

ARTICLE

“You, as of Now, Are Someone Else!”: Minoritization, Settler Colonialism, and Indigenous Health

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ABSTRACT

This article challenges the dominant notion that the health of Palestinians inside the Green Line can be framed or understood as an issue of “minority health” characterized by a “gap” that needs bridging in order for health equity to be attained. It situates the health of Palestinians in Israel within the realm of Indigenous health and claims that the settler-colonial nature of the state of Israel, the minoritization of Palestinians, and their depeasantization through land policies and water infrastructures have produced an Indigenous community alienated from its lands and from nature. These processes, I argue, contribute to adverse health outcomes that are then reported simply as “minority health” phenomena, chalked up to behavioral patterns or biology. The article seeks to challenge the entire notion of “minority health” as a purportedly neutral statistical unit and to launch a conversation on the health effects of minoritization in settler-colonial contexts.

KEYWORDS

Indigenous health; settler colonialism; environment; Palestine; Israel; ecocide; Nakba; minority health; minoritization

Indigenous Health in Settler Colonies

... we had longevity here, before England’s rifles, before French wine and Influenza, we used to live as we should live, companions of the gazelle.

—Mahmoud Darwish

IN SETTLER COLONIES SUCH AS THE UNITED STATES, CANADA, AUSTRALIA, AND NEW ZEALAND, Indigenous peoples have a shorter life expectancy than their counterparts of European settler extraction. They suffer from significantly higher rates of infant mortality and of overall morbidity, including such chronic conditions as obesity, hypertension, diabetes, and heart disease.¹ A growing body of research has been dedicated to the study of Indigenous health, exploring topics such as racism, land alienation, ecosystem degradation, and historical trauma—and their toxic effects on Indigenous health.² A series of articles published by *The Lancet* in 2006 and 2009 explored the issue in depth, describing how colonialism had shattered the fabric of “traditional” societies, destroying “traditional” farming, fishing, and food gathering practices in the process, and thus contributed to an epidemic of obesity, hypertension, and heart disease.³

The Lancet series posed the “traditional” as an undefined but somehow self-evident distinction between the settler and the native. The term falls in the trap of romanticizing the Indigenous societies as static and morally superior, living in perfect harmony with nature, in contrast to settler societies that are positioned as modern and dynamic. This ahistorical

depiction flattens the lives, histories, and health of Indigenous peoples with all of their complexities. It is also anachronistic in its understanding of settler communities, as it presupposes their modernity and understands them to be devoid of tradition. More importantly for the present discussion, was the series’ exclusion of Palestine from the very category of Indigenous people. While the articles were extensive and covered the health of Indigenous peoples across the globe, including Australia, New Zealand, Pacific Island countries, North America, Latin America, the Caribbean, and Africa, Palestine was glaringly absent.⁴ Despite *The Lancet’s* assertion that understanding Indigenous health required critical engagement with colonization,⁵ in 2018 the journal published another series celebrating the Israeli healthcare system in which Israel was described as a high-income, multiethnic state where “Israeli Arabs”—a misnaming of Palestinians with Israeli citizenship—suffered from higher rates of diabetes and obesity because of socioeconomic disparities and despite national health insurance and public investment in the health sector.⁶ The series completely elided the settler-colonial character of the state and its racist policies, thereby erasing the effects of the Nakba and land alienation on the health of Palestinians.⁷

Parallel to the exclusion of the Palestinian Nakba from the “trauma genre” in psychology,⁸ the health of Palestinians is often excluded from Indigenous health studies. When addressing Palestinian health, the effects of settler colonialism are reduced to a question of minority health for Palestinians in Israel,⁹ an issue of health in conflict zones for Palestinians in the West Bank and the Gaza Strip,¹⁰ or of migrant or refugee health in regard to Palestinian refugees.¹¹ While they can be strategically important, such framings fail to capture the entire eco-social context¹² that has produced and shaped the material and social conditions, behaviors, and patterns of disease for Palestinians, or the antecedents to their being a minority, refugees, or living in a conflict zone.

Focusing on the health of Palestinians inside the Green Line, I argue that it follows similar patterns to those found among Indigenous peoples everywhere (see Table 1). In Israel, nine out of the ten towns with the highest overall mortality rates and all ten towns with the highest

Table 1. Life expectancy and age-adjusted death rates (per 100,000) for Indigenous and non-Indigenous populations.

