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RESEARCH ARTICLE

Coloniality and Necropolitics in the Age of COVID-19: The Question of Palestine

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Abstract

This article interrogates the necropolitical logics of the Israeli settler-state apparatus towards Palestinians in the Occupied Territories during the COVID-19 pandemic. It examines these logics and practices through the prism of coloniality, which conceptualizes manifestations of colonialism (whether material, epistemic, or ontological) as a diffuse set of practices, opening up the conversation to discuss the ways in which international organizations, other states, and the Palestinian Authority continue to inflict the colonial harm through the employment of particular policies. Centring coloniality as an analytic allows a more global perspective and widens the discussion to include the ways in which Palestinians practise decoloniality, building and imagining "otherwise" worlds. This article maps the ways in which the devastation of the pandemic is not a product of the pandemic itself, but larger legacies of material, epistemic, and ontological colonial intervention.

Keywords: Palestinian liberation; international solidarity; Israeli settler colonialism; vaccine apartheid; decoloniality

1. Introduction

In May of 2021, Israel had the highest vaccination rate in the world at 60%. The Palestinian Occupied Territories (hereafter OPT), on the other hand, remained one of the least-vaccinated areas in the world, with the inoculation rate at a mere 5%.[1] Nearly six months later, while Israel's vaccination rate approached 70%, the OPT had only reached 25%. Crucially, the stark disparity between Israel and the OPT is not an exclusively local phenomenon, but one prevails globally vis-á-vis colonized and racialized peoples. I contend, following scholars Mark Muhannad Ayyash and Jeanne Perrier, that Palestinians' experiences of daily life in crises (and daily life as crises) are profoundly shaped by *coloniality*.[2] This article, building on their work, seeks to uncover the ways in which coloniality is uniquely revealed through the COVID-19 pandemic.

This article aims to elucidate the terms and conditions of the OPT's interaction with and capacity to respond to the COVID-19 pandemic through the lens of what Peruvian sociologist Aníbal Quijano conceptualizes as *coloniality*, which explores the diffuse and often contradictory manifestations of colonialism (whether material, epistemic, or ontological) that emerge not only from the colonizer, but through various members of colonized and racialized groups as well as other actors. More specifically, *coloniality* lends itself to the analysis

[1] In Israel, this represents the proportion of the eligible population, which initially consisted of those aged 60 and over, those in elder care, the immunocompromised, and front-line health-care workers; however, by February, all Israelis aged over 16 were eligible; ourworldindata.org (2021).

[2] Quijano (1991).

not only of the settler-colonial state, but to dispersed sets of practices that reinforce Israeli violence and control, specifically international organizations, state actors, and Palestinian elites. Although *coloniality* is certainly not the first or the only theoretical formation to elucidate the interconnectedness of the material, epistemic, and ontological, it does facilitate the mapping of the ways in which the devastation of the pandemic are not only a product of the pandemic itself, but larger legacies of colonial intervention that are deeply informed by and continue to inform global colonial practices. In addition to this framing, I will employ the concept of *necropolitics*, as conceived by Cameroonian philosopher and political scientist Achille Mbembé.[3] Broadly understood as an expansion of the Foucaultian concept of biopower and biopolitics (i.e. state control over life), *necropolitics* speaks to the ways in which late-modern colonial states control the conditions of both life and death, condemning racialized peoples to the cheapening of life and the habituation of death. Indeed, for Mbembé, it is the Israeli occupation's relegation of Palestinians to the fine line between life and death that provides the most trenchant example of this concept (p. 27). Together, *coloniality* and *necropolitics* provide key theoretical insights into the COVID-19 pandemic that may otherwise be obscured.

As disaster punctuates the daily experience of Palestinians under Israeli occupation, scholars have been quick to emphasize that while Covid presents some novel challenges in terms of public health and wellbeing, the presence of difficulties is by no means new. Palestinian sociologists, epidemiologists, and anthropologists, notably Ruba Salih, Yousif M. Qasmiyeh, Mark Muhanned Ayyash, and Danya M. Qato, have gone to great lengths to show how Israel's policies of apartheid[4] threaten the health, safety, and mortality of Palestinians continuously, not only during pandemics. These scholars' engagement with data on wellbeing, health, mortality, and morbidity privilege broader analyses of colonial power, calling into question metrics-based paradigms that elevate the production of scientific data above knowledge and intervention relating to analytics of power. As argued by Palestinian Epidemiologist Danya M. Qato:

> just as provision of medical care is not justice, data is not justice .... Health is relational and is informed by dynamic social and political conditions that evolve and metamorphize over time. The Covid-19 pandemic unmasks the complexity of these relationships, as well as the enduring role that racism, racial capitalism, heteropatriarchy, settler colonialism, and white supremacy have played in obstructing clinical medicine and public health globally. Medicine, data, and human rights advocacy alone cannot fix such structures of violence. In fact, our overemphasis on these tools upholds and further entrenches conditions of deteriorating health. (pp. 11, 12)

Instead of continuing to invest in these metrics-based paradigms, Qato argues toward larger historical analyses of power that are capable of the tactics and rationales of colonialism that cause these inequalities in the first place.

To that end, this paper aims to elucidate the long-standing processes and logics of power employed by the Israeli settler state, international organizations, state actors, and Palestinian elites, particularly as they manifest during the long COVID-19 pandemic. It is essential to note at this point that these conditions are by no means inflicted on passive, unknowing, or uncritical Palestinian subjects; on the contrary, the Palestinian people in all their heterogeneity continue to resist *coloniality* through various means, both in ways that are exceptional (such as through hunger strikes, prison escapes, global organized movements, etc.) and "every-day" (such as through practices of mutual aid, *sumud*,[5]

[3] Mbembé & Meintjes (2003).
[4] Shahak (1988); Davis (2003); Abdelnour (2013).
[5] Meaning "steadfastness" or "steadfast perseverance."

