

Beyond “causes of causes”: Health, stigma and the settler colonial urban territory in the Negev\Naqab

Abstract

This article critically analyses and theoretically conceptualises the links between settler colonialism, planning and health. Based on the case of the Bedouin community in the Negev\Naqab, we argue that the production of settler colonial space has a profound impact on health, and should therefore be referred to as a specific category for analysing health disparities, simultaneously entangling territorial control and biopolitics towards indigenous communities. Furthermore, we suggest that this relationship between space and health constructs stigma that justifies and facilitates – in turn – the ongoing territorial control over the indigenous Bedouin population in Israel. By reviewing existing data on health and planning, especially in relation to infrastructure and access to services, we contribute to the growing literature on the nexus of settler-colonialism\health with urban and regional planning. Importantly, throughout this paper we refer to the Bedouin localities as part of the production of urban territory, illuminating the urban as a multidimensional process of political struggle, including the metropolin informal fringes.

Keywords

Health, informality, infrastructure, politics

Introduction

In 2005 a petition was filed to the Israeli Supreme Court of Justice on behalf of Ennas Al-Atrash by the Association for Civil Rights in Israel and the Physicians for Human Rights. Ennas was a three-year-old child living in an unrecognised Bedouin village who was diagnosed with aggressive Rhabdomyosarcoma cancer in her chest. Following sessions of chemotherapy and surgery for the partial removal of the tumour, Ennas needed constant antibiotic treatment and injections to strengthen her immune system; medication that must be stored at temperatures of 0-4° Celsius. A hygienic, air-conditioned environment was also essential for her recovery, especially during the hot summer days.¹ The appeal to the Supreme Court was filed against the Minister of Health, the Minister of National Infrastructure, and the Minister of Interior Affairs. It demanded that the child's home be connected to the electricity distribution network in order to allow her proper healthcare. The petitioners emphasised that the state, in refusing to provide the girl's home with an electricity supply, had violated its commitment to protect children and to place the welfare of the child above bureaucratic, land and ideological considerations.

The Supreme Court rejected the appeal, and accepted the state's proposal to provide the child's family with 16,000 NIS (3,500 GBP) in order to purchase fuel for a generator owned by their neighbours, which the family had been using. Although the judges stated that this solution was far from adequate, they did not obligate the state to connect the home to the electricity network, claiming that the child's parents had chosen to live in an unrecognised village "knowing that they would therefore not be able to connect to basic infrastructures".²

¹ For further details about this case see: <https://www.acri.org.il/he/1162>.

² Petition to the High Court no. 862\05, Ennas Al-Atrash et al. vs. the Minister of Health et al., Verdict.

However, in their decision the judges did not ignore the claims of the petitioners, that the child's right to life overpowers planning and bureaucratic considerations, and declared their "hope and prayer that [Ennas] will fully recover".³ The court recommended that the family move from their home in an unrecognised village to a formally planned township in which houses and proper infrastructure are provided. Ennas and her parents were therefore left to face her illness and treatment on their own.

The above case illustrates the entanglement of orientalist stigmatization and spatial control that characterizes Israel's attitude towards the Bedouins; constructing the image of the Bedouins as irrational invaders who chose to live in unrecognised, un-serviced space. Such linkage between illegality and backwardness is central in stigmatising the Bedouins, exemplified in Moshe Dayan's (former Chief of the General Staff in the IDF, then the Minister of Agriculture) famous quote from 1963:

The Bedouins should be made into urban workers [...]. It is indeed an acute transition. It means that the Bedouin will not live on his lands with his herds but become a city man that comes home in the afternoon and wears slippers. *His children will get used to a father that wears trousers, without a Shabriyah, and does not remove lice in public. They will go to school combed with parted hair.* It will be a revolution, but it can be fixed within two generations. Not by force but with governmental guidance this reality named Bedouins – will be gone. (in Abu-Saad, 2004. Emphasis added)

³Ibid.

Though the case of Ennas Al-Atrash is not unique, and other instances show similar characteristics (Filc, 2009: Chapter 3), it is used here as an illustration of our main argument, namely that the production of settler colonial space has a profound impact on health and should therefore be referred to as a specific category for analysing health disparities, simultaneously combining territorial control and biopolitics towards indigenous communities (Wolfe, 2006; Shalhoub-Kevorkian, 2014). Furthermore, we argue that this relationship between space and health constructs stigma that justifies and facilitates – in turn – the ongoing territorial control over the indigenous Bedouin population in Israel.⁴

In this paper we therefore illustrate the profound impact the production of settler colonial urban territory has on populations' health using the case study of the Bedouins in the Negev (in Hebrew)\Naqab (in Arabic) in Israel. Based on empirical data sources produced mainly by human rights organizations, we critically discuss this case study with regard to the settler colonial spatial logic as well as the stigmatisation of the settler colonial indigenous subject. Considering that space is a social product which produces and reproduces power relations and inequality (Lefebvre, 1991), the fact that premature death, diseases and suffering are disproportionately concentrated within poor communities and minorities located in specific locations stresses the necessity to consider space when discussing health.

Urban theorists have been well aware of the impact of space on social relations. A critical body of literature doubts the myth that planning and urban development are rational and objective professional activities that generate social equity. Rather, this literature points to the oppressive power of planning which is used as a tool for social control, and proposes that

⁴ Following the work of Nasasra (2017) we refer to the Bedouins in the Naqab as indigenous people.

urban space reflects and often reproduces power relations (Yiftachel, 1998; Sandercock, 1998). Various studies have highlighted the influence of planning over urban governance, deliberative practices (Forester, 1999), the mobilization of social movements (Castells, 1983), economic and social stratification (Harvey, 1996), and access to urban services such as public housing and employment. Nevertheless, very little has been written specifically about the effects of the organisation of space, especially in the urban context, upon health. Jason Corburn's work is one of the few that discuss the links between health and planning, by posing questions such as: how can planning return to its health and social justice roots? What are the connections between planning and health equity? What new political processes can help reconnect planning and public health, with a focus on addressing the social determinants of health (Corburn, 2009: 1)?