Health outcome	Israel		USA		Australia	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Life expectancy (years)	Female: 82.3 Male: 78	Female: 85.1 Male: 81.7	Female: 75 Male: 68.6	Female: 78.1–84.4 Male: 71.3–79	Female: 75.6 Male: 71.6	Female: 83.4 Male: 80.2
Neonatal mortality rate (per 1,000 live births)	5.4	2.4	8.2	4.6–5.8	5.1	2.9
Rate ratio	2.25		1.8		1.8	
Mortality from diabetes	31.5	14	49	19.7	76.9	16.3
Rate ratio	2.25		2.48		4.7	
Mortality from cerebrovascular disease	21.5	12.9	41.5	34.8–31.2	N/A	N/A
Rate ratio	1.66		1.19–1.33		1.5	
Mortality from ischemic heart disease*	23.7	14.5	198.9	106.9–165.7	138.1	78.7
Rate ratio	1.63		1.2–1.86		1.8	

SOURCE: Compiled by the author through the use of several sources, including statistics, primarily for 2017–19, that were taken from different governmental data sets.¹¹⁶

*Because the primary cause of death is categorized differently in various countries, mortality from heart disease may not be wholly comparable. Nonetheless, the emphasis here is on the relative risk between Indigenous and non-Indigenous populations within the same country.

death rates from heart disease are Palestinian localities.¹³ Palestinians in Israel have significantly higher rates of obesity and diabetes than Israeli Jews¹⁴ and they suffer from heart attacks at a much younger age with the worst survival rates in the years that follow.¹⁵ By and large, the medical literature ascribes such patterns to a minority health issue, a statistically accurate and neat phrasing that is supposedly neutral, even though the reductionism is saturated with violence and erasure. If we understand the Nakba as a form of foundational violence that “obliterates instead of exploits” and “does not merely distort reality but annihilates the meanings permeating a pre-existing reality,”¹⁶ then it becomes evident that the term “minority health” operates within a larger logic that imagines Israel as having declared statehood in 1948 with a ready-made, so-called Arab minority. The disadvantaged status of this purported minority is often attributed to vaguely referenced socioeconomic and cultural factors. Akin to other groups in Israel like the ultra-Orthodox Jewish community, as well as minority populations elsewhere in the world (African Americans or Latinx communities in the United States, for example), the “Arab minority” is deemed to experience health problems or a gap that needs bridging. This logic operates within what medical anthropologist Paul Farmer has called the “erasure of history,” a subtle and incremental tool that architects of structural violence use to erase links across time and space to create “desocialized” hegemonic accounts.¹⁷

This article situates the health of Palestinians inside the Green Line within Indigenous health studies and explores how settler-colonial infrastructures and policies have distorted Palestinian environments, landscapes, waterscapes,¹⁸ food sovereignty, and therefore health. It expands on Indigenous health literature and the health effects of settler colonialism. Unlike the plethora of studies on Indigenous health in North America and Australia, there is a paucity of public health literature examining how upstream factors (fundamental causes or macro factors) such as structural racism, land confiscation and alienation, racist zoning policies, ecosystem degradation, and historical trauma shape downstream factors (individual factors such as lifestyle, smoking, nutrition) and produce health disparities inside the Green Line.¹⁹ Studies examining the upstream effects of colonization on downstream determinants of Palestinian health are rarely conducted by Israeli or Palestinian scholars. Given the scarcity of primary sources, this article examines the health of Palestinians inside the Green Line against the backdrop of other Indigenous peoples who have been subjected to similar processes.

The Making of a “Minority” in “Minority Health”

The vast majority of Palestinians were expelled from their homeland and territory in 1948. These refugees were forcibly dispossessed and removed from their cities, villages, farmlands, and every life-giving thing that was familiar. Alienated from their lands in a variety of ways (confiscation, seizure, expulsion, pauperization, and so on) the minority of Palestinians that remained in pre-1948 Palestine following the creation of the state of Israel numbered some 160,000 people in 1948;²⁰ today, this minority is 1.7 million strong and constitutes around 20 percent of the Israeli population.²¹ The vast majority, an estimated 90 percent, live in segregated Palestinian towns often referred to as Arab localities.²² Most of these localities can be found in the lower third of the ten-point socioeconomic cluster scale maintained by Israel’s Central Bureau of Statistics (CBS).²³ A small proportion of Palestinians in Israel live in so-called mixed cities, mainly the urban centers of Akka, Haifa, and Jaffa that were emptied of their native populations during the Nakba and repopulated by Jewish settler majorities.²⁴