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refusal, etc.). It is through careful analysis of Israeli socio-legal policies and protocols, Palestinian quasi-state and community responses, and international aid and solidarity campaigns that this article attempts to shed light on the ways in which not just colonialism, but *coloniality*[6] shape the *necropolitics*[7] of the COVID-19 pandemic. Given the limited scope of the paper, it must be noted that there are key groups who have not been included, but that are examined elsewhere[8] and nonetheless require continued attention: namely, those incarcerated under the Israeli regime, Palestinian citizens of Israel, trans and gender non-conforming Palestinians, women, students, the elderly, and many others. Their absence from this piece is not an indication of their importance.

2. Coloniality in Palestine

My decision to use *coloniality* (which must be understood as in dialogue with other intellectual traditions, in particular *post-colonialism*) as a guiding framework is motivated by two interrelated concerns. The first, as previously mentioned, regards the expansion of simplistic and often unidirectional understandings of colonial power. The second, and my primary focus in this section, concerns the ways in which it captures the global interconnectedness of colonial projects and thus the shared stakes of liberation.

Formulated by Peruvian sociologist Aníbal Quijano as an alternative to world systems theory's[9] explanation for the "underdevelopment" of Latin America, *coloniality* attributes persistent global inequalities to European colonization of the Americas in the late fifteenth century, which initiated the project of Eurocentric modernity. This conquest created the material conditions of possibility for Europe to become the economic centre of the world, which in turn allowed Europe to enforce Enlightenment epistemologies as well as its own notions of "development" along the lines of linear and progressive time. This project relied not only on the extractions and physical violence of colonialism, but on the spatial and temporal principles that codify difference as hierarchical and assign ultimate value to the category "human" (which is necessarily separate from and above other forms of life and non-life). Within this framework, Europeans occupied the "now" of history (and were therefore fully human) and those outside of Europe, to varying degrees, are relegated to the primitive past: less-than-human, racialized, enslaved, disconnected from their land (which was understood now as property), and marked for destruction. In other words, Europe was only able to become the wealthy "core" of the world through the violent transformation of both space *and* time. Therefore, it is not only colonialism present and prior that punctuates and colours global inequality, but the epistemic and ontological project that made it possible in the first place.

Crucially, Quijano's distinction cannot be understood as separate from modern colonial projects in other parts of the world, particularly those rooted in the logics of the European liberal state such as Israel.[10] This is not to say, of course, that the twentieth-century colonization of Palestine is comparable to that of the fifteenth-century conquest of the Americas, but rather that they were possible through similar logics and tactics that were mutually reinforcing. Zionism, the ideological basis for the state of Israel, is defined by Palestinian historian Nur Masalha as "an invented European colonial discourse which included the secularization, nationalization and racialization of the Hebrew Bible and

[6] Quijano, *supra* note 3.

[7] Mbembé & Meintjes (2003).

[8] See e.g. Hawari (2020); Carvalho, Santos, & Santos (2020); Ali & Rosenberg (2021); Saban et al. (2020); Hammoudeh et al. (2020); Maraqa et al. (2021); Bilal Hamamra et al. (2022); Al Zabadi et al. (2021); Shadeed & Alawna (2021).

[9] See e.g. Rodney (1972); Wallerstein (1974); Wallerstein (1980); Wallerstein (1989); Wallerstein (2011).

[10] Massad (2006); Khalidi (2006); Robinson (2013); Shohat (2017).

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its deployment in support of the settlement and colonization of modern Palestine."[11] This article is also in dialogue with post-colonial scholar Ella Shohat, who explicitly builds on Quijano, arguing that the conquest of the Americas in the late fifteenth century cannot be understood as separate from the history of persecution experienced by the Jewish people, which is often used as justification for Zionism. For in fact, the conquest of the Americas was only possible through the use of wealth confiscated by Spanish Jews and Muslims during the Spanish Inquisition (*Reconquista*) that inaugurated the principle of racialization based on "blood purity" and was subsequently taken up by Columbus against the indigenous in the Americas.

From its inception, the Zionist project has relied on the hierarchical division of both space and time and the codification of difference as hierarchical; in other words, it has employed *coloniality*. The Zionist project, similarly to other colonial ventures, relies on what Palestinian anthropologist Ruba Salih and international relations scholar Olaf Corry call the "fossilization" of land and life (what Joseph Massad at an earlier time referred to as "space time compression"),[12] or the relegation of the Indigenous to the historical, even ancient, past.[13] Doing so casts their relations and interactions with the land in terms of the production of historical artefacts, not as a vital component of the continual cosmology of a people. Salih and Corry contend:

> In Palestine, like in other settler colonial contexts, the elimination of the Indigenous population rested on more than just physical displacement, destruction and ecological alteration. Settler colonialism drew an equivalence between Indigenous Life and Nonlife, with humans and nonhumans together fossilized or desertified by the ongoing settler colonial project which aimed at turning settlers into the new Indigenous. Like in other settler colonial contexts, nature was not simply destroyed. It was assigned the ontological status of Nature (capitalized to indicate its supposed pristineness) only when appropriated by the settlers, and then worked upon to subsequently become the blooming "settler-Nature."[14]

Therefore, it is not only the dehumanization of Palestinians that characterizes the Zionist project, but the imposition of the ontological divide between "human" and "nature" and the banishment of the former to the historical past. It is important to understand subsequently that movements toward *decoloniality* (the critical undoing of *coloniality* and replacement of it with "otherwise" forms of being, doing, and thinking) in Palestine would thus imply the reinstatement of reciprocal relations between "people" and "land" to that between "life" and "life."[15] Otherwise stated, Palestinian liberation cannot be understood as separate from land—as Eve Tuck and K. Wayne Yang famously argue, "decolonization is not a metaphor." It is through these conversations that I aim to place the current global crisis of COVID-19 within pre-existing necropolitical structures.[16]

2.1 Coloniality in public health

To get a sense of *coloniality* in Palestine as it relates to public health, it is necessary to go over the major historical and legal conjunctures that epitomize Israeli/Zionist relations to

[11] Masalha (2007), p. 2.