However, these questions assume the existence of a common liberal social contract and ideological context, overlooking structural-political mechanisms of colonial domination (Roy, 2006; Salamanca, 2016) and view planning and the urban as detached from their origins in the global centres of power (Watson, 2009). Indeed, the links between planning, health and control are inherent to the history of colonial cities. Providing measures to secure and improve public health, particularly among the lower classes of society, has been one of the main missions of urban planning from its initiation (King, 1990; Sandercock, 1998). The perception that unplanned and informal urban spaces equal illness and filth (and hence should be demolished and their inhabitants evicted) are deeply rooted in the practical and bureaucratic logic that guides planning (Njoh, 2009).

With the above in mind, let us mention the work of several scholars who have noted the links between settler colonialism and health. Richmond et al. (2005), for instance, identified

a number of processes through which the people of the Namgis First Nation in Canada have experienced decreased access to and control over environmental resources within their traditional territory, which had a detrimental impact on community health and well-being. In research that focused on the indigenous people in Winnipeg, Canada, Snyder and Wilson (2015) demonstrated how mobility is an intergenerational phenomenon, influenced by colonial practices. They concluded that although migrations of indigenous communities can contribute to positive health experiences, in many cases residential mobility, which is largely involuntary and linked to stressors such as neighbourhood safety, results in negative health effects. Hudson-Rodd (1998) shows how controlling the places of First Nations affects the health and healing practices of indigenous people, while Patrick (2011) points to the way in which technocratic approaches to “fix” water quality problems have resulted in only limited success among First Nations in Canada. Smit et al. (2015) examine how economic, social and political forces affect non-communicable diseases (NCDs) in Khayelitsha, a low-income area of Cape Town, South Africa, by shaping the built environment. They show two main pathways through which the built environment impacts NCDs: by forming a complex food environment in which it is difficult to achieve food security, and by creating an environment that is not conducive to safe physical activity and that generates high levels of depression and stress.

While focussing on health, the above scholars implicitly – we suggest - highlight the spatial factors that characterise settler colonial geographies which are the subject of slow violence and echo Nixon’s notion of “unimagined communities”, those who are “internal to the space of the nation state...[and] whose ‘vigorously unimagined condition becomes indispensable to maintaining a highly selective discourse of national development” (Nixon,

2011:151). Accordingly, isolation, segregation, limited mobility, control and exploitation of environmental resources mentioned above, affect indigenous people health and wellbeing.

In this paper we aim to take this insight as a vehicle for developing our argument, and to contribute to this evolving conversation by explicitly interweaving the nexus of settler-colonialism\health in urban territories in general and in the case of the Bedouins in Israel in particular. The significance of our attempt, which is too often neglected from the literature, was recently highlighted by Danya M. Qato who claims that settler colonialism is not a social or political determinant of health. Rather, she argues:

[...] settler colonialism precedes and is fundamental to all other determinants of health—be they clinical, economic, social, or political. 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. (Qato, 2020: 9)

Throughout this paper we refer to the Bedouin localities as part of the production of urban territory. Such a reference is not reflected in the literature, which tends to focus on unrecognised localities as a non-urban phenomenon (Meir and Karplus, 2017). It was Cedric Parizot, a French anthropologist, who suggested “another approach to the Negev Bedouins in the Israeli-Palestinian space”, linking their economy, social ties, employment, political activity and personal connections to the wider territory that includes the urban centres, including Beer Sheva (Parizot, 2001). Indeed, our approach to refer to it as part of the urban process stems from growing urban studies literature suggesting that we combine the “non-urban” with the study of the urban itself (Walker and Leitner, 2011). Though it is not within

the scope of this paper to discuss in detail this emerging discussion, let us mention Brenner and Schmid who call for reconceptualising the urban as “... an essential epistemological and political pre-condition for understanding the nature of society itself” (Brenner and Schmid, 2015: 6). They further suggest that there is a necessity to illuminate the urban as a multi-layered process of social, spatial and economic transformation (ibid: 16). In order to understand urbanization as such, urban theory must widen its spatial scope and pursue an “urban theory with an outside” (Jazeel, 2018; see also Goonewardena, 2012; Roy, 2009).

Extended urbanization involves, first, the operationalization of places, territories and landscapes, often located far beyond the dense population centres, to support the everyday activities and socioeconomic dynamics of urban life. The production of such operational landscapes results from the most basic socio-metabolic imperatives associated with urban growth—the procurement and circulation of food, water, energy and construction materials; the processing and management of waste and pollution; and the mobilization of labour-power in support of these various processes of extraction, production, circulation and management. (Brenner and Schmid, 2015: 18).

We join the above by discussing the Bedouin localities not as spatial configurations but rather as vibrant, relationally developing entities which configure and re-configure the urban territories and communities residing in them (Massey, 2005). They struggle for access to urban services and goods (such as health), and for the power to re-produce them (Harvey, 2012). Our case falls into this category not solely from a spatial perspective but also from

economic, cultural and social angles, as well as by virtue of the use of services by the Bedouin community (including health and welfare, for example, on the metropolitan scale). The stigmatization of the Bedouins as invaders at the frontier of the metropole as well as their forced urbanization further emphasizes the relevance of the urban context to the study of the Bedouin localities.

In the next section of the paper we will focus on settler colonialism in Israel and its specific impact on the Bedouin population. We will then review existing research and data that exposes the crucial effect of spatial organization on the health of the Bedouin population. In the final part of the paper we contextualize the empirical evidence regarding the health-space nexus in the political context of settler colonialism. We examine the ways health inequalities are spatially produced, and are in turn mobilized to stigmatize indigenous communities as part of the settler colonial spatial project of dispossession and displacement.

Settler colonialism and the Bedouins in Israel

Settler colonial society is based on a project of settling newcomers on contested “frontiers” in order to achieve political control as well as to access key resources (Stasiulis and Yuval-Davis, 1995). It is based on the desire to create a new society through the cultivation of what is considered as *terra nullius*, a land under no formal ownership, awaiting to be seized and used by the modern, advanced nations of the world, displacing its native communities.⁵ Settler societies may be “external” or “internal”; the former relates to the organised movement of

⁵ In the scope of this paper we will not be able to further discuss the settler colonial paradigm and its distinction from other forms of colonialism. For a detailed discussion see: Veracini, 2010; Wolfe, 2006. Also, for the discussion on health, sanitation and colonial urban spaces see: Fanon, 1963; Mitchell, 1998.

people across borders, often into other continents, as in the period of European colonialism. The latter refers to the planned ethnicization of “internal frontiers” in which the state manipulates the local geography to further the interests of a dominant group (Yiftachel, 2006; Plonski, 2018; Falah, 2003). Both processes produce uneven patterns of ethnic, race and class segregation, as exemplified in the case of the Negev\Naqab region in Israel.⁶