From 1948 to 1966, during the initial phase of Israel's state building project, the Palestinians who remained inside the Green Line were placed under martial law as they were viewed as an enemy population and an inherent security threat. During that period, Israel seized almost all of rural Palestinian-owned land inside the Green Line and transformed it into state land, which all but annihilated Palestinian rural life.²⁵ Today, the so-called Arab localities sit on less than 3 percent of total state land,²⁶ and what had previously been Palestinian villages mutated into highly dense concrete townships that have lost all trace of their rural character as the continued growth of the population resulted in "unplanned and illegal" construction to provide essential shelter.²⁷ Given that most rural lands were either confiscated or became inaccessible due to their designation as military "closed areas" and the ensuing restriction on the villagers' freedom of movement, the rural Palestinian population of Israel has undergone a process of depeasantization.²⁸ Land per capita in rural areas fell precipitously from 19 dunum (1 dunum is about 0.25 acres) in 1945, to 3.4 in 1950, and 0.84 in 1981,²⁹ and the percentage of Palestinians working in agriculture dropped correspondingly from 58 percent in 1954 to 10 percent in 1985 as Palestinians became unable to make a living from farming or animal husbandry.³⁰ Although such processes took different forms in different regions, similar patterns can be discerned across sites from the Galilee to the Naqab. Rural Palestinians became landless peasants and were transformed into the Israeli economy's unskilled marginal proletariat.³¹

While much has been written about these processes, they have rarely been connected to health. In other words, how can we read and understand the health of Palestinians inside the Green Line in light of these transformations? And how, in particular, does the examination of Israeli land and water policies help us better understand the role of settler colonialism in producing health disparities? It is now well appreciated in the public health literature that the social determinants of health—that is, the economic, social, political, educational, and cultural variables that create the material conditions in which human beings grow, work, live, and age—are the strongest predictors of a population's health and wellbeing.³² Since they do not exist in a vacuum, these determinants are shaped by state policies and the policies and actions of nonstate actors such as the Jewish National Fund (JNF), the World Zionist Organization, and others.³³ Thus, in order to understand health disparities between populations, it is crucial to understand the policies that shape the social determinants of health rather than focus primarily on individual-level variables such as lifestyle, nutrition, exercise, or smoking.³⁴

The Genocide-Ecocide Nexus of Settler Colonialism

[Israel] was celebrated as one of the great postwar achievements; the country that made the desert bloom, farmed the wastelands, redesigned the environment, created democracy.

—Edward Said³⁵

The theft of nature, the overexploitation of land, water, and other resources, and the destruction of Indigenous peoples' connections to their culture and land have been primary features of colonialism and imperialism in what might be called the genocide-ecocide nexus.³⁶ The eco-destructive processes of intensive agriculture and extractive industrial projects have been central to the violent settler colonization of Indigenous lands everywhere.³⁷ Industrial mining, farming,³⁸ and even the seemingly benign pursuit of national park creation³⁹ have been integral to settler-colonial land grabs and the destruction of Indigenous peoples' relationship to nature. In the colonies (previously the margins of capitalism), the habitat of Indigenous peoples was

reduced to an abundance of natural resources to be commodified and directed to global networks of capitalist production, circulation, and exchange, often under the guise of tropes such as “progress,” “development,” “modernity,” and “constructive imperialism.”⁴⁰ These interventions generated wealth primarily for the metropole, as has been well documented, and the processes of private ownership and commodification involved were foundational to the alienation of Indigenous peoples from their lands.⁴¹ Obviously, the lives of Indigenous communities prior to colonization were neither idyllic nor perfectly in tune with their habitat as humans have been altering nature since before the agricultural revolution, manipulating landscapes, waterscapes, fauna, and flora in the process. The damage such human activity may have inflicted is beyond our scope, however. What this article seeks to do is explore the contours of the damage and distortions that the process of settler colonialism has had on the natural habitat of Palestinians and the consequent effects on their health.

Settler colonialism in Palestine differs considerably from settler colonialism elsewhere. It arose during a century when national identities and material technologies permitted the exponential growth of the settler population on a relatively small and bordered territory that was closer to Europe than most previous settler colonies (aside from Algeria). Palestine was a bordered piece of land in the so-called Old World that was connected to global capital trade and not an entire uncharted continent in the “New World,” which allowed Israel to double its population in the first three and a half years of its existence.⁴² This exponential growth resulted in a much more rapid process of land requisition and resource management, both of which were accomplished in a collective and centralized fashion rather than through a more scattered process such as the gradual frontier expansion efforts in the United States and Australia that were fueled by private or corporate actors, such as banks, corporations, railway companies, as well as individuals. Within just a few years of the Nakba and Israel’s declaration of statehood in 1948, more than 93 percent of the land inside the Green Line had been designated national state lands⁴³ and the Water Law of 1959⁴⁴ nationalized all of the country’s water resources. Both of these measures facilitated a centralized and tightly controlled process of strategic national planning that encompassed both the population and the environment.⁴⁵

From Land of Milk and Honey to Arid State: Journey from Abundance to Scarcity

Land and water are central to public health since they determine habitat, physical activity, and connection to animals, plants, and food. Their configuration is intrinsic to both the built and natural environments and have a major influence on the occurrence of infectious and non-infectious diseases by virtue of their determining impact on such things as food sovereignty and water safety and quality.⁴⁶

