

Sarah S. Willen

Department of Anthropology  
University of Connecticut

## Do “Illegal” Im/migrants Have a Right to Health? Engaging Ethical Theory as Social Practice at a Tel Aviv Open Clinic

---

*As the notion of a “right to health” gains influence, it is increasingly deployed in ways that are diverse, contextually variable, and at times logically inconsistent. Drawing on extended fieldwork at an Israeli human rights organization that advocates for “illegal” migrants and other vulnerable groups, this article contends that medical anthropologists cannot simply rally behind this right. Instead, we must take it as an object of ethnographic analysis and explore how it is invoked, debated, and resisted in specific contexts. Critical ethnographies of right to health discourse and practice can enlighten us, and help us enlighten scholars in other fields, to the complexity, messiness, and “mushiness” (Sen 2009) of this right, especially in the context of advocacy on unauthorized im/migrants’ behalf. It can also deepen understanding of the complicated and sometimes tense relationships among human rights, humanitarianism, and other contemporary idioms of social justice mobilization, especially in the health domain. [right to health, migrant “illegality,” im/migrant health, human rights, idioms of social justice mobilization]*

---

In seeing health as a right, we acknowledge the need for a strong social commitment to good health. There are few things as important as that in the contemporary world.

—Amartya Sen, 2008

In the context of Western democracies, health today appears to be endorsed as a kind of meta-value, and speaking in the name of health is one of the most powerful rhetorical devices. The discourse of human rights reflects the fundamental value ascribed to health, by addressing health itself as a kind of meta-right. At the same time, at a national level the notion of a “right to health” appears now more controversial and problematic than ever.

—Monica Greco, 2004

Vulnerable Migrants Have a Right to Health

—Editorial headline, *Lancet*, 2007

---

MEDICAL ANTHROPOLOGY QUARTERLY, Vol. 25, Issue 3, pp. 303–330, ISSN 0745-5194, online ISSN 1548-1387. © 2011 by the American Anthropological Association. All rights reserved. DOI: 10.1111/j.1548-1387.2011.01163.x

---

As the 5:00 P.M. hour drew near, a multinational, polyglot crowd gathered on the stoop outside the narrow storefront housing the volunteer-run Open Clinic for Migrant Workers in south Tel Aviv. The clinic, run by the Israeli human rights organization Briut ve'Zhuyot Adam (BZA; Hebrew for "Health and Human Rights"),<sup>1</sup> is the only primary health care institution consistently open and accessible to the estimated 150,000 unauthorized transnational migrant workers who began settling in Israel in the latter half of the 1990s. Located on an otherwise sleepy block in the heart of the city's, and country's, largest migrant enclave, the tiny storefront was readily identifiable from afar by its green-lettered sign in Hebrew, English, and Arabic and by the array of world flags affixed to its floor-to-ceiling streetfront windows.

By the time the director removed the heavy steel padlock from the front door and invited patients to be seated in the row of white plastic patio chairs lining the improvised waiting room, the front stoop was crowded with people hoping for a chance to see a doctor. Given the high patient volume, the unwieldy doctor-patient ratio, and each evening's scant four hours of clinic time, patients' waits were inevitably long, and latecomers were sometimes turned away. Each day, an unpredictably diverse assortment of patients came to the clinic with an equally varied array of health concerns. On this particular Sunday, for instance, the list included regulars like Frederick, a chatty, middle-aged Nigerian man who had stopped in for his periodic blood pressure check, along with new patients like Norma, a middle-aged Filipina woman with a stubborn rash on her arm; Constantin, a Romanian man whose girlfriend needed a gynecology appointment; and Linda, a disgruntled young South African mother who, the clinic director told me in a whisper, the doctor suspected might be HIV positive, as might her one-month-old, Israeli-born baby.

For the clinic's patients, marginalization, "illegalization," and criminalization are no mere abstractions. Whereas Israeli migrant advocates and activists identify people like Frederick, Norma, Constantin, and Linda in descriptive terms as "unauthorized labor migrants" (*mehagrei avoda le'lo ashra*), in vernacular discourse they often are labeled disparagingly as "illegal foreign workers" (*ovdim zarim lo khuki'im*)—a term with powerful negative associations. Linked semantically to the biblical term for idol worship (*avodah zara*), the Hebrew term for "foreign worker" (*oved zar*) foregrounds these im/migrants' Otherness, and it ascribes social value only to the labors of their "working hands" while diminishing, or even denying their humanity. At the same time, it also ignores the crucial fact that the condition of migrant "illegality" is nothing natural or self-evident, but, rather, a complex, ideologically charged social construction.<sup>2</sup> For these uninvited residents, and for their counterparts in other migration settings, the forms of discursive, social, and biopolitical exclusion that accompany migrant "illegality" often translate into adverse living and work conditions, poverty, the perpetual threat of arrest and deportation, chronic stress, and other factors that interact syndemically (Singer 2009) to heighten vulnerability to illness and injury and to increase their likelihood of abandonment by prevailing systems of public health and clinical care. Undergirding these embodied forms of "bio-inequality" is a fundamental denial of what Fassin (2009) calls "biolegitimacy." Put bluntly, neither the state nor society finds unauthorized im/migrants' health, or their lives, particularly deserving of attention or concern (cf. Willen forthcoming-a, 2010b).

