded conditions of multifamily homes and refugee camps. Just as Palestinians are heterogeneous in their class, and social and political capital, they are heterogeneous with respect to their capacity to withstand exogenous stressors under conditions of prestructured concentrated risk and vulnerability. An approach that centers the possibility of health and thriving also centers the very people for whom health is always in question and perpetually compromised, those most vulnerable among the vulnerable—what one scholar has called the "viral underclass."[57] Among the most vulnerable and most at risk are surely: those with disabilities, women, day laborers, and just as surely, Palestinian prisoners and detainees. The over 4,760 Palestinians in Israeli prisons[58] and the indeterminate number held by the PA have all been largely left out of the state response.

This is not to say, however, that they were left out altogether.

Mutual Aid, Carcerality, and Structural Precarity

Covid-19 has resurrected and amplified extant and decades-old networks of mutual aid across Palestine, as well as in refugee camps and exile communities globally. The ethnographic literature

on mutual aid and solidarity among Palestinians, especially that which emerged during the First Intifada, is massive.[59] Amid a growth in scholarly, activist, and public interest on the politics and practices of care, care work, and unwaged labor, an opportunity arises to consider Palestinian contributions to this form of care work and its granular politics. In her essay for this special issue, Elena Fiddian-Qasmiyeh writes here about practices of care work in Beddawi refugee camp in Lebanon and, in so doing, insists on Palestine as a citational necessity in theorizations of care during prolonged crisis. On a call to them in June, with birds chirping in the background, my maternal aunts in Tulkarm, Palestine,[60] reminded me of the women-led mutual aid networks that emerged during the First Intifada. Every day of Covid-19 quarantine was a reminder to them of that crucial community solidarity and care.

The economic and political blockade of the Gaza Strip has all but decimated the health-care system there. Ghassan Abu-Sittah's contribution probes Israel's strategic opportunism in the face of the Covid-19 pandemic, examining the mechanisms of replication and innovation within and beyond Gaza that Israel uses to advance its settler-colonial ambitions. As it explores the challenges and opportunities presented by the pandemic, his essay sheds light on the capitalist approaches taken by Israel to further entrench its siege on the Palestinians in Gaza, including the export of increasingly advanced technologies of surveillance and state control that it has long deployed against the Palestinian people.

Abolitionist praxis is also taking center stage as an organic Black Lives Matter movement gains ground globally. Simultaneously, public health advocates are refocusing their advocacy around the adverse health impacts of carcerality, policing, and imprisonment. What of incarcerated Palestinians who cannot practice the central tenet of our public health strategy, social distancing? How will this pandemic and its afterlife shape conditions for the prisoners of a settler colony? Through a deeply personal essay, Hind Shraydeh explores incarceration as a condition of capture that forecloses all possibilities for health. She traces the predicament of her partner who has been incarcerated since December 2019 and accurately positions prisons as sites of public health crisis.

The Economy and Health

A direct link can be drawn from the signing of the Oslo Accords to the deterioration of health for the Palestinians in the West Bank and Gaza. The Oslo Accords created a PA that accepted greater oversight over the Palestinian population as a token symbol of sovereignty while Israel maintained full control over border crossings, foreign relations, water resources, and land. Prior to Oslo, Israel—as occupying power—was legally understood to be responsible for health-care provision to the occupied Palestinian population. Oslo thus enabled Israel to retain its political and economic control over Palestinians with little responsibility for them as occupier.[61] It has long been argued that Oslo entrenched the political and economic asymmetry between the Israeli government on the one hand and the PA on the other.[62] In particular, the Paris Protocol component, formally the Protocol on Economic Relations between the Government of the State of Israel and the PLO, facilitated the acute and long-term dependence of the Palestinian economy on Israel. Specifically, the protocol created a customs union between Israel and the PA and thus placed the Palestinian economy under the same customs envelope as that of Israel.