Representations of Palestine in Zionist propaganda have been contradictory. When Zionist aspirations to settle millions of Europeans in Palestine were met with British concerns regarding the limited natural capacity of the land to absorb such numbers, Zionist leaders and ideologues deployed seemingly contrary arguments, mixing modern science and ancient tropes. They invoked, on the one hand, biblical narratives referencing the land of milk and honey and (Western) water experts who declared Palestine a water-rich country with the ability to absorb future waves of settlers.⁴⁷ On the other hand, they simultaneously portrayed

Palestine as an undeveloped wilderness, a land of deserts and swamps,⁴⁸ lacking in trees and hygiene and in need of redemption and reengineering.⁴⁹ It is noteworthy that following the Nakba and the declaration of Israeli statehood, the narrative of abundance was quickly replaced by that of scarcity as outlined by Samer Alatout.⁵⁰ The Zionist movement mixed biblical ethos with capitalist logic to modify longstanding colonial tropes, replacing colonial frontier exploration and expansion with the "reclamation" and "redemption" of the Jews' purported ancestral land after it had fallen into a state of neglect under foreign rule.⁵¹ The desire to not simply return to the so-called ancestral land but to transform it with major infrastructural and extractive projects was deeply embedded in the Zionist vision. Even before the first Zionist Congress of 1897 in Basel, Theodor Herzl had noted in his diaries: "Great chemical industries could be established on the shores of the highly sulfurous Dead Sea. The streams that feed it would be diverted and used for drinking purposes. They would be replaced by a canal from the Mediterranean, part of which would have to pierce the hill through a tunnel (a tourist spectacle). The difference between the levels of the two seas (waterfall) could be utilized for driving machines, many thousands of horsepower."⁵² The Israeli nation-building project was thus coupled with a massive restructuring of the entire Palestinian ecosystem. Colossal infrastructural projects like the draining of Huleh Lake,⁵³ pumping water from the Sea of Galilee (Tiberias Lake) to the Naqab in order to "bloom the desert,"⁵⁴ and the establishment of forests by the JNF over the site of many destroyed Palestinian villages⁵⁵ aimed at reshaping the land—in parallel with public health measures aimed at reshaping the nation, its hygiene, and health.⁵⁶ So how did these massive projects impact the health of Palestinians inside the Green Line? A closer look at Israeli land, water, and agricultural policies provide an insight into the changing social determinants of Palestinian health.

Zionist Agriculture: Dispossession and Depeasantization of Palestinians

Robbed of my ancestors' vineyards, and of the land cultivated
By me and all my children. Nothing is left for us and my grandchildren
Except these rocks ... Will your government take them too, as reported?
—Mahmoud Darwish

Antisemitic laws in Europe restricted the occupations Jews could pursue and the ownership of farming lands by Jews, thus contributing to the concentration of Jewish communities in urban centers.⁵⁷ Zionist public health scholars have described Jewish life in Europe as having been urban, distant from nature, characterized by nervousness, with a diet lacking in fruits and vegetables marked by the heavy consumption of meat, eggs, and flour, and a lifestyle lacking physical exercise.⁵⁸ This was seen as a major cause of an entire range of diseases and in need of correction. "Now we must make big changes in our diet," wrote Dr. Asher Goldstein in 1938 while another Jewish physician affirmed, "From abnormal life we would like to return to normal, natural beautiful life ..."⁵⁹ The Zionist project did not aim only to transform the location of the world's Jewry and the demographics and landscape of Palestine. It also aimed to reshape the health, health behaviors, and nutrition of the new settler population. In this mega-transformation project, agriculture was deployed not merely as a tool to break ties with the Jewish condition in Europe and create employment and food security for the growing

number of newly arrived Jewish settlers. It was also a tool to secure frontiers, prevent the return of Palestinians, and establish facts on the ground in the fledgling state with undeclared borders—in short, the Judaization of land and space.⁶⁰ Agricultural workshops were integrated into military training to enable retired soldiers to engage in farming and in the first year of the state's existence; thirty-nine agricultural settlements were established by the Palmach (an elite fighting force of the Haganah, and later of the Israeli army); and demobilized soldiers established fourteen more settlements in the three years that followed. By 1956, more than 360 rural settlements had been created; southern frontier spaces, such as the water-poor areas of the Naqab and around the Gaza Strip, now urgently needed irrigation because of the intensive agriculture that the colonies put in place.⁶¹ This pattern continued after the 1967 war as agricultural buffer zones were created in the occupied West Bank, Gaza Strip, Sinai, and the Syrian Golan Heights.⁶²