Several researchers have identified Israel with the settler society model (Shafir, 1989; Yiftachel, 2006; Shalhoub-Kevorkian, 2016). In such societies, some broad “ethno-class” categories tend to form over time: the “founders,” the “immigrants,” the “locals” and most recently, the “foreigners” (Stasiulis and Yuval-Davis, 1995). These ethno-classes are created by geographical processes of expansion and settlement, and by the associated flows of resources and development which are determined by, and hence reflect, power relations between groups. This creates structural economic and political stratification, in which ethnic origin and class affiliation largely overlap. The founding group gains a dominant status during the critical formative period of the new state. In Israel, this group is mainly composed of Ashkenazi Jews, the “founders” of Zionism and the state. The second group is comprised of various non-Ashkenazi “immigrants,” most notably the Mizrahi ethno-class, and recently also Jews from the former Soviet Union and Ethiopian Jews, who have joined the “founders” in their national project of settlement, albeit from an inferior economic and cultural position (Yacobi, 2011). The third local group are Palestinian-Arabs (including the Bedouin

⁶ The literature on Israel’s society and space, including the critical, is often ignoring the discussion of race and racialization within the settler colonial context. In the case of this article we will not be able to develop this discussion, for a detailed investigation of this topic see: Shenhav and Yona, 2008; Wolfe, 2016: Chapters 6-7.

indigenous population)⁷who resided on the land for generations prior to the arrival of most settlers (Falah, 2003). They are largely excluded from the process of constructing the new nation and are trapped within their inferior ethno-class status. The Bedouin population is further weakened in this settler-colonial hierarchy, based on the refusal to recognize their land rights and the “unrecognized” status of their localities, as will be further detailed in this paper.

The Negev/Naqab is the southern region of Israel, where a large Bedouin population – estimated between 65,000 and 90,000 people – lived before 1948. During the war in 1948, large parts of this population were deported from the area or fled to Jordan, Gaza and the West Bank (Abu-Saad, 2004). Today, the remaining Bedouin population currently numbers around 270,000 who live in three types of localities: (i) governmental planned townships, (ii) recognised villages, and(iii) unrecognised villages. There are forty-six Bedouin localities of which thirty-five are unrecognised by the authorities, and the population living in them is estimated at 65,000 people (Rotem, 2017).

Most of the Bedouin localities were established before 1948 as part of the sedentarization process of nomadic communities under British rule (Falah, 1985; Nasasra et al., 2015). Some villages were also established during the 1950s by Bedouin clans. These were transferred from other parts of the Negev/Naqab into a restricted zone in its north. In the newly created land registration and planning system in Israel, these Bedouin localities were not taken into account (Yiftachel, 2009; Plonski, 2018). The property registration system according to which the Bedouin population operates was not recognised by Israeli

⁷ There is an extensive legal, political and academic debate on whether the Bedouins are indigenous. See: Nasasra, 2012; Nasasra, 2017; Kedar et. al, 2018.

law and hence the Bedouin localities "...which bear the literal designation of nonrecognition, provide a near-transparent instance of the perilous effects of the state's refusal to recognize the legal and historically based rights of the Bedouin to their land" (Bhandar, 2011: 115). Despite being formal citizens, they were defined as invaders who hindered the development and planning of the region (Nasasra et al., 2015; Nasasra, 2017), and as noted by Plonski, several decades of settler colonialism created a situation through which "Israeli-Jewish settlers were turned into indigenous land-owners, and indigenous Bedouin-Palestinian communities were turned into infiltrators and trespassers" (Plonski, 2018: 1349).

The Bedouins reacted to land expropriation and to their living conditions by rapid informal construction, which was defined by the authorities as illegal. These unrecognised villages received no basic infrastructure, nor services. The Israeli authorities view the expansion of informal Bedouin localities as a threat to state control over land, and therefore regularly demolish these illegal shelters (Yiftachel, 2009; Fenster, 1993; Falah, 2013; Kedar et al., 2018). Since the mid-1960s, the Israeli government has followed a plan for re-settling the Bedouins in towns in the Negev/Naqab, where housing, infrastructure, education and health services have been partly supplied (Yacobi, 2004). In order to be eligible for subsidized plots of state-land in the new Bedouin towns, families that moved into them had to withdraw any claim on their unregistered land or informal houses.

The planned towns partially materialized the state's aspirations to forcefully urbanize the Bedouin population. Their construction was countered by opposition as they did not fit with the traditional way of life (Fenster, 1996). The infrastructure provided in these townships is inadequate, and their residents suffer poverty and social immobility. A large

population therefore remained in the unrecognised villages which also lack infrastructures such as transportation, electricity, running water, schools, welfare and health services (Rotem, 2017; Filc, 2009).

INSERT MAP 1

In 2008 a public committee headed by retired Supreme Court Judge, Eliezer Goldberg, was set up in order to find possible solutions for the regulation of Bedouin localities. This committee aimed to end six decades of land disputes. The Goldberg Committee's recommendations included the formation of a legal and planning apparatus that would allow partial recognition of Bedouin land ownership. Planning the Bedouin's re-settlement, according to the committee, should take into consideration traditional housing and land use (Goldberg Committee, 2008). The Committee's recommendations were partially implemented to solve the land dispute, which was named after its formulators: MK Beni Begin and Ehud Praver, Head of the Department of Policy Planning in the Prime Minister's Office. This plan integrated the Bedouin localities into TMM 23/14/4, the master plan for the Be'er-Sheva metropolin.