[12] Massad, *supra* note 9, pp. 39–40.

[13] Indigenous scholars across geographies have argued this as well. See e.g. Country et al. (2015); Gross (2014); Todd (2016).

[14] Salih & Corry (2021), p. 3.

[15] Mignolo & Walsh (2018).

[16] Tuck & Yang (2012).

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Palestine and Palestinians. This overview, although certainly not exhaustive, will provide the context necessary to capture the theoretical importance of *coloniality* as a way of understanding both Israeli and Palestinian interactions with and responses to the COVID-19 pandemic.

Although Palestine has been implicated in various empires for much of its history, it was recognized globally as a geographically and culturally distinct region, even enjoying periods of semi-autonomous rule, for the 4,000 years preceding Zionist colonization.[17] With the fall of the Ottoman Empire after World War I and under the auspices of the 1916 Sykes-Picot Agreement, the British established a Mandate in Palestine, which would ostensibly provide support towards self-governance and eventual sovereign statehood for Palestine. The long-standing British involvement in the Zionist project in Europe, however, foreclosed the possibility of a direct transition from Mandate to statehood for Palestinians. In fact, since the mid to late nineteenth century, Zionists had been systematically purchasing large tracts of Palestinian land and encouraging mass migration in an effort to obtain ethnic majority status in Palestine. After much resistance (including but not limited to the 1936–39 Arab Uprising)[18] in February of 1947, the British handed the official fate of Palestine to the UN. The UN Member States ultimately voted to partition the region into three distinct states: Israel, which would get 56% of the original land of Palestine; Jerusalem, which would get approximately 1%; and Palestine, which would get 43%. Within hours of Britain's formal retreat in April of 1948, Zionist forces began their violent campaign of Palestinian expulsion and conquest. In what would later be celebrated by Israelis as the "War of Independence," Zionist forces captured 78% of historic Palestine, expelling at least 750,000 Palestinians, internally displacing over 30,000 and murdering 15,000 in what would be called *Nakba* or "catastrophe" by those in the Arab world, which many argue continues to this day.[19] Although the Israeli colonization of Palestine was illegal under international law, in 1949 Israel reached armistice agreements with the surrounding states, thus establishing Israel's borders at the Armistice Demarcation Lines, far beyond the borders of the UN's partition plan, which itself was never agreed upon by Palestinians.[20] Almost immediately following, the new Israeli state began to seek liberal forms of legitimation, putting in place legislation surrounding land procurement such as the Land Acquisition Law (1953) and the Absentee Property Law (1960), which guaranteed the legal disenfranchisement of Palestinians. This pattern of unsanctioned physical violence followed by attempts to legitimize that violence through domestic law are legacies of the Zionist project that continue to this day.

3. Palestinian sovereignty and public health administration post-1948

The question of public health administration in post-1948 Palestine thus fell on the occupying powers of Israel,[21] Jordan, and Egypt. Jordanian forces gained control of the West Bank and East Jerusalem, and between 1950 and 1967 Palestine was functionally incorporated into the state of Jordan. The careful and often sordid political manoeuvring that resulted in Jordanian sovereignty in Palestine is too complex to address here, but ultimately, Palestinians within this period had limited political representation under King Abdullah; they were appointed as governors over their own territories and eventually

[17] See Doumani (1995); Masalha (2019).

[18] As a result of the uprising, the British introduced the White Paper, which limited Jewish immigration, while simultaneously giving Jewish people unprecedented power within the Mandate.

[19] Khalidi (1997); Pappe (2006).

[20] Birzeit University Archives.

[21] This project does not focus on 1948 Palestinians within the state of Israel, but for reference, Shira Robinson's *Citizen Strangers* (2013) covers many of these important historical points.

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came to occupy half of the seats in Parliament. Comparatively, in 1948, Gaza fell under the control of Egypt and a police-state regime and was ruled symbolically by the All Palestine Protectorate (APP)[22] until 1962 when the semi-sovereign Palestinian Legislative Council replaced the APP under the auspices of the United Arab Republic.[23] For both the West Bank and Gaza, this meant that they were also implicated within scope of those states' (Jordan and Egypt, respectively) institutional networks, including those pertaining to health care, although necessarily in ways that were both limited and largely inadequate. For those living in refugee camps, the most significant providers of health-care services to this day are international aid organizations, particularly the United Nations Relief and Works Agency (UNRWA).[24]

In 1967, when Israel invaded the Sinai Peninsula, the West Bank, Gaza, and the Syrian Golan Heights, it functionally severed the institutional connections Palestinians had to both Jordan and Egypt, including those pertaining to public health. Importantly, this greatly impacted the lives of Palestinians in an administrative sense: over the course of the 1967 Six-Day War (referred to in Arabic as the *Naksa*, or "setback"), another 300,000 Palestinians were displaced, approximately half of which whom already refugees from 1948. The civil administration of these areas fell under Israeli military control, placing already precarious Palestinian health in the hands of those who stood to benefit the most from their annihilation. Speaking to the fate of the public health sector in the hands of the Israeli state, Physicians Public health scholars Rita Giacaman, Hanan F. Abdul-Rahim, and Laura Wick from Birzeit University in the OPT explain:

> Following the [1967] occupation, the Israeli Civil administration (under the Ministry of Defense and *not* the Ministry of Health) took over the governmental health care system and proceeded to administer it in a manner that kept it stunted and underdeveloped, with severe budget restrictions, referral to Israeli hospitals for tertiary care, and restrictions on licenses for new medical and health care projects, thus creating a total dependence on the Israeli health system (Giacaman 1994) .... Although the actual service providers were all Palestinians, institutions were not developed to meet the changing needs and growth of the Palestinian population, nor were they strengthened so that they could function autonomously.[25]