The Naqab desert was specifically targeted for Judaization. Ben-Gurion wrote as early as 1963, “the Negev is a desolate area which is currently empty of people ... it lacks ... water and Jews ... two million Jews can be settled there with agriculture and two million with industry.”⁶³ Ariel Sharon, for his part, stated in 2001 that “water is not merely an economic resource but a means of settling the periphery, protecting state land and a means of conserving farmers and farming.”⁶⁴ Thus, plans for “blooming the desert” and establishing water-intensive agriculture in water-scarce regions were legitimized in the name of national security,⁶⁵ even though securing the frontiers made no ecological sense. The construction of the National Water Carrier (NWC), Israel's largest infrastructure project, started in 1959 and went into operation in 1964. The construction process required an estimated 4.5 million workdays, with approximately 7 million cubic meters of dirt dug up, some 1.7 million cubic meters of rock quarried, approximately 500,000 cubic meters of concrete poured, about 75,000 tons of steel sunk, and 15,000 concrete and steel pipes laid. NWC uses electricity to pump water from Lake Tiberias (212 meters below sea level) 130 kilometers southward to the Naqab (150 meters above sea level). Some 80 percent of the water was allocated for agriculture and the remaining 20 percent for private use.⁶⁶ The project had devastating effects on the region's environment as water levels fell significantly in the lake, as well as in the Jordan River and in the Dead Sea, and soil salination levels increased significantly.⁶⁷

Israeli water and land policies were the central driving force of the dispossession and depeasantization of Palestinians and the state's water infrastructure did not only ignore what remained of Palestinian agriculture in its planning, it damaged it. The building of the NWC and the associated water reservoirs were materialized through the appropriation of the fertile agricultural land of the Sahl al-Battuf (in the Lower Galilee region) and surrounding Palestinian villages like Eilabun. The NWC cut through what little remained of Palestinian agricultural land without providing irrigation. In 1980, 64 percent of Jewish cultivated areas were irrigated compared to 8 percent among that of the Palestinians, who consumed a meager 2.7 percent of total irrigation water consumption. Such policies continued throughout the years with public investment in Arab agriculture in 1981 amounting to a mere 5.8 percent of total in Israel.⁶⁸ In 2008, no more than 12 percent of agricultural lands owned by Palestinians in Israel was irrigated and only 2.2 percent of fresh water was allocated to agriculture on land owned by Palestinians.⁶⁹

While Israeli governments were engaged in the state-building project at full speed, the Palestinians were being expelled and detached from their land and water as an integral part

of the settler colonial "logic of elimination."⁷⁰ Notwithstanding the fact that Palestinians who remained inside the Green Line were given Israeli citizenship, a number of Palestinian scholars have pointed out how this form of settler-colonial citizenship operates as a tool for dispossession, domination, and erasure, rather than equality. The writings of Lana Tatour, in particular, explore how naturalized Palestinian citizens in Israel are seen as aliens or intruders on the land, while Jewish Israelis are considered authentic natural citizens.⁷¹ For her part, Areej Sabbagh-Khoury argues that citizenship in a settler-colonial context enables the process of accumulation by dispossession wherein the Indigenous group's material and symbolic claims to the land are hollowed out, further facilitating territorial dispossession.⁷²

The land alienation and depeasantization processes are closely linked to the alteration of food culture from locally grown to industrially grown and processed food as the Indigenous become consumers rather than producers of their own food. Food justice, defined as the right of communities to grow, sell, and eat healthy food that is fresh, nutritious, affordable, culturally appropriate, and grown locally with care for the wellbeing of the land, workers, and animals, is tightly bound to notions of self-determination.⁷³ In North America, settler-colonial infrastructures of industry and water have completely distorted food traditions and consumption among Indigenous peoples. The pollution of lakes and rivers has resulted in the poisoning of fish and disturbed the cultivation of wild rice, one of the main sources of nutrition for Indigenous populations. This has caused a transition to a high-fat, high-sugar diet that has been accompanied by a rise in obesity, diabetes, hypertension, and cancer.⁷⁴ A similar pattern can be observed among Palestinians in Israel, particularly Bedouins in the Naqab, whose subjection to massive land confiscation and ghettoization⁷⁵ has had a devastating impact on the community's nutrition, lifestyle, and disease incidence. Naqab Bedouins who have been forced to urbanize suffer from significantly higher diabetes rates than those who continue to live in so-called unrecognized villages, despite the fact that the unrecognized village residents suffer formal neglect by the authorities, including a lack of basic infrastructure such as running water, electricity, or health facilities.⁷⁶ Life in the Naqab's planned new townships is now associated with a higher intake of processed high caloric food, a transition from locally grown food to commercial food, and a decrease in physical activity.⁷⁷ Diabetes, once an extremely rare disease among the Bedouin, has become so prevalent it constitutes a public health crisis⁷⁸ affecting up to 70 percent of adult women. Palestinians in Israel develop diabetes at a significantly younger age (57 on average compared to 68 among Jewish Israelis) and Palestinian women older than 50 have an alarming rate of diabetes, up to 50 percent.⁷⁹