However, the plan included some discriminatory restrictions on the Bedouins which were not applied to the Jewish settlements in the same area. For example, the Begin/Praver Layout did not recognise some Bedouin villages, claiming that they were too small to be acknowledged as localities. At the same time, small Jewish settlements were included in the plan and recognised institutionally. The Begin/Praver Layout and a law for its implementation were submitted for the approval of the Knesset in 2013. Fierce resistance

from both sides of the political divide, caused by the discriminating restrictions for the left, and by the partial recognition of the Bedouins' land claims for the right, led to the termination of the discussion and, in fact, to the shelving of the Layout and the proposed law.⁸

Health inequalities and spatial (non-)planning

In this section we present the findings of studies revealing the relationship between land, (non-)planning, infrastructure and the deteriorated health of the Bedouin population. Despite the recognition of some Bedouin villages and the urbanization which was accompanied by the supply of infrastructure and services, health disparities between the Bedouins and the general Israeli population still exist (Filc, 2009). A telling illustration lies in the difference in life expectancy between the Arab and Jewish populations in Israel. The most recent report by the Central Bureau of Statistics (2019) indicates that the life expectancy of Jewish women is 84.6 and 81.2 for Jewish men, while in the Arab population this number is 81.2 for women and 77.2 for men.⁹ Since in Israeli statistics the Bedouins are included in the general Arab population, no exact numbers can be found regarding this specific population. However, their life expectancy is significantly lower even in relation to other Arab communities (Alpasi-Henly 2016). The statistics regarding the different regions in Israel support this claim, with the southern region of Israel (including the Negev\Naqab) having the lowest life expectancy in Israel (Koch Davidovich, 2020: 5).

⁸ In the scope of this paper we will not be able to detail the Prawer\Goldberg Plan. For a detailed discussion see: Kedar et al., 2018; Nasasra 2017.

⁹The Central Bureau of Statistics, publication no. 1763 retrieved from: https://www.cbs.gov.il/he/publications/DocLib/2019/1763/h_print.pdf

We will explore the space-health nexus that emerges from these studies, highlighting the role of infrastructure, environmental (in)justice and health care provision and their effect on everyday life and health. Our main argument here is that the right to land – and hence recognition and the provision of urban infrastructure – is the condition for the right to health, and that inaccessibility to water, electricity, or proximity to environmental hazards, are not neutral facts but rather the results of policy and planning (Yacobi, 2019).

Infrastructure

As widely discussed, infrastructure connects people and goods and is also a focal element through which we can understand the formation of the political (Annand et al., 2018). However, infrastructure also has a violent side (Rodgers and O'Neill, 2012), restricting access to essential resources and services to the marginalized. The latter, in our case, is based on the state's "Dead Negev Doctrine," i.e. the use of Western and colonial land claims by the state to dispossess the Bedouins (Kedar et al, 2018) and justifies the state's withdrawal from any responsibility of providing services. A telling illustration is reflected in the inaccessibility of clean water and electricity that has a critical influence on the Bedouin population's health. According to a UN Resolution from 2010, "equitable access to safe and clean drinking water and sanitation" are "an integral component of the realization of all human rights". The UN therefore "recognises the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights" (United Nations, 2010).

Water infrastructure is not provided to the unrecognised villages, which consequently suffer severe water shortages for drinking, cooking and hygiene purposes. A special

committee of the Israeli Water Authority is responsible for approving such connections due to “humanitarian considerations”. Between 1997 and 2010 only 106 out of 675 submitted requests were approved (Bas Spektor, 2011). The committee usually argues that these connections weaken water pressure in the pipeline, or that such connections will make it more difficult to evict inhabitants from the unrecognised villages. Importantly, as of 2015, nine villages were still not connected to any water system (Rotem, 2015: 5).

Water supply is also provided by “water centres”, as the one presented in Figures 1 and 2, that consist of central pipes to which families can connect a water meter and a secondary pipe. Water centres operate in the recognised villages of the Abu Basma Regional Council.¹⁰

INSERT FIGURE 1

INSERT FIGURE 2

In 2010, a request was submitted to the Parliamentary Finance Committee to order the establishment of ten more such water centres in the Abu Basma localities, stating that water centres will constitute “an efficient temporary solution for more than 90% of the unrecognised villages’ residents” (Physicians for Human Rights, 2010). A common way of transporting water is via plastic or metal tanks, filled outside the village and delivered to houses by trucks. Other than the problems caused by the high price of water and its

¹⁰Abu Basma Regional Council was a regional Council in 2003-2012 covering several Bedouin villages in the north-western Negev\Naqab region. Following the Minister of Interior’s decision on November 5, 2012 it was split into two newly created bodies.

transportation, these tanks are kept outside, exposed to the sun, and tend to develop mould, rust, algae and other infections that cause gastrointestinal diseases.

As mentioned at the opening, electricity is not provided to Bedouin localities (both recognised and unrecognised). Some residents use generators, which operate between 1-4 hours a day, or solar systems that provide low outputs. Both alternatives are expensive and are therefore rare. Lack of electricity is particularly detrimental to the health of chronic patients, who receive regular medications but are unable to store them in proper conditions. A survey (Abas and Alon, 2008) found that 21 percent of the Bedouin population had chronic diseases, out of which 58 percent were children. The most common diseases were respiratory, diabetes, heart diseases and mental disorders. Electricity is essential for the treatment of respiratory diseases: electric oxygen generators are cheap and efficient replacements for expensive oxygen tanks. BIPAP machines, which regulate air pressure in patients' lungs, do not have a non-electric alternative and their absence causes frequent hospitalizations, deterioration in health, and death.

State unrecognition of land ownership means a lack of services such as the collection of waste and sewage disposal facilities, such as presented in Figure 3, which pose severe risks to the Bedouin's health.

INSERT FIGURE 3

Improvised septic pits used in unrecognised villages attract pests, constitute a smell hazard, and cause the seepage of sewage into water sources. The estimated amount of waste produced in the Bedouin localities (as opposed to the assumptions of the Strategic National

Plan) is an average of 0.73 kg per person per day: less than half the average in Israel. In spite of this relatively small amount of waste, improvised solutions for its disposal, such as burning, cause both air pollution and intense smell hazards. House demolitions also constitute an environmental risk linked to waste disposal, since the debris is never cleared from such sites (Abu-Ras, 2011).

Environmental (in)justice

Analyses of the influence of environmental conditions on the Bedouins' lives reveal the devastating effects of environmental injustice on the community's health and life. The lack of recognition of the villages plays a major role in their increased exposure to environmental hazards and their effect on health.

A factor in the Bedouin population's degraded health is living in desert conditions with no infrastructure, thus exposing the people to extreme temperatures, sandstorms and poisonous animals. These conditions are worsened in many localities by their proximity to industrial plants and chemical waste disposal areas, to quarries and phosphate mining areas, and to army training zones.

Lack of recognition "means the failure to consider the location of these populations in the planning process of industrial and military infrastructures" (Bas Spektor, 2011: 16). The industrial plant (IP) Ramat Hovav, for example, includes about twenty chemical industry facilities. The minimal safety radius around such a plant should be five kilometres, while the unrecognised village of Wadi al-Na'am is located only one kilometre away. According to epidemiological researches, Bedouin populations residing up to 20km away

from the IP suffer from increased mortality rates due to symptoms/ill-defined conditions and non-external causes (Karakis et al., 2008; Sarov et. al, 2008).