Thus, the Palestinian health-care system in the OPT was relegated to a perpetual state of "undercare"[26] under Israeli occupation, a colonial entity deeply invested in the *necropolitics* of Palestinian life. The occupation itself prohibited the physical movement of life-saving technologies and life itself out of the West Bank and Gaza, thus further conditionalizing Palestinian's access to care.[27]

This infrastructure, crafted and upheld by the Israeli military, designed to uphold the necropolitical structures of the Zionist project, was inherited by the quasi-state governing body that was put in place during the 1993 Oslo Accords: the Palestinian Authority (PA), and subsequently the Palestinian Ministry of Health (MoH). Importantly, the Accords were agreed upon by a select few from the elite Palestinian leadership and against the express needs and desires of many Palestinians both inside the original land of Palestine and in the diaspora.[28] Aside from the occupation itself, it is this structure and the ways in which the

[22] Feldman (2015).
[23] Shlaim (1990), pp. 37–53; Feldman (2008).
[24] Nazer & Tuffaha (2017), pp. 150–5; Feldman (2018).
[25] Giacaman, Abdul-Rahim, & Wick (2003), pp. 59–67.
[26] Feldman, *supra* note 20.
[27] Qato (2020).
[28] See Khalidi (2020); Naser-Najjab (2020).

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Accords foreclosed the growth of the health-care system that determine Palestine's capacity to respond to COVID-19. It is important to note as well that precarity in the West Bank is amplified by the occupation of over a million Zionist settlers who are incentivized by the state of Israel with funding for homes, infrastructure, and military protection.[29] In Gaza, which has been under the political purview of Hamas since 2007, precarity is enforced by the Israeli military blockade, which makes the movement not only of people and life-saving medicine and medical technology difficult, but even of infrastructural supplies such as building materials for hospitals and clinics damaged by Israeli bombing.[30]

As is argued by venerated Palestinian historian Rashid Khalidi, Oslo marked the beginning of the formalized investment of elite Palestinian leadership in securitization (of Israel) over the health, wellbeing, and lives of Palestinians. To get a sense of how this priority is institutionalized, one need only look at the Palestinian administration's annual expenditure reports, which disclose nearly double the spending for securitization over health care.[31] To get the full picture, it is crucial to go even further back and understand how the quasi-state of Palestine collects funding in the first place. Since 1994, the PA's annual budget has come from three distinct sources: taxes collected from Palestinian residents of the OPT, aid from international donors, and taxes collected from imports. Importantly, this third source is mediated entirely by the Israeli government and comprises anywhere from 44% to 70% of the PA's annual budget.[32] These funds, in accordance with the 1994 Paris Agreement, are collected by the Israeli government and must be shared with the PA on predetermined dates. However, predictably, these critical funds have often been leveraged against the PA, as exemplified by the Israeli state's decision to withhold Palestinian funds in the wake of the 2012 UN recognition of Palestine as an observer state.[33] However, it is not only sparse funding but *access* to vital health-care materials and services that characterize Palestinian health-care disparities; this is particularly visible in the sale, production, and distribution of pharmaceuticals. Israel acts as an intermediary between Palestine and the global pharmaceutical market, limiting Palestinian access to only those drugs registered for use in Israel at Israeli prices.[34] Indeed, for Palestine, it is not only the increasing privatization of the pharmaceutical market that presents a problem, but the fact that they are unable to access the low-cost pharmaceuticals that are made available to low-income countries.[35] Additionally, even if Palestinians were to produce their own pharmaceuticals, the import of raw materials, as well as the permission to export finished products are beholden to Israeli approval and are therefore subject to oscillating and often extreme limitations. For Gaza in particular, the Israeli military blockade dictates that once medications finally do enter, they cannot leave, which places the burden of toxic waste disposal for expired medications entirely on Gazans who are already facing water shortages and sanitation issues. Now that the institutionalization of Israeli necropolitics has been historically established, it is possible to pivot to the current crisis of COVID-19 and the ways in which those relate to it.

[29] A recent example of this can be found in the Hebron hamlet of Masafer Yatta.

[30] Sen (2020).

[31] Pmof.ps (2021); reliefweb (2015).

[32] Pmof.ps, *supra* note 29.

[33] UNCTAD (2015).

[34] Global market prices for pharmaceuticals operate on a sliding scale according to the socioeconomic status of the country in question.

[35] Pmof.ps, *supra* note 29.

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4. COVID-19

Palestinian geographies, made separate and distinct by continuous Israeli occupation, have differential COVID-19 infections, public health policies, access to testing, and vaccine roll-out conditions.[36] Interestingly, at the beginning of the pandemic, both Gaza and the West Bank experienced low rates of infection, particularly compared to neighbouring Israel.[37] For Gaza, this is largely attributed to the quarantining of incoming travellers, resulting in the delay of a serious outbreak until November of 2020.[38] Subsequent analysis has revealed that for the OPT at large, this trend most likely points to the lack of available testing early in the pandemic, the absence of transparency from the Israeli Occupation Authority (IOA) regarding confirmed cases in East Jerusalem, limited travel to and from the West Bank and Gaza, and initial co-ordination between the PA and Israeli military to quickly lock down the population in Bethlehem where the first case was confirmed.[39] As Mark Muhannad Ayyash notes, however, this co-ordination should not be lauded as a victory of co-operation or a sign of care; on the contrary, it is revelatory of the degree to which Israel has systemized and streamlined the procedure of locking down Palestinian populations.[40] Despite this early lead, within a few months, Palestine began to resemble neighbouring regions in terms of cases and deaths, thus plunging the already inadequate health-care system into a state of further precarity.