As settler colonialism is a land-centric project,⁸⁰ the accumulation of land and natural resources for the settler inevitably results in land alienation for the native, a part of the accumulation by dispossession process.⁸¹ This dispossession and depeasantization disfigure the physical and social environment of oppressed, marginalized, and colonized peoples, altering their behaviors, physical activity, and nutrition,⁸² causing health inequities and a higher incidence of metabolic and infectious diseases.⁸³

While examples of the connections between settler-colonial infrastructures and disease can be found in many settler colonies, an account most worth mentioning here is the case of the Pima Indians or "River People," who reside on the Gila River Indian Reservation in Arizona. The community suffers from one of the highest rates of diabetes in the world, with over half of the adult population on the reservation diagnosed with diabetes. In three decades, the number of diagnosed cases doubled.⁸⁴ Previously, the high prevalence of diabetes was seen as a consequence of unhealthy lifestyles, poverty, and genetic predisposition. More recently,

scholars have shifted the emphasis⁸⁵ to structural and environmental factors with studies demonstrating the relatively low prevalence of diabetes among the Pima Indians living in Northern Mexico, a genetically comparable population that continued to cultivate and produce the majority of their own food for sustenance.⁸⁶ In the United States, settler-colonial infrastructures such as the Roosevelt Dam (1903) and the Florence Diversion Dam (1922) have decreased the Pimas' water allocation by more than 60 percent,⁸⁷ resulting in irreversible damage to irrigation, food sovereignty, and lifestyles among the Pima people and thus led to an epidemic of obesity and diabetes. For generations before colonization, the Pima people were skillful water engineers, using techniques like microirrigation, canals, and check dams to regulate the Gila River's high-flow variability. And while these techniques may not have been perfect, with canals and check dams requiring constant maintenance and repair, and despite crops often being damaged by floods and changes in water flow, the Pima Indians were able to adapt, survive, and establish a lively agricultural society growing corn, beans, and squash. The Desert Land Act of 1877 clearly demonstrates the settler-colonial logic of viewing nature as "natural resources" and the land as a profit-generating asset to be exploited for the production of commodities or cash crops traded in colonial networks of capital.⁸⁸ According to the Desert Land Act, frontier lands were arid and in need of irrigation in order to produce profitable crops, the act justified the appropriation of Native land and water.⁸⁹

For the Pima Indians, Palestinian villagers, and other Indigenous peoples, the connection to the environment and land goes beyond economic sustenance. It is embedded in their way of seeing, being, and acting in the world. It is an integral part of their worldview and culture.⁹⁰ Colonial laws and infrastructures, under the pretext of development, completely transformed the environment and produced new settler-environment relations, mainly private ownership and commodification, while disposing of or destroying Indigenous lands, water, agriculture, and, with time, agricultural skills. This causes ecosystem degradation and land alienation among Indigenous peoples and new patterns of disease. While very little research has been dedicated to the effects of settler colonialism on Palestinian health, the same processes in other settler states have been demonstrated to be the upstream factors for Indigenous communities' ill health and for the glaring health disparities between settlers and natives. Ahistorical and decontextualized health sciences reproduce harm by locating the problem, as well as the research question, within Indigenous genes, bodies, and behaviors, rather than in the mutilation of their environment and their subsequently fractured relationship to that environment.

Shifting Narratives on Health

The first conference on the health of Palestinians inside the Green Line was held in Nazareth on April 12, 1986. Organized by the National Committee of Arab Mayors, the Galilee Society for Health Research and Services, and the Medical Committee of the Nazareth Academics' Union, it addressed the themes of racism, living conditions, and health inside the '48 territories (*al-dakhl*). Conference participants noted that the Palestinian community in Israel was in a state of transition between developing and developed society and suffered from the dual burden of infectious diseases typical of impoverished communities living in crowded settings and chronic diseases such as obesity, diabetes, and hypertension that are typical of more affluent societies. Also notable were infant mortality rates, which were double those for the Jewish population, a ratio that persists today. In his intervention, Nazareth's mayor, Ramiz