INSERT FIGURE 4

A study by The Ministry of Health (2011) indicates that living up to 20km from Ramat Hovav is related to significantly higher rates of Bedouin infants suffering from congenital malformations and severe defects in their nervous, heart and skeletal systems. These may cause mental retardation, disability, miscarriage, and the death of the infants. Neighbours of Ramat Hovav also suffer from significantly higher rates of respiratory diseases such as asthma and pneumonia. These findings include both adults and children, and are characteristic of Bedouin communities as well as Jewish Kibbutzim in the region. Another hazard that is expected to pose severe potential health risks to the residents of Bedouin localities is the planned phosphates mining site in Sde-Barir, to which several objections were submitted. Professional reviews demonstrate that the mining of phosphates at such proximity to villages will expose the population to respirable particles containing radioactive materials, causing respiratory illnesses and lung cancer (Spector Ben-Ari, 2013). The plan for Sde-Barir will clearly have detrimental effects on the health of the adjacent Bedouin communities such as Al-Furaa', where the school is located only 1.5 km away.

Our discussion above echoes Nixon's notion of "unimagined communities" presented at the opening of this paper and exemplifies how the toxic and polluted environment, which is actually an outcome of the state's policy, not only risks the health of the Bedouins, but also

excludes them from resources such as land that previously offered them livelihood and health.

Health services

Non-recognition also has a major effect on the accessibility of health services. In accordance with the Israeli National Health Insurance Law, most of the Bedouin population is insured in one of the Health Funds operating in Israel (Filc, 2009). The first clinic was established in 1994 in the unrecognised village of Al-Grien. Most other clinics were established following petitions to the Supreme Court by a coalition of human rights NGOs. By 2011 there were twelve clinics in such villages. According to some reports (Abas, 2009, Davidovich, 2020), the clinics operate in temporary structures such as caravans. Though they are connected to water infrastructure and have adequate sanitation, electricity is not regularly supplied, and it is impossible to keep equipment and medication that requires cooling (Davidovich, 2020).

INSERT FIGURE 5

The doctor-population ratio in Israel is one doctor to every 1,200-1,400 people, whereas in the Bedouin localities this ratio is one doctor to every 3,116.7 people. According to the 2009 survey, clinics operate 13 weekly hours to every 1000 people, while clinics in neighbouring Jewish localities operate 21 weekly hours. The doctors working in the clinics in the Bedouin villages are general practitioners; there are no specialists such as gynaecologists or paediatricians. Research conducted in 2008 found that “Bedouin children arrive to the emergency room in critical stages of the disease, due to late diagnosis resulting from the lack

of medical services” (Abu-Sharab, 2008: 8). Furthermore, the lack of pharmacies in the localities limits the medicine inventory available.

The lack of convenient transport infrastructure further affects accessibility to health services. For example, residents of Tal al-Malah, where there is no clinic, use the clinic in Kseifa, located 15-18km from their houses. The average arrival time using public transport is 2.5 hours in each direction. Transportation problems also affect the arrival of the staff to the clinics, causing “late arrivals and early departures of some of the staff, thus shortening the clinic's official reception hours” (Abas, 2009: 15).

The health crisis in the Bedouin population most prominently affects two vulnerable groups: children and women. For example, mother-child health stations providing antenatal care are essential in a community with high birth rates such as the Bedouin community. However, only after a petition was filed to the Supreme Court (High Court Appeal 7115/97), six stations were established in the villages in 2001. In 2015, there were still only six active stations in the localities. A portable station, which had travelled between the villages, had stopped operating (Rotem, 2015: 11) and the active stations had similar problems to the other clinics. The lack of specific health services for women such as gynaecologists and antenatal care in their communities (given that, as mentioned by Gottlieb et al.[2011], women are dependent on male chaperoning to go outside of their communities), has indeed a critical effects on women’s health.

The Physicians of Space: Promoting Stigmatization and Dispossession

In an attempt to regulate the Bedouin localities, seven townships were built by the state during the 1970s and 1980s: Tal Sheva (Tal al-Saba’, established in 1968), Rahat (1972),

Segev Shalom (Shqeib al-Salam, 1979), Kseife (1982), Ar'ara BaNegev ('Ara'ra al-Naqab, 1982), Lakiya (1985) and Hura (1989). The state's formal narrative for moving the Bedouins to these townships was access to services and infrastructure, which the unrecognised localities lacked. In critically examining the findings reviewed in the previous section, we conclude that the lack of infrastructure, the intensive exposure to environmental hazards and the lack of accessibility to health services are therefore not the result of negligence or a "blind spot" in the planning of the region. They are inherent to the mobilization of spatial planning to the settler colonial production of space and the effort to dispossess the Bedouins and push them into the designated, limited area of the new townships.

The systematic violation of the Bedouins' right to health, we conclude, has to be understood not solely as public health concerns. They should be contextualized within the settler colonial planning and urban framework, which is the very ideological and legal basis for the production of informal urban territories. In their analysis of inequalities in non-communicable diseases between population groups in Israel, Muhsen et al. (2017) conclude that despite universal health coverage and improvements in the overall health of the Israeli population, substantial inequalities persist. This fact, they suggest, might be explained by gaps in the social determinants of health (SDoH)- namely people's "access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities" (CSDH, 2008: 1). The SDoH are defined by the World Health Organization (WHO) as "the causes of causes" of health inequality. Reducing health inequalities by improving SDoH is possible, according to the WHO, by tackling "Inequitable distribution of power, money, and resources" (ibid: 2). To this end, it is necessary to have "a strong public sector that is committed, capable, and adequately financed. [...] legitimacy, space, and

support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action” (ibid).

SDoH as an explanatory framework for health inequalities and the active approach for their amelioration are therefore defined and understood in the context of liberal socio-political conditions. Applying this approach in analysing health disparities in Israel, specifically in regards to the Bedouin population, fail to consider the very political context in which they are produced. Settler colonialism is about the erasure and replacement of indigenous communities based on the devaluation of their claimed rights to the land (Milner, 2020). Providing solutions for the Bedouin health crisis in the spirit of the WHO’s understanding of SDoH stands, hence, in stark contradiction to the political logic of this project.