In addition to differences between the West Bank and Gaza, each region is characterized by internal stratification, which is perhaps most notable within the West Bank. The socio-economic and political elite share a reality almost entirely separate from working-class Palestinians.[41] By way of example, the majority of new COVID-19 cases during the first few months of the pandemic were contracted and brought in by Palestinian day labourers, who out of economic necessity (thanks to the Israeli state) must travel back and forth between Israel and the OPT to earn a living.[42] In a report for the Middle East Research and Information Project, geographer Lucy Garbett describes Palestinian day labourers as "caught between indispensable and disposable," arguing that:

> Construction and infrastructure projects in Israel, and in Israeli settlements within the West Bank, are hugely dependent upon Palestinian labor. Under a lockdown in a pandemic this means that Palestinian workers are exposed to serious health risks while helping Israel cement its control over Palestinian land and people.[43]

Indeed, Israeli labour dependency is revelatory of their *necropolitical* practices, wherein Palestinian life is instrumentalized towards the ends of the occupation and discarded without care or consideration once that need is fulfilled. Ostensibly due to international pressure and fear of the infection of Israelis, in March of 2021, Israel agreed to vaccinate 100,000 of the Palestinians from the OPT who possess permits to work in Israel. However, as is argued by an interviewed Palestinian worker Jasem Al-Hroub, by not also vaccinating the communities with whom they are in close contact, they did not reduce the risk of death and disease for Palestinian communities as a whole.

Given the relative weakness of the quasi-state apparatus, the most powerful tool at the PA's disposal to curb infection rates is lockdowns, and it is during these lockdowns that

[36] Corona.ps (2021).
[37] Porcher (2020).
[38] Alsaafin (2021).
[39] See AlKhaldi et al. (2020); Tartir & Hawari (2020); Qato, *supra* note 25.
[40] Ayyash (2020), pp. 123–31.
[41] Dana (2020), pp. 247–63.
[42] Abed (2020).
[43] Garbett (2020).

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those who already experience the greatest financial precarity are barred from earning an income. As noted by Yara Hawari, Middle East political scholar and senior analyst for the Palestinian Policy Network *Al-Shabaka*, these lockdowns place working-class Palestinians who work within the OPT in an impossible situation; Palestinians are unable to work because of the lockdown, yet the absence of a social safety net under the PA makes it impossible for them to purchase food and pay for housing.[44] Forced to wait until vaccines become readily available, working-class Palestinians must balance on the knife's edge between life and death, affirming that under the necropolitics of the Israeli regime, they are both "disposable and indispensable."[45]

The stark socioeconomic stratification in the OPT (particularly the West Bank) manifests not only in better life and health outcomes in general for the affluent minority, but in very different relationships to the Israeli state and *coloniality* more broadly. As noted by political scientist Jeanne Perrier (2021), the PA often acts directly against the interests of Palestinians themselves by employing the same tactics as the Israeli state uses in order to achieve the ends of a precarious and uncertain quasi-statehood. As Mark Muhannad Ayyash argues, it is because the PA seeks liberation through the formation of a state (which still relies on the colonial conceptions of linear time, bounded space, and the separation of life), "they were always bound to replicate the colonial system and indeed support it" (p. 23). In other words, the PA, by limiting their notion of liberation to the project of statehood, have foreclosed the possibility of liberation from *coloniality* and thus are actively investing in and working towards the very logics they are trying to escape. This plays out perhaps most obviously in terms of the PA's aforementioned emphasis on securitization over the health and safety of Palestinians, and more insidiously across local infrastructures such as those pertaining to the allocation of water and the building of infrastructure that interrupt Palestinian's traditional relation with the land.[46]

In the case of COVID-19, the PA reinscribes Israeli necropolitics by determining who has access to life, and thus who is relegated to death. This manifests not only through the prioritization of elites over ordinary Palestinians through economic policy, but via vaccine access. As reported by Jerusalem-based journalist, Adam Rasgon:

> Like many governments worldwide, the Palestinian Authority ... has officially prioritized its senior administrative leadership and front-line health workers, as well as people who come into regular contact with the authority's president and prime minister. But in secret, the authority has diverted some of the thousands of vaccines it has received to some senior members of the ruling party in the West Bank who have no formal role in government .... Vaccines have also been secretly given to top figures at major news outlets run by the authority, according to one of the senior Palestinian officials and two employees at those outlets. Family members of certain government officials and Fatah leaders were also given the vaccine.[47]

Indeed, if these initial vaccines had been distributed based on need, working-class Palestinians would have received them before those who had the means and access to work remotely or take time away from work. These initial vaccines, 10,000 from Russia and 2,000 Israel, marked the beginning of the PA's vaccine campaign, which ultimately needed to serve 5.2 million.[48]

[44] Hawari (2021).
[45] Garbett, *supra* note 41.
[46] Perrier (2021).
[47] Rasgon & Kingsley (2021).
[48] Pcbs.gov.ps (2021).

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When the vaccine was initially approved for use and distribution in Israel in December 2020, it became clear that the state's campaign to inoculate the country would outpace not only those of other states in the MENA, but those in the West as well. What also became clear was that Palestinians in the OPT would not benefit from this unprecedented access; in fact, the first vaccines were not administered until early February of 2021—a clear example of what many are calling "vaccine apartheid."[49] As discussed earlier, the PLO must abide by the 1993 Oslo Accords that make it nearly impossible to secure necessary medical supplies under normal conditions, much less under the immense pressure of a global pandemic. The discourse from Israeli officials to corporate and national news outlets was one of responsibility: that it was the PA's responsibility to care for their populations by providing the vaccine, and that it was due to poor planning that they did not secure it earlier.[50] This is not only nearly impossible due to the restrictions under the Oslo Accords, but distracts from the larger issue, which is that Israel as an occupying power is actually required under the Geneva Convention to "ensure that all the necessary preventive means available to it are utilized to 'combat the spread of contagious diseases and epidemics'," which in this case means providing vaccines, according to UN Special Rapporteur for the Palestinian Territory.[51] However, instead of fulfilling their obligations under international law to vaccinate Palestinians, in early 2021 Israel donated thousands of doses to other states, namely Honduras, the Czech Republic, and Guatemala, all who have agreed to increase their diplomatic presence in Jerusalem, thus further illustrating Israel's necropolitical aims and priorities.[52] In June, Israel offered to trade approximately a million ageing vaccines with the PA who would subsequently share an equal number of vaccines in later months as they received them. Ultimately, however, the PA rejected the trade, citing incongruencies between the expiration date agreed upon and that of those vaccines delivered.[53]