Despite Israel's nationalized health care system, world-class systems of medical education and care, and proud position on the global cutting edge of medical technology, when people like Frederick, Norma, Constantin, and Linda have health needs, they have virtually nowhere to go but the tiny, resource-strapped BZA Open Clinic. Since its establishment in 1998, this small, makeshift health center has accumulated well over 50,000 patient files, undergone multiple changes in professional leadership, and relocated several times. In material terms, it has little to offer its patients other than a small stock of donated medications, a few pieces of donated medical equipment (an ultrasound, an EKG), and a seemingly boundless supply of volunteer energy. With these meager resources, as I observed during my years as a volunteer receptionist and participant-observer (2000–03) and briefer return visits (2005, 2007, 2008, 2010), the clinic's director and volunteer team struggled daily to help patients with health problems ranging from childhood illnesses and common colds to work injuries, chronic diseases like heart disease and cancer, and infectious killers like tuberculosis, hepatitis, and HIV. What leads BZA activists to recognize and respond to the suffering of people whom the Israeli state and society seem comfortably to ignore? As I argue in this article, what unites BZA's activists, including both their professional staff and their large team of volunteers, is a fundamental rejection of political discourses and government policies that deny unauthorized im/migrants' biolegitimacy—that is, that categorically exclude im/migrants from the broader moral community. Significantly, however, it would not be accurate to say that all activists at BZA, which explicitly self-identifies as a human rights organization, are equally committed to the proposition that “illegal” im/migrants have a right to health. A close ethnographic look at BZA reveals that this beguilingly simple assertion is actually a matter of considerable epistemological, ethical, and practical confusion and debate.

Although the anthropology of human rights has grown by leaps and bounds in the past 15 years, the notion of a human right to health—for unauthorized im/migrants or anyone else—has yet to become a robust object of anthropological study. Perhaps this paucity of attention should come as no surprise, for as recently as 1994 it was possible to say that, “The phrase ‘right to health’ is not a familiar one” (Leary 1994:24). Since these words were published (notably, in the inaugural issue of the now well-established journal *Health and Human Rights*), the right to health has become a prominent concern in myriad fields of scholarship including legal studies,<sup>3</sup> bioethics,<sup>4</sup> public health,<sup>5</sup> clinical medicine,<sup>6</sup> and medical anthropology.<sup>7</sup> Beyond the academy, it has also become a crucial rallying point for communities of advocacy, activism, and practice. In these pages, I reframe this burgeoning discussion about the nature, content, and implications of the right to health through the lens of my long-term fieldwork at BZA's Open Clinic to pose several questions for anthropological consideration. First, what is meant, or implied, by the notion of a right to health? How do the meaning and significance of this right vary when it is invoked—either with enthusiasm or with disdain—by activists, lawyers, moral philosophers, public health professionals, medical anthropologists, and politicians, among others? Second, what do divergent actors seek to accomplish by invoking this right, lobbying for it, or repudiating it? Third, whose right is this? Whose is it to claim, and whose is it to enforce? Fourth, how do invocations of this right intersect with humanitarian, Hippocratic, and other impulses to mobilize in response to social

injustice? Finally, how ought medical anthropologists to engage the right to health theoretically, empirically, and in practice?

Rather than tackling each of these questions in turn, this article instead explores ethnographically how a single human rights NGO translates—or, more precisely, struggles to translate—personal and institutional commitments to unauthorized im/migrants' right to health into particular forms of discourse and practice. Running alongside this empirical thread is a theoretical challenge. Medical anthropologists, I propose, need to avoid simply rallying behind the notion of a right to health; instead, we ought to approach it as an ethnographic object and critically examine how it is invoked, debated, advanced, and resisted in specific local contexts. We need to survey and analyze the broad constellation of claims that employ this common discursive framework, and we need to explore this right ethnographically in all its guises: as a legal instrument, a social object, a rhetorical flourish, a node of contingent and precarious political consensus, a framework for translating theory into practice, and, finally, a recognizable, branded strategy for advancing a particular set of ethical or political commitments—what we might call a contemporary *idiom of social justice mobilization*. Finally, and as importantly, we need to ask ourselves what *we* mean when we invoke the right to health in our own research, writing, teaching, and advocacy efforts.

These are crucial questions for medical anthropology, not least because there exists a strong, indeed uncharacteristic, tendency among medical anthropologists to support this proposition almost without question. The notion of a right to health is appealing because it taps into a deep desire for social justice that many of us share. It evokes a sense of moral clarity absent from much of our professional engagement, and it implies a forceful, even immediate call to action. Specifically, it offers a pointed response to the scourge of preventable injuries that are not prevented, curable diseases that go uncured, and other forms of useless suffering that medical anthropologists witness regularly in the course of our work. It is the language of key leaders in our field—for many of us, our heroes. Few moral or political claims touch anthropologists as deeply or evoke as uniform a response. Without questioning the nobility of these aims or the legitimacy of these desires, we need to acknowledge the fuzziness or, to borrow from Amartya Sen (2009:355), the “mushiness” of this particular right and subject it—and our reflexive support for it—to critical review.