Among its many consequences, the protocol also facilitated the creation of a captive Palestinian pharmaceutical market for Israel: the link between the Paris Protocol and the current predicament of chronic shortages in essential drugs and medical supplies cannot be overemphasized.[63] Specifically, the Israeli Ministry of Health controls the import of pharmaceuticals to the West Bank and Gaza Strip, allowing only the importation of products already registered in Israel, effectively blocking imports from neighboring markets (including Jordan) that could sell medications to Palestinians at lower prices. Even in the throes of the pandemic, the principal concern for both the Gaza[64] and Ramallah health ministries has been acute and chronic supply shortages, including of masks and personal protective equipment necessary for the mitigation of Covid-19.[65]

Further, and in direct violation of the Paris Protocol, Israel persistently withholds PA tax monies and revenues owed to the PA and Palestinian workers, amounting to nearly $1 billion USD annually.[66] These "fiscal leakages" compromise the fiscal health of the PA and Hamas authorities as well as their annual health budgets.[67] There is simply less and less funding available for sustained quality health-care provision in the West Bank and Gaza. As a result, medical workers, like teachers and other civil servants, are not paid regularly, resulting occasionally in strikes and the reduction of the working week.[68]

The precarity and nature of an economy can be central to undermining or undergirding health. In 2018, the Palestinian gross domestic product (GDP) was approximately $14.6 billion USD, 96 percent lower than Israel's $370.6 billion GDP.[69] In his essay, Sobhi Samour turns our attention to the all-encompassing sector that defines, for better or worse, our conditions under captivity and our ability to effectively formulate national health strategies. As the global economy spirals down into depression and unemployment soars worldwide, Samour's essay reflects on the consequences for the Palestinians, both politically and economically, of economic decimation in the shadow of the pandemic. Samour asks us to consider these questions with a mind to emerging theorizations of necropolitics and necroeconomics, especially in the context of day laborers from the West Bank—approximately one third of the Palestinian work force—who have been targeted by the Israeli government in the "fight" against the spread of Covid-19.

Measuring Health

This present essay does not reproduce the literature that details the availability of health-care infrastructures that define care provision (for example, the availability of well-trained health-care providers, pharmacies, clinics, dialysis centers, and hospitals). Several existing resources already do this, including those provided by the Palestinian Central Bureau of Statistics,[70] the Palestinian National Institute of Public Health,[71] and the WHO.[72] Notwithstanding the fixation on numbers as remedy, one central indicator, life expectancy, is necessary for context and comparison. Life expectancy is a measure of the average length of time a person is expected to live and is widely considered a strong indicator of the quality of health care and the health of a population. The life expectancy of Palestinians in the West Bank and Gaza is about ten years below that of Israelis[73] and has been so for over a decade; and Jewish Israelis live, on average, four years longer than Palestinian citizens of Israel.[74] These disparities in survival and quality of life between Palestinians and Israelis can be found across every health metric.[75]

MENTAL HEALTH

Yet all measures are not created equal. Coping, resilience, and survival are core categories in mainstream mental health approaches to crisis—both in Palestine and elsewhere. The roundtable on mental health featured in this issue offers a collective rejoinder to such approaches, seeing in the current pandemic an opportunity to revisit how we understand and advocate for critical approaches to mental health in the midst of prolonged crisis.

Contributors to the roundtable speak to the topic of mental health through a variety of prisms. Weeam Hammoudeh traces the primary questions that drive research on mental health and how the Covid-19 pandemic upends and offers an opening for renewed conversations on mental health and social well-being. Cindy Sousa addresses the mental health effects of not just the pandemic but of political violence writ large, and asks us to consider the role of a liberation movement in supporting social formations that promote mental health. Finally, Samah Jabr and Maria Helbich examine the response of the Mental Health Unit at the Ministry of Health in Ramallah, revealing the challenges encountered by mental health professionals as they attempted to provide a refuge of care amid confusion and concern.