More than one year after Israel started its unprecedented vaccine campaign, the vaccination rate amongst Palestinians in the OPT is just over 50%, with the West Bank experiencing higher rates overall than Gaza.[54] Now, the PA has secured enough vaccines to inoculate the eligible population, but the barriers to vaccine use are not only related to the availability of the vaccine, but to trust—trust in government officials, the safety of the vaccines, and finally in the vaccine's efficacy. As we have established herein, the PA has not earned the trust of many Palestinians in the OPT due to its upholding of Israeli necropolitical structures though the prioritizing of elites and sidelining of the needs of working-class and refugee Palestinians, and centring Israeli securitization over Palestinian health and wellbeing; recent stringent vaccine requirements have only made this relationship worse. In a move criticized by some human rights activists, the PA (both in the Fatah in the West Bank and Hamas in Gaza) have instituted mandatory vaccinations for government employees, those employed in the private sector, and even those who wish to visit schools, including parents. Notably, the government is the largest single employer in the West Bank, and thus their promise to place employees who refuse to get vaccinated on unpaid leave is deeply felt, particularly given the economic precarity experienced by many. To get a sense of how these restrictions are being implemented discursively, PA premier Mohammad Shtayyeh's widely disseminated quote is instructive: "Not being vaccinated isn't a matter of personal freedom. Your personal freedom ends when your freedom harms others' health."[55] While this argument certainly has its merits, being forced to

[49] Banerjee (2021).
[50] See Himmel (2021).
[51] United Nations Human Rights: Office of the High Commissioner (2020).
[52] Kingsley (2021).
[53] Al Jazeera and News Agencies (2021); Agence France Presse (2021).
[54] Corona.ps, *supra* note 34.
[55] Rasgon (2021).

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take the vaccine over the looming threat of unemployment results in increased feelings of mistrust between Palestinian residents of the OPT and the PA. Indeed, the same ends may have been met with positive incentives (later adopted in some areas) and the option of regular COVID testing for those who chose to forgo the vaccine altogether.

In terms of the specifics of vaccine hesitancy, in Palestine, as in many other regions, fear of side effects and uncertainty of the efficacy of the vaccine in preventing infection, transmission, and death are among the most significant barriers. It is not lost on Palestinians in the OPT that the potency of the vaccines administered earlier on in the pandemic in Israel has waned significantly due to the emergence of novel variants, which only increases scepticism about the vaccine's importance. Although there have been informational campaigns via radio, social media, and even billboards set in place both by local and international organizations to dispel myths regarding risks of inoculation and concerns around waning efficacy, it appears that the PA mandate alone is what has made the largest difference in vaccination rates.[56] Between August, when the mandate was put in place, and early October alone, the vaccination rate increased from 23% to 50%.[57]

4.1 Interstate/national solidarities and visions of liberation

During the COVID-19 pandemic, international solidarities materialized in particular ways: some in the form of aid (medical and otherwise), others in refusal to collaborate with the Israeli government, and others still through forms of less tangible support. With this in mind, it is crucial to discuss the layers of international support Palestine has accrued during this crisis, all of which can be organized in various registers: those from aid organizations and non-governmental organizations (NGOs), state actors, and those engaged in other liberation struggles not necessarily tethered to a state project, such as solidarities among Indigenous peoples that stretch across geographies of difference to work towards global *decoloniality* and against colonial necropolitical structures.

Private-sector aid organizations and NGOs make up a significant portion of available health care in the OPT, but this is particularly true in Gaza where fewer are registered as refugees, which would place them under the purview of the UNRWA (which itself is guilty of providing "undercare").[58] As previously discussed, medical support is necessary, but not sufficient for liberation from *coloniality*. By tending to health as if it can be separated from the political entanglements of settler-colonial occupation, those providing medical support alone effectively normalize the settler-colonial enterprise and, in many ways, prevent the actualization of a liberated Palestine. Epidemiologist Danya M. Qato goes as far as to argue that "by participating in a prolonged performance of epidemiological solidarity, the international community, and those it subcontracts with in Palestine, have disabled, if not foreclosed, possibilities for health." Legal and philosophical scholars Reem Bahdi and Mudar Kassis take Qato's point further by arguing that aid intended for development in general only further entrenches conditions of colonialism, and that these organizations are:

> displacing international law and institutions as the main mechanism through which northern states engage with Palestine, perpetuating an image of Palestinians as a people in need of technical assistance rather than liberation, and institutionalizing northern control over Palestinian priorities and decision-making.[59]

[56] Zakkout (2021).
[57] Boxerman (2021).
[58] Bahdi & Kassis (2021), p. 87.
[59] Qato, *supra* note 25.