In proposing that medical anthropologists take the right to health as an ethnographic object, my aim is neither to impute naïveté to its advocates nor to undercut the growing movement to translate it into law, policy, and practice; to the contrary. Instead, I propose that critical ethnographic engagement with right to health discourse and practice can enlighten us, and help us enlighten scholars in other fields, to the complexity, messiness, and “mushiness” of this right, both in general and for activists on behalf of unauthorized im/migrants in particular. At the same time, it can also deepen our understanding of the complicated and sometimes tense relationships among human rights, humanitarianism, and other scholarly and popular *idioms of social justice mobilization*, especially in the health domain.<sup>8</sup>

One important step in this regard is to strengthen the bridge between medical anthropology and the anthropology of human rights. A decade ago, Richard Wilson noted that human rights language had become “detached from its strictly legal foundations and [become] a generalized moral and political discourse to speak about power relations between individuals, social groups, and states” (2001:xv).

He called on ethnographers “to look beyond the formal, legalistic, and normative dimensions of human rights, where they will always be a ‘good thing,’” and instead look “at how rights are transformed, deformed, appropriated, and resisted by state and societal actors when inserted into a particular historical and political context” (Wilson 2001:xvii). In a similar vein, Mark Goodale charges anthropologists to maintain a “skeptical distance from the exalted claims of human rights” while analyzing the “different registers through which the idea of human rights is conceived” (2006:32), and Levitt and Merry call attention to the “vernacularization” of human rights discourse by local actors (2009). Analytic tools like these can help clarify what is meant, what is desired and, no less importantly, what is feared when the right to health is invoked. Medical anthropologists have asked similar questions of humanitarianism,<sup>9</sup> but our relative inattention to right to health claims has impeded both our analyses and our understanding of the complex relationships among different *idioms of social justice mobilization*—including those identified as human rights-based or humanitarian. As I elaborate below, the relationship between these two idioms of ethical engagement can become especially complicated in the context of health advocacy on behalf of unauthorized im/migrants in industrialized countries.

To develop this argument, I draw on extended fieldwork at BZA, an Israeli NGO that works to advance right to health claims on behalf of “illegal” im/migrants and other vulnerable groups, including Palestinians in the Occupied Palestinian Territories (OPT), prisoners and detainees in Israeli custody, refugees and asylum seekers, and average Israeli citizens who are having difficulty realizing their right to health. The article begins by surveying the landscape of contemporary formulations and interpretations of the right to health. An overview of my research approach and methods follows. In the remainder of the article, I draw on ethnographic findings to explore how right to health commitments are expressed and negotiated by BZA activists. Here I trace the Open Clinic’s origins, activities, and internal political fissures, then introduce three BZA activists with divergent backgrounds, political inclinations, and personal motives to exemplify the organization’s internal diversity. The final section then analyzes the arc and content of a fiery intraorganizational debate revolving around the core question of this article: What does it mean to assert that unauthorized migrants have a right to health? Read in tandem, this trio of activist portraits and closely related “critical event” (Das 1995) reveal the epistemological and ethical friction between human rights and humanitarian modes of advocacy on unauthorized im/migrants’ behalf. These findings also show how the specific content of this right, as well as its potential for realization, often depend less on formal points of national or international law than on vernacular assessments of “deservingness” (Willen forthcoming-a)—that is, on questions of ideological commitment, morality, and ethics bearing a distinctly local cast.

## The Right to Health: Foundations and Contestations

What exactly are human rights? Are there . . . really such things?

—Amartya Sen, 2009

According to Amartya Sen, a commitment to human rights “can be very attractive as a general belief, and it may even be politically effective as rhetoric,” yet “[m]any

philosophers and legal theorists see the rhetoric of human rights as just loose talk—well-meaning and perhaps even laudable loose talk—which cannot, it is presumed, have much intellectual strength” (2009:355). This skepticism, Sen notes, is as old as the idea of rights itself. In a blistering 1791 attack on the recently declared “rights of man,” for instance, philosopher Jeremy Bentham declared natural rights “bawling on paper” and “rhetorical nonsense, nonsense upon stilts” (cited in Sen 2009:356). Are human rights as “loose” or “nonsensical” as critics allege?

In principle all human rights are equal and indivisible, but civil and political rights (sometimes called “first-generation rights”) have garnered much broader recognition and support, and proven more readily justiciable, than economic, social, and cultural rights (ESCR, or “second-generation rights”). In Paul Farmer’s terms, ESCR have long been “the neglected stepchildren of the human rights movement” (2005:xxiv). Yet things have begun to change because of, in part, increased attention to ESCR in diverse fields of scholarship; increased interest and commitment at the United Nations, which in 2002 created the new role of Special Rapporteur on the Right to Health; and the work of international NGOs like Partners in Health and, more recently, Amnesty International (Khan 2009).