Jaraisy, highlighted that “racial discrimination and land confiscation suffocate” Palestinian localities economically and socially,⁹¹ with just 2.3 percent of the total budget for localities going to Palestinian localities, which was equivalent to less than 9 percent of what they paid in taxes. In his intervention, the poet and politician Tawfiq Zayyad emphasized the extent to which the health of Palestinians in Israel was impacted by pervasive racial discrimination in every facet of life, from unemployment to poverty, and the lack of investment in basic infrastructure like water, sewage, and garbage disposal. Situating health in its larger biopolitical context, Zayyad emphasized, “Before we discuss the right to health, we must discuss the right to life. We, on a daily basis, smell the smoke of the ongoing war against our Palestinian people. Our people have the right to live, and a just peace can only occur when the people have the right to self-determination and to enjoy total independence.”⁹² Dr. Hatim Kanaaneh, the first Palestinian public health researcher inside the Green Line, pointed to the anomalies of the Palestinian situation. He described the widespread unplanned and poor construction in Arab localities and the environmental hazards of living there due to neglected water and sewage infrastructures, comparing them to enclaves of poverty in “Third World cities.”⁹³ He also compared labor conditions among the Arab community in Israel to those in developing countries, qualifying Arab localities in Israel as dormitory towns for Palestinian laborers working in Jewish towns and settlements. The laborers, whether engaged in industrial or farm work, were generating profits outside of the community similarly to the way industrial and farm laborers in the Third World produced commodities and profits for the “advanced countries.”⁹⁴ Uncovering Palestinians’ economic dependency and colonial captivity in Israel and the hostile environment’s impact on their health,⁹⁵ Kanaaneh went on to warn about the dangers of the liberal discourse: “In this charged atmosphere ... the prevailing view is that health is an individual responsibility and that any ailments afflicting the individual result from their own shortcomings, with infectious diseases caused by the ailing person’s lack of personal hygiene, and chronic diseases caused by their bad habits.”⁹⁶ Blame is heaped not only on the ailing individual, Kanaaneh argued, but also on their community while their material and social environments are completely discounted. Kanaaneh concluded by highlighting the role of healthcare workers in investigating the root causes of disease, rather than their mere treatment, and the importance of direct political action in the redistribution of wealth, power, and income. He also emphasized the political duty of the Palestinian leadership and public representatives in Israel to work toward self-determination in health services and the urgent need to educate communities to recognize and claim their health needs and rights, and to develop services based on these.⁹⁷ Unfortunately, Kanaaneh’s warnings about the dangers of the liberal individualist discourse have materialized: while there has been a huge surge in the number of Palestinians studying medicine and going into the healthcare professions in Israel, they have almost without exception integrated into the Israeli healthcare workforce so seamlessly that most neither question Israel’s hegemonic narrative nor critically analyze or responsibly engage with the issue of Palestinian health in a manner that is contextually or historically grounded. By and large, most Palestinian physicians in Israel behave like cautious guests in a hostile, scrutinizing environment and produce research that merely reports health disparities or examines individual-level causes of morbidity rather than addresses the root causes of diseases in their eco-social context. This phenomenon is directly correlated to the paucity of critical research in medicine and public health on the connections between settler colonization, racism, and Indigenous health inside the Green Line.⁹⁸

From Native Majority to Ethnic Minority: Producing “Minorities” and “Minority Health”

Censuses are central pillars in the construction of what Benedict Anderson has called imagined communities, or the creation of ethno-racial categories devised by nation building projects. The category “Others” is often used by governments to contain those who do not easily fit easily into these racial or religious categories. As Anderson points out, “The fiction of the census is that everyone is in it, and that everyone has one—and only one—extremely clear place, no fractions.”⁹⁹ As far back as the 1917 Balfour Declaration, and arguably ever since inside the state of Israel, Palestine’s native inhabitants have been negatively defined by what they are not, namely “non-Jewish communities” without political identity or territory while Zionist settlers, who were a tiny minority at the time, were defined as a “people” awaiting a national homeland.¹⁰⁰ This approach continues to prevail in Israel’s health statistics that categorize the population as “Jewish” and “non-Jewish” or “other religions.” In CBS publications, being of “other religions” is a risk factor for a shorter life expectancy,¹⁰¹ higher infant mortality,¹⁰² and adolescent obesity.¹⁰³