Rather than SDoH as the “causes of causes” of health inequalities in the Negev\Naqab, we therefore conclude that the settler colonial logic and ideology is the main cause. Access to water, electricity and services, or proximity to environmental hazards, are not neutral facts but rather the results of intentional policy. As illustrated throughout this article, since health determinants are spatial, the colonial project of appropriating, controlling and ordering space is crucial to understanding the institutional foundations that produce health disparities:

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. (Qato, 2020: 10).

Furthermore, planners, policymakers and similar "physicians of space" (Lefebvre, 1996: 99) play a major role in defining these policies, and therefore in the settler colonial project as the "cause of causes" of health inequalities. Under the guise of professional, benevolent neutrality, planners use their authority and expertise to promote the goals of the settlers (Njoh, 2009: 4), clearly exposing the oppressive side of planning.

The systematic production of health inequalities, we further suggest, shape the stigma of Bedouins as invaders and criminals who threaten not only urban residents but also the well-being of the environments in which they live. Israel's Strategic National Plan frames the Bedouin population as an "environmental hazard", devoting a distinct section to the negative effect of the Bedouins on the environment that results not solely from "over-usage" of resources and the increased production of waste (Abu-Ras, 2011) but also as an outcome of natural growth (The National Development Strategic Plan for the Negev, 2005: 9-10). The health inequality created in the Bedouin community, we suggest, is part and parcel of the work of settler colonialism, aspiring to dispossess the Bedouins and to forcefully relocate them into townships, where conditions are not necessarily better. Producing health inequalities facilitates the stigmatisation of the Bedouins as backward and unhealthy, a community that should be contained in designated areas where it can be forced into modernization and urbanization. This stigma is then mobilized for justifying the dispossession of the Bedouins through forced urbanization and an attempt to transfer them into the planned townships.

Going back to the case of Ennas Al-Atrash, the suggested solution for the family was indeed moving to the planned town, which involved the withdrawal of their claim to their

land in the unrecognised village. The family's refusal of this solution allows for further justifications of the policy of forced urbanization, backed by a stigmatising rhetoric of backwardness and child neglect. The stigmatisation of the Bedouins as unclean and unhealthy is interwoven into the image of them as the racialised invader and criminal, that was historically constructed already with the establishment of Israeli state in 1948. Unauthorized housing construction results from the very basic need to supply shelter and protect land rights. Yet this phenomenon significantly contributes to the criminalization of the Bedouins. It is an image that has been transformed into a 'social problem' and attached to the discourse of "illegality" that "endangers" the Be'er-Sheva metropolin.¹¹

The above is also expressed in the words of Israeli Prime Minister Benjamin Netanyahu, who commented in a government meeting about the "demographic threat" of losing the Jewish majority in the Negev\Naqab region. His argument, which followed the demolition of houses in one of the Bedouin's unrecognised villages, exposes the logic behind the production of a settler colonial space, saying that "...different elements will demand national rights within Israel, for example, in the Negev, if we allow for a region without a Jewish majority".¹² Violence, destruction and erasure of landscapes and communities contributes to state narratives of contamination which are not detached from biopolitics over the colonized subjects, and this, in turn, affects health (Baldwin and Rawstrone, 2019). Stigma, as we have shown, functions indeed "as a means of formal social control" (Goffman in Tyler and Slater, 2018: 729).

¹¹In the scope of this article we will not be able to discuss how the Bedouin property and settlement formation still operates and hence creates a form of resistance to the settler colonial state. For a detailed discussion see: Kedar et. al, 2018; Nasasra, 2012.

¹² <https://www.hrw.org/news/2010/08/01/israel-halt-demolitions-bedouin-homes-negev>

In conclusion, spatial changes initiated by the state and resulting from planning (such as those created in the planned townships), or from legal processes (such as the recognition of informal villages) are not sufficient to reach health equity. A profound political and institutional change is requested in order to improve the health of disadvantaged urban dwellers and to "... move urban politics toward planning more healthy and equitable cities" (Corburn, 2009: 2). Rather than assuming liberal political conditions in which formal spaces are serviced and informal spaces are not part of the spatio-political system, we follow Roy (2009) who suggested that informal settlements cannot be viewed as external to the planning system and thus to health disparities. Within the settler colonial context, housing and infrastructure are marked by deep patterns of inequality and exclusion that minimize the control of minority members over resources and territory. This situation, in turn, dictates health disparities. Dealing with health should therefore go beyond physical, psychological and social determinants; rather, the political project of exclusion should be understood as the "cause of causes".

References

Abas W (2009) *Going by Duty: Health Services in the Unrecognised Villages in the Negev*.

Tel Aviv: Physicians for Human Rights.

Abas W and Alon L (2008) *Condemned to Darkness: The issue of electricity and chronic patients in the unrecognised villages in the Negev*. Tel Aviv: Physicians for Human Rights.

Abu-Ras T (2011) Environmental Injustice in Israel - The Case of the Unrecognised Villages in the Naqab. *Adalah Electronic Issue 87*

Abu-Saad, I (2004) Education as a Tool for Expulsion in the Unrecognised Villages. *Adalah Electronic Issue 8*

Abu-SaadK (2016) Indigenous data matter: spotlight on Negev Bedouin Arabs. *The Lancet* 388: 1983-1984

Abu-Sharab H (2008) *Israel's Stepchildren: On the lack of paediatric medicine in the unrecognised villages in the Negev and its implications*. Position paper of the 'Women Leading Health' group and Physicians for Human Rights. Tel Aviv: Physicians for Human Rights.

Al-Krenawi A and Graham JR (2006) A Comparative Study of Family Functioning, Health, and Mental Health Awareness and Utilization Among Female Bedouin-Arabs from Recognised and Unrecognised Villages in the Negev. *Health Care for Women International* 27(2): 182-196

Alpasi-HenlyM(2016) Bedouins with Disabilities in the South of Israel: Population size, characteristics and employment. The Ministry of Economy and Industry. Retrieved from: <http://economy.gov.il/Research/Documents/X13230.pdf> (accessed xxx)

Annand N (2018) A Public Matter: Water, Hydraulics, Biopolitics. In: Anand, N, Gupta A and Appel H (eds) *The Promise of Infrastructure*. Durham, NC: Duke University Press, pp.155-176

Baldwin C and Rawstone P (2019) Public understanding of risk in health impact assessment: a psychosocial approach. *Impact Assessment and Project Appraisal* 37(5): 382-396.