These developments notwithstanding, human rights concepts, and especially the notion of a right to health, often are deployed in a freewheeling manner. As Gostin (2002:18) explains, this frequent overextension generates conceptual and epistemological confusion, and it begs the question: What *is* the right to health? Is it a legal instrument, as proposed in a recent *Lancet* editorial (2008b)? Is it a framework for developing and implementing policy, as proposed by the inaugural UN Special Rapporteur Paul Hunt (2007)? Is it a moral imperative demanding a lifetime of committed action, as Paul Farmer frequently insists (2005, 2010)? Is it a floating assertion that neglects crucial questions of duty and priority, as bioethicist James Dwyer contends (2004)? Or is it simply a catchy slogan or bumper sticker? From a medical anthropological perspective, how might we make sense of these “different registers” (Goodale 2006) of right to health discourse and the divergent ways in which this right becomes “transformed, deformed, appropriated, and resisted” (Wilson 2001)?

Until recently, three broad orientations to the right to health predominated: (1) legal approaches grounded in post-WWII international law (incl., in particular, Article 12 of the International Convention on ESCR [Office of the High Commissioner for Human Rights 1976] and UN General Comment 14 [United Nations 1966]); (2) ethical approaches grounded in moral philosophy; and (3) symbolic or rhetorical approaches. A fourth approach emerged in the mid-2000s when public health leaders began translating this right into the language of policy making and evaluation, and a fifth approach may be emerging in the clinical realm, for instance among European physicians using top-tier medical journals to debate the meaning of this right in clinical practice.<sup>10</sup>

Across this range of approaches, divergent interpretations abound. Are all entitled to the “highest attainable standard of health,” as stipulated by General Comment 14? If so, how is that “highest attainable standard” defined, and by whom? Are all entitled to the social determinants of good health? To be healthy, *tout court*? Some have argued that the notion of a right to health *status* is “obviously absurd” (e.g., Leary 1994:28). Others, including Yamin (1996), argue that it is

possible to define health in a manner that permits discussion of a right to health status. The boldest medical anthropological voice in these conversations comes from Farmer, who sees the right to health—“perhaps the least contested social right” (2005:19)—as one thread in a tightly woven fabric of economic and social as well as civil and political rights. As he declared in his keynote at the 2006 American Public Health Association convention in Boston, “if we believe in health and human rights, we will need to broaden, very considerably, our efforts to promote social and economic rights for the poor. This, I would argue, is the leading human rights issue now facing public health” (Farmer 2008:8). Clearly the meaning of this right broadens, contracts, shifts, and evolves as it cycles through divergent spheres of discourse, policy, and practice.

### Do “Illegal” Im/migrants Have a Right to Health?

What do these debates have to say about the health needs, rights, or entitlements of unauthorized im/migrants? Thus far, relatively little. In the past several years, the adverse health implications of migrant “illegality” have begun to garner increasing attention in medical anthropology and related fields, and a handful of scholars have engaged unauthorized im/migrants’ right to health directly.<sup>11,12</sup> Yet, as several colleagues and I contend (this issue), we still lack a clear, robust theoretical framework for research on “illegality” and health, both within medical anthropology and writ large. In sketching the contours of a viable research agenda, we prioritize four concerns whose cascading consequences have profound implications and raise thorny dilemmas for unauthorized im/migrants, their families, and the broader social and political communities in which they live and work. These include (1) the socially, politically, and ideologically constructed nature of migrant “illegality”; (2) the broad question of who benefits from contemporary processes of unauthorized labor migration; (3) the syndemic relationships among “illegality,” inequality, and health-related vulnerability and risk; and (4) the symbolic politics, ethical grounding, and discursive contours of debates about migrants’ “deservingness” (Willen forthcoming-a, forthcoming-b) and “biolegitimacy” or lack thereof. In this article, I am concerned primarily with this final point and, specifically, with the fact that moral debates about “deservingness” often take place in a human rights idiom that draws strength from the purportedly universal discourse of international law.

How do local attitudes toward human rights in general, and toward the right to health in particular, affect advocacy efforts on unauthorized im/migrants’ behalf? With this question in mind, let us now turn to Israel, where human rights are not viewed by the general public as an inherently “good thing,” but instead carry powerful connotations of a highly contentious brand of local politics: vocal opposition to the Israeli occupation of Palestinian people and lands. Under circumstances like these, what does it mean to advance an argument on behalf of unauthorized im/migrants’ right to health?

#### *Research Methods and Approach*

To engage these questions, I draw on more than 30 nonconsecutive months of ethnographic research conducted between 2000 and 2010 with unauthorized

transnational im/migrants and Israeli im/migrant advocates in the southern neighborhoods of Tel Aviv. In broad terms, the study aims to make sense of how “illegal” migration status is configured by the Israeli state and civil society and, moreover, how this rapidly evolving form of legal (non)classification shapes and constrains im/migrants’ embodied experiences of health, illness, pregnancy, and reproduction, as well as their broader experiences of subjectivity, morality, and being-in-the-world. Put differently, the study employs intersecting lenses of legal anthropology and the anthropology of the state, medical anthropology, and the anthropology of experience in taking a “critical phenomenological” (Desjarlais 1997) approach to migrant “illegality” (see, e.g., Willen 2007a, 2007c, 2010a).