Palestine, beyond Fragments

Insofar as Palestine's very geography is fragmented, so too are health-care access and provisions. Lack of coordination between health service providers and the inability for Palestinians to move freely within, between, and outside East Jerusalem, the West Bank, and Gaza, make it difficult to coordinate longitudinal care over the life course. This is especially egregious given the population's increasing chronic disease burden, particularly of cancer and heart disease,[76] requiring specialized, costly care not often available locally.[77]

While the Palestinian health-care system and infrastructure are deliberately targeted for destruction by the Israeli regime, the health care provided inside Israel is touted as among the best available. Osama Tanous takes us there, inside the Green Line, where it is well known that Palestinians confront second-class citizenship in every aspect of life. However, what is less known is the emergence of Palestinians as central players in the health infrastructure of the country—representing nearly a fourth of doctors and nurses, and half of all pharmacists.[78] In contrast with the United Kingdom and the United States, where the discourse on immigrant health-care professionals talks of them "saving" citizens, this is a case of Indigenous doctors "saving" settlers (and of course, other Palestinians). In his essay, Tanous offers his personal reflections on the ironies of this condition and the political uses to which it is being put in increasingly militarized medical spaces.

Returns to Causal Inference and the Future of Public Health

In this overarching essay, I ask that we reconsider our approaches to research on the health of Palestinians. I also ask that we turn a mirror to ourselves and to the global structures of power that have long dictated the public health agenda of our people, channeling vast research and

advocacy efforts in service of proximal and poorly defined outcomes while asking us to collectively ignore our political condition and goals for freedom. Causal inference, a process of understanding cause-and-effect relationships in epidemiology, invites us to thoughtfully and rigorously triangulate the many factors that may prefigure health and disease.[79] What might a return to causal inference look like in this moment of transformation offered by the pandemic portal?[80] If we are to imagine public health as continuously transforming and evolving with the needs of our people, we need to imagine anew what it would mean for the science of public health in Palestine to challenge epidemiological approaches that focus on calculating rather than restoring health, and on reifying power rather than dismantling it. Put another way, I hope we can approach statistical models with more critical rigor and never assume a model or study is agnostic because we or our funders are beguiled by the abundant data, numbers, and figures. More concretely, we cannot continue to disaggregate our material conditions from our political conditions and must insist on cause-and-effect relationships anchored in an understanding of the interconnectedness of the two, even if this means a wholesale abandonment of models altogether. Foundational and serial displacement, land theft, and genocide cannot be rendered as singular events, variables to be inputted and controlled for in a regression model. They are all-encompassing structures of violence[81] that no single statistical metric can contain.

The Palestinian health sector, in line with the global and globalizing movements toward "big data," has heavily invested, with international aid support, in developing electronic health record systems that allow for more unified and patient-centered engagement across health system platforms to ultimately improve care. At the same time, these systems also allow for the accumulation of granular and more comprehensive data that will be accessible to researchers and governments, locally and internationally. The UN special rapporteur on the rights of Indigenous peoples wrote of the "double-edged sword" for Indigenous peoples that had been ushered in by the global data revolution.[14] On one hand, data offers greater visibility and power through knowledge generation and analysis and the potential for the development of positive public health interventions. On the other, if a people are not engaged from the beginning, in the collection, ownership, stewardship, and use of data, it may be used to further marginalize them and curtail their aspirations for freedom. As we imagine what health care can look like, now and after liberation, we must consider the role of data and data technologies, including those ultimately operationalized in service of greater social control and surveillance.[82]

Finally, many questions remain in this quest for greater clarity, responsibility, and accountability in health-care research and advocacy. One especially important, yet often-ignored, question left unaddressed here is that of the possibilities—or impossibilities, perhaps—of integrating or making claims for Palestinian health across a transnational *shatat*, or diaspora. If we are going to take on structures of violence through our renewed analytics of public health, we need to reckon with the structure of violence that scatters our people across multiple geographies and systems of health. It is no longer possible or responsible to ignore and sideline these fundamental questions—because by doing so, we merely reproduce the very violence that continues to fracture us. We must also consider the material and health costs as well as the ethics of the multitude of studies and experiments that have been done on our people.[83] Are these studies even necessary when there

has already been significant work elsewhere that has established this causal connection between our dispossession and our suffering?

The stories told in these pages offer us new ways of thinking about and seeing public health, and imagining for ourselves a better, healthier tomorrow—one of reparations, return, and repair.

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