Minorities are never simply a statistical unit or a risk factor for diseases, nor do they exist in the absolute. Minorities (and majorities) are often constructed through violent political and historical processes that include genocide, ethnic cleansing, migration, and expulsion. Thus, in settler-colonial settings, the census becomes a political battleground for competing notions of “real identities” to be recognized, categorized,¹⁰⁴ and access resources.¹⁰⁵ The processes of mass settlement, genocide, and expulsion that create and delineate the borders of minorities and majorities¹⁰⁶ are the same upstream drivers that create land alienation and toxic living environments for those constructed as “permanent minorities” that survive, subsist,¹⁰⁷ or continue to exist despite the logic of elimination.¹⁰⁸ Once an Indigenous population is reduced to a minority, their health data and statistics are often simply reported as “minority health.” Thus, the sentence, “the Arab minority suffers from a higher rate of obesity and diabetes” is frequently deployed to advance the same simplistic reasoning that undergirds statements about natural biological minorities such as, “4.2 percent of the population carry AB blood type and are more exposed to contract tuberculosis.”¹⁰⁹ The medical community often tries to explain so-called minority health by referring to genetic factors, beliefs, and behaviors, or bad luck as a result of genes or poor life choices.¹¹⁰ Responsibility is on the individual or community that is often asked to “do better,” eat more healthy, exercise more, have fewer children, follow doctors’ recommendations more strictly, especially with regard to taking pharmaceutical drugs. In Israel, one might get the impression that the Palestinians are repeatedly disappointing the CBS by damaging the country’s national health statistics that would otherwise enhance Israel’s statistical standing in the Organisation for Economic Co-operation and Development (OECD) of which it is a member.¹¹¹ The recurring theme in many reports and medical articles¹¹² is that Palestinians in Israel are a population in “transition” who are undergoing modernization and are in need of culturally appropriate intervention in order to “perform” better when it comes to health. The structures and infrastructures that eviscerated these communities and cast them into minority status, poverty, crowded living conditions, psychological stress, and alienation from their natural environment—what I will call the health effects of minoritization—are strategically left out of the discussion.

Saluting Resistance

And I rise from the dryness of the bread and the confiscated water.

—Mahmoud Darwish

Our work as scholars committed to justice and decolonization, and our positionality as Palestinians, require that we go beyond documenting injustice and analyzing the settler-colonial logic of elimination. As Rana Barakat argues, while the settler-colonial lens is useful when examining Zionism and the structures, infrastructures, and policies that impact the lives of Palestinians, it also centers the settlers' narrative and violence. Barakat's call for our ongoing resistance in praxis and scholarship urges us to transcend the settler-colonial framework and extend the study of Palestinian history to the field of Indigenous studies; this not only centers the voices, the resistance, and the endurance of Palestinians beyond the parameters of settler triumph or defeat, but is also a necessary step toward rooting our knowledge in politically transformative ways. In the case at hand, namely the health of Palestinians, such an approach allows us to better understand how Palestinians live, become ill, age, and heal or die and how they refuse and reject the violence inflicted on them in struggling for a decent life, and in our case, better health.¹¹³

In Palestine, as elsewhere, settler colonialism is not a finished business. Under the brutal and suffocating military regime from 1948 to 1966, Palestinians in Israel were not passive subjects watching their land and water being stolen. The villagers of Kafr Manda, which was slated for evacuation to make place for a water reservoir, resisted the evacuation orders with their bodies and were met with police violence and mass arrests in one of the first confrontations between the state and Palestinians inside the Green Line following the Nakba. But it was their stubborn resistance that saved the village from destruction. Peasants from the nearby villages of 'Arraba and Sakhnin also resisted the confiscation of their land and their deprivation of water in a number of ways, including petitions to the Israeli Supreme Court, demonstrations, sit-ins, and by collectively halting Israeli bulldozers. Although their struggle only temporarily delayed their dispossession as Israeli forces, including hundreds of policemen, were able to violently suppress the resistance and confiscate the land in what the local community dubbed "the day of looting."¹¹⁴ When resisting the plunder of their lands and waters, these Palestinian were described by Israel as "anti-development" and enemies of the state. Palestinians in Israel have been resisting colonial policies and infrastructures related to land and water ever since.¹¹⁵ It is crucial to document, celebrate, and build upon those struggles and to frame them as struggles for livelihood *and* health.

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Settler-colonial infrastructures and environmental policies have a central role in changing the landscapes and waterscapes in Palestine to make them fit the settlers' vision and imaginary. They are tools to tighten Israeli's grip on the land and in so doing, distort the Palestinians' connection to land, nutrition, lifestyle, and thus their very health. A panoply of tightly woven arguments is deployed to explain the gap or health disparities between Israelis and Palestinians that use depoliticized terms such as socioeconomic status, culture, and behavior while ignoring the larger political context of settler colonialism and minoritization that have produced the entire statistical category of the "Arab minority" or "non-Jew" in Israel and its worst health outcomes. A historically rooted and nuanced reading is needed in order to decolonize knowledge production regarding the health of Palestinians and its relation to settler-colonial processes and

infrastructures. Interventions aiming to promote “minority health” using the tropes of development and closing the gap should center reparations and justice-based approaches and focus on changing the living conditions of Palestinians rather than blaming them and their lifestyle for their worst health outcomes. This article is an invitation to reflect on the entire concept of “minority health” in a variety of settings—among migrants, refugees, Indigenous, and previously enslaved populations. It is also a call for a larger conversation about how such communities became minorities in the first place, how that reality continues to affect their health, and the similarities, differences, and ways forward in health research and interventions.

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