The ethnographic anchors for the study include (1) two communities of unauthorized im/migrants in Tel Aviv (the Filipino and West African communities),<sup>13</sup> and (2) three Israeli migrant advocacy organizations. Since my initial research questions involved unauthorized im/migrant women’s experiences of fertility decision-making, pregnancy, and reproductive health, many of the migrants I first met were pregnant women or new mothers (see Willen 2005). I accompanied a subset of these women, and sometimes their male partners, as they sought either abortions or prenatal checkups, diagnostic tests, and in three cases, labor and delivery in Israeli hospitals. I also participated actively in the home, family, and community lives of key research participants and attended a wide variety of community activities including church services, life-cycle events (i.e., weddings, christenings, funerals), holiday and community celebrations, and community meetings.

Of the three migrant advocacy organizations in which I conducted fieldwork, two—BZA’s Open Clinic and a hotline for im/migrants in detention—are local human rights organizations (NGOs) serving migrant workers, asylum seekers, and refugees. The third organization, an Aid and Information Center that serves the same groups, is municipally funded and operated. Intensive, long-term involvement with these three very different organizations provided invaluable opportunities to meet migrant workers, to become a familiar face in the city’s im/migrant communities, and to set the study into motion. Furthermore, it enabled me to train a long-term ethnographic gaze on the complicated and dynamic im/migrant advocacy community itself.

Here I focus on research conducted at BZA’s low-tech, small-scale Open Clinic, where I spent approximately three evenings (15 hours) per week as a participant-observer and reception-desk volunteer during my primary period of field research (fall 2000; summer 2001–summer 2003). At BZA I also attended, audio-recorded, and took notes at weekly staff meetings, occasional clinic staff meetings, periodic executive board meetings, and annual planning retreats. Additionally, I conducted a 68-item, self-administered survey in 2002–03 with a multinational convenience sample of 170 English-speaking clinic patients. Survey questions covered basic demographics, migration motives, experiences of everyday life in Israel, current health status, health care management strategies, and beliefs about deservingness to health care in Israel (Willen 2005, forthcoming-a). Since 2000, I also have conducted more than 25 semistructured interviews (13 of them audio-recorded) and dozens of informal interviews with BZA staff members and volunteers (clinic directors, the coordinator of the Project on Migrant Workers, young adults performing National Service at BZA in lieu of compulsory military service, clinical volunteers, and



reception-desk volunteers). The study was conducted with approval from BZA and from the institutional review boards at Emory University, Harvard Medical School, and Southern Methodist University.

### A Shoestring Clinic—and a “Fig Leaf for Shame”?

As I learned early on from Eran Moyal,<sup>14</sup> the first coordinator of BZA’s Project on Migrant Workers and inaugural director of the Open Clinic, the clinic was created with two goals in mind: first, to offer policymakers concrete evidence that the country’s growing undocumented population urgently needed health care, and second, to hand responsibility for the clinic, and the problem, over to the state. At no point was it meant to serve as a constant or comprehensive source of health care for this large, linguistically and culturally diverse population. Neither was it meant, as a senior Israeli physician and longtime clinic volunteer put it, to serve “as a fig leaf for the shame of the state and Israeli society” (Fried 2003). Given the scope and depth of need among the country’s migrant workers, the first goal was relatively easy to accomplish. The second, however, has bordered on the impossible, and the clinic remained open and busy as this article went to press.

During my fieldwork, the clinic was open four evenings and one morning per week (approximately 20 hours), and it served as the place of first, and often last, resort for transnational im/migrants with health concerns, especially those without authorization status. The tremendous diversity among the patients mirrored the diversity of health concerns that brought them in seeking care.<sup>15</sup> Clinic volunteers, almost all of them Jewish Israelis, were less diverse. Most volunteered in the clinic about one evening per month, although some came more or less frequently. Physician volunteers ranged in age and experience from medical residents to well-known division chiefs at area hospitals, and almost all were middle- or upper-middle-class Ashkenazim (Israelis of European descent). Nurses also ranged widely in age, and the majority were middle class and Ashkenazi. The volunteer reception staff included university students of both Ashkenazi and Mizrahi (Middle Eastern) backgrounds, pensioners, and a rotating array of others including a veterinarian, a former army medic, the owner of a trendy bookstore–café, and an artist and longtime area resident who volunteered in gratitude to her new neighbors for replacing the drug addicts who used to hang around the neighborhood. Although some volunteers came to the clinic on just one or two occasions, the clinic was staffed by a relatively stable rotating group of volunteer physicians, nurses, and reception staff throughout my primary period of fieldwork. A few volunteers did drop out in this period; for instance, one physician moved away from Tel Aviv, another had a stroke, and a third took a lengthy break but later returned. Several elderly volunteers stopping coming when they became hampered by failing eyesight or an inability to drive, and some younger volunteers stopped coming when they left the country to travel or study abroad. All clinic staff and volunteers were continually challenged, and often deeply frustrated, by the high patient volume, the gravity of the health issues patients faced, and the clinic’s embarrassingly limited resources. The risk of burnout was highest, however, for the professional staff member responsible for directing the clinic, a role that changed hands several times during my fieldwork.