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Indeed, it is this emphasis on "technical assistance rather than liberation" that perpetuates the conditions of *coloniality* through the denial of the core causes of the need for assistance. This can be traced in the proliferation of both financial and organizational aid after the Oslo Accords, which is clearly correlated to the decrease of decision-making power of Palestinians themselves due to the contingencies put in place by funders.[60] Through inaccurate characterizations of the realities on the ground in Palestine, these organizations also inadvertently contribute to the intensification of colonial violence; this is evident in the allocation by many aid organizations of the post-Oslo OPT as a "post-conflict" zone, which changed the type of aid offered and obfuscated the escalating violence of the encroaching Israeli settlers that ultimately materialized during the Second *Intifada* ("uprising") in 2000.[61]

In terms of bilateral state support and solidarity, it is Cuba who rises above the pack in (almost exclusively) rhetorical terms. With a record of support towards Palestine even before the 1959 Cuban Revolution, it was one of the few states in active opposition to the partitioning of Palestine in 1947, citing the racist and imperialist aims of the burgeoning Zionist state. As historian Robert Austin Henry (2019) notes, it is Cuba, in conjunction with the Non-Aligned Movement (NAM), that helped internationalize Palestine's struggle against colonialism. This is clearly embodied by Che Guevara's 1959 visit to Palestine shortly after the Cuban Revolution, which occurred:

> on behalf of the newly-independent nation and at Egyptian president Nasser's request. It was, recalls Palestinian intellectual Salman Abu Sitta (2015), the first sign that "the Zionist colonization of Palestine" was "transforming ... from a regional conflict to a global struggle against colonialism."[62]

Although Cuba developed its own vaccines, it did not send these to Palestine, ostensibly due to the restrictions on pharmaceuticals cited previously. Cuba continues to advocate for Palestine within the UN and, in July of 2021, issued a statement to the Security Council decrying the continued Israeli military occupation and attacks against Palestinians, particularly in light of the pandemic.[63]

Perhaps the most obvious show of interstate medical support for Palestine during the COVID-19 pandemic is through the COVID-19 Vaccines Global Access (hereafter COVAX) initiative. An initiative led by the Coalition of Epidemic Preparedness Innovations (CEPI) along with Gavi, the Vaccine Alliance, and the World Health Organization (WHO), co-ordinated by UNICEF and other civil society organizations, COVAX acts as a way for wealthy states to provide medical support via vaccines for so-called "developing" states during the pandemic.[64] As of late July 2022, COVAX has provided 1.87 million doses of the vaccine to Palestinians in the OPT, which is enough to vaccinate approximately 36% of the entire population.[65] These vaccines have been supplied by the US, China, Russia, Egypt, the United Arab Emirates (UAE), and Israel.[66] Although the necessity for redistributive programmes such as this cannot be overstated, as was the case with aid organizations, they cannot be confused with doing the necessary work of liberation, which in this context requires immediate divestment from Israel and the multifaceted and nefarious project *coloniality*.

[60] *Ibid.*
[61] *Ibid.*
[62] Henry (2019), pp. 245–6.
[63] Cubadiplomatica.cu (2021).
[64] Unicef.org (2021).
[65] *Ibid.*
[66] *Ibid.*

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Although the relations among the states that participate in COVAX, Israel, and Palestine are complex, I will attempt to establish a basic characterization of their relations and thus partially elucidate the significance of the medical aid they have offered. Importantly, the US is the largest contributor of aid to Israel and has been more so than any other state since World War II.[67] Having voted for the partition of Palestine in 1947 and continually supported Zionist expansion in general, they continue to provide significant aid to Israel annually that goes primarily towards the military, totalling to 3.8 billion in 2020 alone, along with approximately 8 billion in loan guarantees. In terms of diplomatic relations, the US is considered one of Israel's closest allies, and as one of the permanent members of the Security Council, can be understood as largely responsible for the failure of the UN to hold Israel accountable to international law. Thus, while the significantly smaller (and inconsistent) amount of aid they contribute to Palestine is life-saving and important, their relations with Israel harm Palestinians more than the aid they offer helps them.

Israel's relationship with China is currently characterized by economic co-operation; in fact, they are currently Israel's third largest trading partner. Although China abstained from the 1947 UN vote to partition Palestine in and support the Palestinian right of return in 1955, their relationship with Israel continues to flourish in spite of these earlier commitments.[68] Relations between Israel and Russia (formerly the USSR) have been far from consistent, marked by support for the partition plan of 1947 and the Israeli state in general during the first few years of its existence, then pivoting to provide greater support to Palestinians and the Arab world in general as Israel's relationship with the West (particularly the US) grew stronger.[69] Contemporarily, the discourse emerging from Russia reflects the desire for peace, not justice, which as many have argued, serves to obfuscate the settler-colonial nature of Israel's state.

Egypt, although in some ways a crucial ally in the contemporary period, has a sordid history with Palestine; of note are Egyptian efforts in the nineteenth and mid-twentieth centuries (particularly post-1948) to expand their land holdings at the expense of Palestinian sovereignty. However, in an official capacity, Egypt has consistently condemned Israeli colonization, making this show of epidemiological solidarity far from surprising. Finally, the UAE, although historically supportive of Palestine, as many other Arab states have been, began bilateral talks with Israel in 2018, which led to the Palestinian rejection of all offered medical aid from the UAE during the COVID-19 pandemic.[70]

Although the context of Palestine is distinct in many ways, the settler-colonial necropolitics surrounding the COVID-19 pandemic are by no means unprecedented or unique to the indigenous of Palestine. In fact, they are a shared historical experience of Indigenous and racialized peoples globally as Palestinian Epidemiologist Danya M. Qato argues:

> The Indigenous have always prepared for and anticipated pandemics. First, because pandemics and disease have long been weaponized as biological warfare deployed in service of conquest, containment, and genocide; and second, because they already live amid the ever-present threat of annihilation—experienced in the settler-inflicted rupture between the land and the Indigenous that "represents a profound epistemic, ontological, cosmological violence."[71]

In this way, Palestine is understood not as isolated and thus incommensurable, but deeply connected to global *coloniality*. Although states, private aid organizations, and NGOs

[67] sgp.fas.org (2020).
[68] Cooley (1972), pp. 19–34.
[69] See Franzéén (2007), pp. 6–24; Gresh (1998), pp. 67–77.
[70] Melhem (2020).
[71] Qato *supra* note 25, pp. 8–26.