Bas Spektor S (2011) *Health and environmental issues in the unrecognised Bedouin villages in the Negev*. Report submitted to the Joint Committee of the Interior and Environmental Protection Committee and of the Labor, Welfare and Health Committee for Environment and Health. The Knesset: Center for Research and Information

Bhanda B(2018) *Colonial Lives of Property: Law, Land, and Racial Regimes of Ownership*
Durham, NC: Duke University Press.

Brenner N and Schmid C (2015) Towards a new epistemology of the urban? *City* 19(2-3):
151-182

Castells M (1983) *The City and the Grassroots: A Cross-Cultural Theory of Urban Social Movement*. London: Hodder Arnold.

Corburn J (2009) *Toward the Healthy City: People, Places, and the Politics of Urban Planning*. Cambridge, MA: The MIT Press.

CSDH (2008) *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organization.

Cwikel J, Lev-Wiesel R, Al Krenawi A (2003) The Physical and Psychosocial Health of Bedouin Arab Women of the Negev Area of Israel: The Impact of High Fertility and Pervasive Domestic Violence. *Violence Against Women* 9(2): 240-257

Falah G (1985) The Spatial Pattern of Bedouin Sedentarization in Israel. *GeoJournal* 11(4):
361-368

Falah G (2003). Dynamics and Patterns of the Shrinking of Arab Lands in Palestine. *Political Geography* 22(2):179-209

Fanon F (1963) *The Wretched of the Earth*. London: Penguin.

Fenster T (1996) Ethnicity and Citizen Identity in Planning and Development for Minority Groups. *Political Geography* 15(5): 405-418

Filc D (2009) *Circles of Exclusion: The Politics of Health Care in Israel*. Ithaca, NY: Cornell University Press.

Forester J (1999) *The Deliberative Practitioner: Encouraging Participatory Processes*. Cambridge, MA: MIT Press.

Foucault M (1997) *Discipline and punish: The birth of the prison*, New York: Pantheon Books

Goldberg Committee Report (2008). Available at:

http://www.moch.gov.il/SiteCollectionDocuments/odot/doch_goldberg/Doch_Vaad_a_Shofet_Goldberg.pdf (Hebrew) (accessed xxx)

Goonewardena K (2012). Space and Revolution in Theory and Practice: Eight Theses. In: Brenner N, Marcuse P and Mayer M (eds) *Cities for People, Not for Profit*. London and New York: Routledge, pp.86-101.

Gottlieb N (2008) *Ana Huna (I am Here): Women and the right to health in the unrecognised villages in the Negev*. Tel Aviv: Physicians for Human Rights.

Gottlieb N and Feder-Bubis P (2014) Dehomed: The impacts of house demolitions on the well-being of women from the unrecognised Bedouin-Arab villages in the Negev/Israel. *Health & Place* 29: 146–153.

Gottlieb N, Belmaker I, Bilenko N and Davidovitch N (2011) Bedouin-Arab women's access to antenatal care at the interface of physical and structural barriers: A pilot study. *Global Public Health* 6(6): 643-656.

Harvey D (1996) Social Justice, Postmodernism, and the City. In: Fainstein S and Campbell S (eds) *Readings in Urban Theory*. Cambridge, MA: Blackwell, pp.415-434.

Harvey D (2012) *Rebel Cities*. London: Verso.

Hudson-Rodd N (1998) Nineteenth century Canada: indigenous place of dis-ease. *Health & Place*. 4(1): 55-66.

Jazeel T (2018) Urban Theory With an Outside. *Environment and Planning D: Society and Space* 36(3): 405-419.

Karakis I, Bolotin A, Kordysh E, Belmaker I and Sarov B (2008) Mortality in the Bedouin population and proximity to a regional industrial complex. *Environmental Health Insights*, 1:21-29

Kedar A, Amara A and Yiftachel O (2018) *Emptied Lands: A Legal Geography of Bedouin Rights in the Negev*. Stanford, CA: Stanford University Press

King AD (1990) *Urbanism, Colonialism and the World Economy - Cultural and Spatial Foundations of the World Urban System*/ London and New York: Routledge.

Koch Davidovich, F (2020) *Family Health Services, Women's Health and Tipat Halav Stations in the Bedouin Localities in the Negev*. The Knesset: Center for Research and Information.

Lefebvre H (1991) *The Production of Space*. Oxford and Malden, MA: Blackwell.

Lefebvre H (1996) *Writings on Cities*. Oxford and Malden, MA: Blackwell

Massey D (2005) *For Space*. London: SAGE.

Meir A and Karplus Y (2017) Production of space, intercultural encounters and politics: Dynamics of consummate space and spatial intensity among the Israeli Bedouin. *Transactions of the Institute of British Geographers* 43(3): 1-14.

Milner EL (2020) Devaluation, erasure and replacement: Urban frontiers and the reproduction of settler colonial urbanism in Tel Aviv. *Environment and Planning D: Society and Space* 38(2): 267-286.

Mitchell T (1988) *Colonising Egypt*. Cambridge: Cambridge University Press.

Muhsen K, Green MS, Soskolne V and Yehuda N (2017) Inequalities in non-communicable diseases between the major population groups in Israel: achievements and challenges. *The Lancet* 389(10088): 2531-2541. [http://dx.doi.org/10.1016/S0140-6736\(17\)30574-3](http://dx.doi.org/10.1016/S0140-6736(17)30574-3).

Nasasra M (2017) *The Naqab Bedouins - A Century of Politics and Resistance*. New York, NY: Columbia University Press.

Nasasra M, Richter-Devroe S, Abu-Rabia-Queder S and Ratcliffe R (eds) (2015). *The Naqab Bedouin and Colonialism: New Perspectives*. London, Routledge.

Nasasra M (2012) The Ongoing Judaisation of the Naqab and the Struggle for Recognising the Indigenous Rights of the Arab Bedouin People. *Settler Colonial Studies* 2(1): 81-107.

Nixon R (2011) *Slow Violence and the Environmentalism of the Poor*. Cambridge, MA and London: Harvard University Press.

Njoh AJ (2009) Urban planning as a tool of power and social control in colonial Africa. *Planning Perspectives* 24(3): 301-317.