Although the clinic's initial mission focused narrowly on primary care, it quickly expanded well beyond its original scale and scope. During my years in the clinic, staff and volunteers worked assiduously to confront virtually every health issue that arose, even when a patient's need far surpassed the small clinic's capabilities. Typically the more challenging cases involved finding volunteer physicians willing to perform procedures in their own (publicly funded) clinic offices or in a donated (often private) surgical space. Through such efforts, the clinic managed to arrange minor outpatient surgeries like the removal of suspicious moles; more substantial surgeries like hernia operations; and occasionally major surgeries, for instance to treat breast cancer, ovarian cancer, and in one case a benign but rapidly growing brain tumor. At one point, a volunteer oncologist even administered chemotherapy in his own kitchen. Clearly, the clinic was far from equipped to meet its patients' needs; its efforts were like trying to sip water from a gushing fire hydrant.

During the first decade of the 2000s, the clinic underwent several administrative changes and multiple relocations. The size and composition of its patient population also changed dramatically following two major developments: an expensive, high-profile, and occasionally violent mass deportation campaign targeting unauthorized im/migrants (Willen 2007a, 2010a), and a more recent influx of Sudanese and Eritrean asylum seekers and refugees arriving overland via Egypt (Anteby-Yemini 2009; Kritzman-Amir 2010; Willen 2010b). The latter of these events completely overwhelmed the clinic's capacity, and in spring 2008 BZA temporarily closed the clinic down to protest the government's neglect of this new im/migrant population's health needs. Indeed, this temporary closure lays bare the fundamental question that has lingered unanswered since the establishment of the BZA clinic in 1998: Is it most fundamentally a humanitarian endeavor—and, as such, has it become a fig leaf for an eroding welfare state and an array of exclusionary government policies? Or, alternatively, is it a human rights project whose aim is to rectify the causes of individual and group suffering using ethical concepts and legal instruments of international provenance?

### BZA and Its "Stepchild"

Sunday afternoon, summer heat, a long row of patients squeezed shoulder to shoulder in white plastic lawn chairs. The clinic director and a volunteer receptionist rush back and forth through the cramped clinic space, blue cardboard patient files in hand, crisscrossing multilingual clouds of conversation: Tagalog here, Igbo there, a whispered conversation in Spanish, broken Hebrew accented with Russian, Turkish, Romanian, Chinese. In the improvised examination rooms in back, clinical encounters are staged in whatever language works: Hebrew, English, perhaps Spanish or French, occasionally Russian. For patients, there is little space for privacy, and for clinic volunteers, there is little time or patience for things like patient confidentiality or "cultural competence." Here volunteers do the best they can: to obtain enough information to open a patient file; to understand a patient's chief complaint; to find a volunteer specialist here or a discounted procedure there; to squeeze in just one more patient; to keep volunteer doctors from noticing they've stayed an extra half hour, hour, two hours.

Despite BZA's explicit self-definition as a health and human rights organization, the decision to establish the clinic in 1998 was controversial, and a decade later it still had not won the unanimous support of the NGO's activist base. Since its creation, a certain tension lingered between the Project on Migrant Workers, which runs the clinic, and BZA's other projects, especially those focused on the OPT. As one staff member put it, the clinic operated as "a kind of independent autonomy" or a "stepchild of the organization." On occasion (incl. the turbulent moment addressed in the final section), this "stepchild" status stimulated heated debate about the clinic's mission, its goals, and even its very existence. To understand what animates these debates, we need to turn back to BZA's establishment in 1988, just months into the first Intifada (Palestinian national uprising) and nearly a decade before Israel had become a destination for transnational labor migration. The founders of BZA, a small group of health care professionals who opposed the health-related human rights violations committed by Israel against Palestinians in the OPT, understood full well that in contemporary politics, health is a "meta-value," and "speaking in the name of health is one of the most powerful rhetorical devices" (Greco 2004:1). The fledgling group began organizing under this banner, and it quickly earned a place of respect among the handful of Israeli groups ready to use a human rights platform to work for change, even if that meant tangling publicly with high-ranking politicians, the military, and the courts. The universalizing meta-discourse of health as a human right, these activists wagered, just might trump particularist moral debates in which their community of concern—Palestinians living under Israeli occupation—would otherwise be cast as categorically "undeserving" of attention or care.