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certainly wield significant power, these structures do not exhaust the networks of solidarity that support Palestinian liberation. Palestine is deeply rooted in Indigenous and national global networks of solidarity; these entanglements, referred to by Palestinian and American Indian Studies scholar Steven Salaita as "inter/nationalism," are solidarities (which range from academic, movement-based, and material support) forged across difference, rooted in the commitment to reciprocal liberation from colonial power.[72] Although the solidarities Salaita is interested in rest primarily within the academe, as he notes, they are deeply informed by and inform praxis. He contends, "A central tenet of inter/national scholarship is insistence on transnational dialogue not only extraneous, but in opposition to the physical and legal parameters of the nation-state." (p. xv), and are thus *decolonial*. Historically, these solidarities have played out in manifold ways, but perhaps most visibly during the 1970 visit of solidarity delegations of the American Indian Movement (AIM) to Beirut to commune with Palestinians, the participation of Palestinian activists in Idle No More, Palestinian solidarity with the Wet'suwet'en and Muana Kea land protectors, the 2007 passage of United Nations Declaration on the Rights of Indigenous Peoples, and through the broad support for the Boycott, Divest, and Sanctions (BDS) movement.

The BDS movement, established in 2005, works to make visible the role of the interstate/national community in upholding the Israeli colonial regime through the purchasing of Israeli products, support of academic institutions, and participation in global events.[73] Beyond simply bolstering support for Palestine, participation in the BDS campaign also shapes the ways the Indigenous of North America conceptualize their own struggles towards decolonization, thus further internationalizing Indigenous struggles as a whole:

> many Native scholars and activists have taken up the cause of BDS and in so doing have broadened the conditions of studying the decolonization of America and deepened what it means to undertake the types of intellectual and political activities one might perform in the service of Palestinian liberation.[74]

While the spotlight on both interstate and international support is certainly important, the ways in which Palestinians create and sustain networks of support and build "otherwise" worlds within their own communities is necessary to disrupt the fixity of Palestinian representation as either simply resilient or simply victimized.[75] Palestinians have long invested in and relied upon networks of mutual support and aid,[76] and this was made particularly visible in the scholarship during the first and second *Intifadas*.[77] For example, as senior researchers from survivor and community-led crisis response organization Local to Global Protection found:

> in Beit Mirsim, Birin, and Umm al-Khair in the West Bank ... several families established house gardens early in the crisis as a means of supplementing their food supplies. This is a strategy forged over time: the occupation has led many Palestinian families and neighborhoods to develop such coping mechanisms.

During the earlier stages of the pandemic, communities also worked together to monitor and, when necessary, isolate individuals who had to go into Israel for work and, in Gaza,

[72] Salaita (2016).
[73] Kawas (2020); BDSmovement.net (2021).
[74] Salaita, *supra* note 70, p. 4.
[75] Qato, *supra* note 25.
[76] Doumani, *supra* note 15; Fiddian-Qasmiyeh & Qasmiyeh (2020); Qato, *supra* note 25.
[77] See Alazzeh (2015); Taraki (2006); Abu Nahleh (2006); Tamari (1993).

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farmers who could no longer sell their produce in stores due to lockdown sold directly from their own carts.[78]

In the context of refugee communities in particular, these networks have acted in place of formal institutions to provide public health information, medical care, and safety measures; this is particularly clear in the refugee camps throughout the OPT and in neighbouring states. As noted by Palestinian scholars Elena Fiddian-Qasmiyeh and Yousif M Qasmiyeh (2020), "displaced and dispossessed people ... have drawn on long-standing traditions of mutual aid[79] and solidarity to seek ways to protect themselves and others"—this is particularly salient during times of crisis, and in this case during the COVID-19 pandemic.[80] Of particular interest to Fiddian-Qasmiyeh and Qasmiyeh is a community group in the Lebanese Beddawi refugee camp that calls themselves "The Palestinian Cultural Club" (PCC), which during the pandemic:

> adapted existing evidence-based informational posters (including World Health Organization materials), translated them into Arabic, and shared the posters and other forms of guidance in print and via social media to reach camp residents of all demographics in an accessible manner. In addition to running special programs on its radio station, the Cultural Club has worked with social media networks that have been established locally for years .... While the threat of COVID-19 is less visible, or audible [than armed clashes], the threat to life is no less real, and information is among a range of resources essential for survival in these circumstances.[81]

By creating and refashioning flexible networks of communication and care, those in the Beddawi camp do more than tend to the health and safety of the community; they are building a world that is not reliant on the logics of the centralized colonial state formation, and thus working towards *decoloniality*. Through engaging with and caring for one another, they embody the notion that a world beyond *coloniality* is a present and tangible project and affirm that the alternative realities many hope to someday inhabit are not only possible, but that they are already here.

5. Conclusions

As pandemics become a normal part of life in what some have hailed as the era of the Anthropocene, it is crucial that lessons from the COVID-19 pandemic are learned and remembered. In order for health equity to be realized, *coloniality* itself must be actively dismantled along with the necropolitical structures built by colonial regimes. This project requires the dismantling of not only the settler state, but the post-colonial quasi-state structure as well. Importantly, this cannot be accomplished without the collective action of Palestinian peoples everywhere, and the participation of various state, national, and organization actors.

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[78] Carstensen et al. (2021), p. 160.

[79] In this sense, "mutual aid" gestures to the interdependence of those within communities under siege, specifically to the practices they use to care for each other beyond state/formal structures.

[80] See Blend (2020), p. 2; Fiddian-Qasmiyeh & Qasmiyeh, *supra* note 74, pp. 349–55; Qato, *supra* note 25, pp. 8–26.

[81] Fiddian-Qasmiyeh & Qasmiyeh, *supra* note 74, p. 352.

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