Parizot C (2001) Gaza, Beesheba, Dhahriyya: Another Approach to the Negev Bedouins in the Israeli-Palestinian Space. *Bulletin du Centre de recherche français à Jérusalem* 9: 98-110.

Patrick RJ (2011) Uneven access to safe drinking water for First Nations in Canada: Connecting health and place through source water protection *Health & Place* 17: 386–389

Physicians for Human Rights and the Regional Council for Unrecognised Villages in the Negev (2010) Position page: installing ‘water centers’ for the residents of unrecognised villages in the Negev.

Plonski S (2018). Material Footprints: The Struggle for Borders by Bedouin-Palestinians in Israel. *Antipode* 50(5): 1349-1375.

Porter L and Yiftachel O (2017) Urbanizing Settler Colonial Studies: introduction to the special issue. *Settler Colonial Studies* 9(2): 177-186.

Qato DM (2020) Introduction: Public Health and the Promise of Palestine. *Journal of Palestine studies* 49(4): 8-26.

Richmond C, Elliott SJ, Matthews R and Elliott B (2005) The political ecology of health: perceptions of environment, economy, health and well-being among ‘Namgis First Nation. *Health & Place* 11: 349–365 .

Rodgers D and O’Neill B (2012) Introduction: Infrastructural violence: Introduction to the special issue. *Ethnography* 13(4): 401-412.

Rotem M (2015) Community Under Attack: the Situation of Human Rights of the Bedouin Community in the Negev-Nagab 2015. Report, Negev Coexistence Forum for Civil Equality, 10 December.

Rotem M (2017) Discrimination in Numbers: Collection of Statistical Data - The Bedouin Community in the Negev/Naqab. Report, Negev Coexistence Forum for Civil Equality, January.

- Rotem M and Gordon N (2017) Bedouin Sumud and the Struggle for Education. *Journal of Palestine Studies* 46 (4): 7-27.
- Roy A (2006) Praxis in the Time of Empire. *Planning Theory* 5(1): 7-29.
- Roy A (2009) Why India Cannot Plan Its Cities: Informality, Insurgence and the Idiom of Urbanization. *Planning Theory* 8(1):76-87.
- Salamance JO (2016). Assembling the Fabric of Life: When Settler Colonialism Becomes Development. *Journal of Palestine Studies* 45(4): 64-80.
- Sandercock L (1998) *Towards Cosmopolis: Planning for multicultural cities*. Chichester: Wiley.
- Sarov B, Bentov Y, Kordysh E, Karakis I, Bolotin A, Hershkovitz R and Belmaker I (2008) Perinatal mortality and residential proximity to an industrial park. *Archives of Environmental & Occupational Health* 63(1): 17-25.
- Shafir G (1989) *Land, Labor and the Origins of the Israeli–Palestinian Conflict: 1882–1914*. Cambridge: Cambridge University Press
- Shalhoub-Kevorkian N (2014) Human suffering in colonial contexts: reflections from Palestine. *Settler Colonial Studies* 4(3): 277-290.
- Shalhoub-Kevorkian N (2016) The Biopolitics of Israeli Settler Colonialism: Palestinian Bedouin Children Theorise the Present. *Journal of Holy Land and Palestine Studies* 15(1): 7-29.
- Shenhav Y and Yona Y (2008) *Racism in Israel*. Jerusalem and TelAviv: Van Leer Institute and Hakibbutz Hameuchad (Hebrew)

Smit W, de Lannoy A, Dover RV, Lambert EV, Levitt N and Watson V (2015) Making unhealthy places: The built environment and non-communicable diseases in Khayelitsha, Cape Town. *Health & Place* 35: 11–18.

Snyder M and Wilson K (2015) “Too much moving...there's always a reason”: Understanding urban Aboriginal peoples' experiences of mobility and its impact on holistic health. *Health & Place* 34: 181–189 .

Spektor Ben-Ari S (2013) Phosphate Mining in Sde-Brir: The Knesset, Center for Research and Information.

Stasiulis D and Yuval-Davis N (1995) *Unsettling Settler Societies: Articulations of gender, race, ethnicity and class*. London: SAGE.

The Ministry of Health (2011) The link between air pollution and health - a review of the latest knowledge in Israel. Jerusalem: The Ministry of Health.

The Ministry of Health, the Health Bureau - Southern District and the National Center for Disease Control (2008) Health status of Bedouin infants and children up to age 6 in permanent settlements and in the unrecognised villages in the Negev. Jerusalem: The Ministry of Health

The National Development Strategic Plan for the Negev (2005). Available at: https://www.gov.il/BlobFolder/pmopolicy/2005_des4415/he/sitecollectiondocument_s_pmo_government_des_negev_appe_env.pdf (accessed xxx).

Tyler I and Slater T (2018). Rethinking the sociology of stigma. *The Sociological Review* 66(4): 721–743.

Tzfadia E and Yacobi H (2011) *Rethinking Israeli Space: Periphery and Identity*. London: Routledge.

United Nations General Assembly (2001) A/RES/64/292: Resolution adopted by the General Assembly on 28 July 2010: The Human Right to Water and Sanitation.

Veracini L (2010) *Settler Colonialism: A Theoretical Overview*. New York, NY: Palgrave Macmillan.

Walker KE and Leitner H (2011) The variegated landscape of local immigration policies in the United States. *Urban Geography* 32(2): 156-178.

Watson V (2009) Seeing from the South: refocusing urban planning on the globe's central urban issues. *Urban Studies* 46(11): 2259-2275.

Wolfe P (2006). Settler Colonialism and the Elimination of the Native. *Journal of Genocide Research* 8(4): 387-409.

Wolfe P (2016) *Traces of History: Elementary Structures of Race*. London: Verso Books

Yacobi H (2004) Social Exclusion, Housing Environment and Tolerant Planning: The Case of the Jahelin Bedouin Tribe. *Hagar – International Social Science Review* 5(1): 69-84.

Yacobi H (2019) The Right to Health is the Right to Land: Notes on Settler Colonialism and Health/Space Politics. *DPU News* 65: 1-4.

Yiftachel O (2006) *Ethnocracy: Land and Identity Politics in Israel/Palestine*. Philadelphia, PA: University of Pennsylvania Press.

Yiftachel O (2009) Theoretical notes on 'gray cities': the coming of urban apartheid? *Planning Theory* 8: 88-101.

Yiftachel O (1998) Planning and Social Control: Exploring the Dark Side. *Journal of Planning Literature* 12(4): 395-406.