### "Dreamers," "Traitors," and "Self-Hating Jews": The Local Politics of Human Rights

Complicating this assumption, however, is the fact that human rights discourse is most commonly associated in Israel with political activism against the occupation and in support of the left-wing "peace bloc." Human rights activists and even journalists who report on Israeli repression and violence in the OPT are publicly doubted, maligned, and subjected to verbal abuse. In early 2011, for instance, one right-wing parliament member sponsored a bill calling for a wide-reaching inquiry into the budgets and finances of local human rights organizations; in expressing support for the bill, a parliamentary colleague went so far as to characterize these organizations as "traitors," "germs," and "enemies of Israel."<sup>16</sup>

Importantly, antagonism toward human rights is not limited to the far right wing of the Israeli political spectrum. In a 2010 poll, for instance, 57.6 percent of Israelis surveyed agreed that "human rights organizations that expose immoral conduct by Israel should not be allowed to operate freely," and a majority supported "punishing journalists who report news that reflects badly on the actions of the defense establishment" (Kashti 2010). These developments resonate with the sort of equations I encountered regularly in the field: "human rights" equals "pro-Palestinian"—which equals "Arab lover," "self-hating Jew," and other such slurs. Given this strong web of association, many of BZA's antioccupation activities elicit strong negative reactions from a large segment of the Israeli public, and the

organization's commitments often draw local condemnation and ire, rather than the reflexive, commonsense support human rights often garner in other contexts.

Although human rights activism on behalf of groups other than Palestinians is less vigorously condemned, it tends to carry a certain amount of guilt by association. As I learned from a veteran human rights lawyer, scholar, and former academic director of a refugee rights clinic at one of Israel's top law schools, such accusations of "guilt" sometimes take the form of *ad hominem* attacks. She and her colleagues, she explained, are accused regularly of being "out of touch with reality, including ignoring the dangers of life in Israel—both physical and economic. You are considered to be a dreamer, an idealist, and that's not a compliment, but rather a term used to refer to someone who is unrealistic, naïve, and immature." To borrow Wilson's term, the social life of human rights in Israel is distinctive indeed.

### Transnational Migration to Israel: Multiple Pathways

Significantly, the impetus for BZA's Open Clinic—the arrival of hundreds of thousands of transnational migrant workers in the mid- to late-1990s—was a direct result of the ongoing occupation. Following the first Intifada of the late 1980s, in 1993, the Israeli government began authorizing the recruitment of transnational workers from Thailand, Romania, Bulgaria, and China, among other countries, to replace Palestinians now denied access to their former jobs in Israel on "national security" grounds. Tens of thousands of agricultural and construction workers who arrived "legally" later lost their status, largely as a result of the country's unregulated and corrupt system of transnational labor recruitment, which has been well documented by Kemp (2004). Briefly, private employment agencies recruit labor migrants and charge them anywhere between \$5,000 and \$20,000 for the "privilege" of coming to work in Israel—in explicit contravention of Israeli laws prohibiting the extraction of such fees—thereby earning billions of dollars for recruitment agencies based both in Israel and in migrants' countries of origin (Kemp 2004; Workers' Hotline and Hotline for Migrant Workers 2007). Local human rights groups estimate that tens of thousands of labor migrants and their families have gone into debt to finance their travel to Israel. Often these recruitment companies have brought workers to Israel even when no jobs were available; in such instances, labor migrants lose their legal status almost immediately after arriving in the country. Meanwhile, tens of thousands of "illegal" migrants from a separate set of world regions (South America, Africa, Eastern Europe, and the former Soviet Union) arrived as tourists or Christian religious pilgrims and found work in housecleaning, childcare, restaurant work, and other informal market sectors.<sup>17</sup> Per definition, none of these economically motivated transnational migrants can stake a bureaucratically legible claim to Israeli citizenship; put bluntly, none are Jewish.

Although health care is considered a public good in Israel and nearly all physicians are publicly employed (growing neoliberal pressures toward privatization notwithstanding [Filc 2009]), transnational migrants are excluded from the country's nationalized health care system. Theoretically all employers are required to ensure that their employees, regardless of status, possess health insurance, yet this obligation is poorly enforced for "legal" workers and completely ignored for "illegal" workers. Private health insurance options are scarce and deficient, and private fee-for-service

options are prohibitively expensive. Several exceptional forms of care are available, at least theoretically, including emergency care (albeit at high tourist rates); subsidized or even free prenatal care and delivery care (Willen 2005); and subsidized or free treatment for tuberculosis, sexually transmitted infections, and HIV in pregnant women (Filc and Davidovitch 2007; Rosenthal 2007).

### Ethical Theory and Social Practice: Activist Motives and Moral Journeys

As the number of transnational migrants grew exponentially in the late 1990s, and as the scope and degree of health need within this diverse population became increasingly evident, some BZA staff and activists felt it necessary to expand the organization's mission and create an Open Clinic in Tel Aviv. Yet not all BZA staff and volunteers concurred that this new population fell within their bailiwick. Of the activists I interviewed and alongside whom I volunteered, most fell roughly into one of four groups. The first group, health professionals who sharply oppose the Israeli occupation of Palestinian people and lands, were attracted to BZA explicitly for reasons of politics and ideology. For them, BZA is a potent megaphone for anti-occupation messages capable of amplifying international legal principles through the trusted, authoritative voices of clinical medicine and the "meta-value" of health (Greco 2004). Some members of this first group saw any expansion of BZA's mission as a potential distraction from the organization's "real" goal: bringing the occupation to an end. A second group included individuals who espouse what is effectively a humanitarian (as opposed to a rights-based) commitment to health care for all. At times, this universalist motivation allowed volunteers to ignore politics and hide in a "Hippocratic bubble" (Portes et al. 2009:495) of individual-level ethical obligation while remaining disconnected, at times myopically so, from the broader social determinants of disease, injury, and ill health, including exclusionary biopolitics and structural violence. Third, although many physicians and nurses were involved with both the Open Clinic and BZA's antioccupation efforts, a small minority clung to one "side" of the organization's agenda while remaining deeply skeptical about, or even openly critical of, the other. Finally, a handful of activists, most of them professional staff as opposed to volunteers, described their motives and commitments explicitly in terms of universal human rights. For activists in the first three groups, the technical definitions and interpretations outlined earlier in this article were far from their minds; instead, BZA served primarily as a vehicle for advancing a locally specific, and often deeply personal, set of ethical or political commitments. For activists in all four groups, however, the choice to become involved with the clinic often initiated a complicated moral journey with transformative implications.

Below I introduce three activists, each of whom brings a very different set of ethical commitments to his or her efforts on unauthorized im/migrants' behalf. The first two, physicians Dr. Sarit Peled and Dr. Guy Barkan, belong, respectively, to the first and second of the groups identified above. The final activist, Kobi Levy, is not a physician but a savvy human rights advocate and member of BZA's professional staff. His role as coordinator of BZA's Project on Migrant Workers, and his radical agenda for the organization, place him in the fourth group and identify him as one of the few BZA activists committed to an explicit, internationally recognizable human rights paradigm.

*Dr. Sarit Peled: "Why do [migrant workers] deserve this? They choose to come here, right?"*

I remember vividly the first time Dr. Sarit Peled visited the Open Clinic in October 2000, primarily because she didn't know why she was there—and said so. A young resident in internal medicine with a warm smile and a soft voice that could turn sharp in an instant, Dr. Peled spent her first visit challenging the clinic's longsuffering director, Yael Grossman, to explain and defend the clinic's *raison d'être*. Dr. Peled was drawn to BZA because of its work in the OPT, she explained, and she "had never thought about 'illegal' foreign workers as a population needing help. Why do they deserve this? Palestinians, prisoners I understand—but why foreign workers? They *choose* to come here, right? My time is limited," she continued defensively. "I'm not sure this is worth it."

Unaccustomed to such demands from potential volunteers, Grossman nonetheless stepped up to the challenge. In the soft, measured tone I had come to know well from our long evenings together at the reception desk, she riffed on an explanation I had heard Israeli migrant advocates at BZA and other organizations offer time and time again. Migrant workers "are not on vacation," she explained. "The situation in their own countries is so bad. Many want to work and return home. . . . I'm not saying that I—or BZA—think the number of migrant workers in the country should be increased. It should be reduced. Also the minimum wage should be raised." As Grossman continued her impassioned defense, she traced lines of causality, pinpointed local problems, and concluded on a practical note: "There are two reasons people come to work in the clinic. Either ideology, or to help people. Either is ok. But above all, don't come if you're not comfortable."

Later in the evening, after Dr. Peled had left, Grossman needed to blow off steam. She had better things to do, she told me, than argue with a potential volunteer. "I'm not going to convince anyone to come." And yet that is precisely what she had done. Two weeks later, Dr. Peled showed up at the clinic as a scheduled volunteer, and again two weeks after that. On that second occasion, I overheard her spontaneously issue a strong defense of the clinic's mission, echoing many of Grossman's points. For Dr. Peled and many other BZA volunteers, a politically motivated desire to help Palestinians was the "hook" that got them involved, sometimes to their own surprise, with the Open Clinic's efforts on behalf of unauthorized im/migrants.

*Dr. Guy Barkan: "Way too radical for me"*

Like Dr. Peled, psychiatrist Guy Barkan also began volunteering at the Open Clinic during his residency. A long-time clinic volunteer with strong research ambitions, Dr. Barkan noted in a 2007 interview that friends and colleagues occasionally criticized his commitment to the clinic. He repeated one such remark using a biblical phrase that figures commonly in such critiques: "A friend once said to me 'first take care of the poor of your city' [*aniyei irha kodmim*]*—but the 'poor of my city' have ID cards, they have social services, they can access a doctor.*"

When I asked about his most memorable experiences at the clinic, Dr. Barkan spoke at length about an African patient who was treated for breast cancer after he had detected a lump in her breast and referred her for specialized care. Because physicians tend to volunteer just once every few weeks, patients rarely see the same

doctor on consecutive visits. About a year and a half after their first encounter, the patient arrived “really, really late in the evening, when we were all ready to go home,” requesting a cream to soothe the dry skin on her breast. “You were my first doctor,” she said, although it was only after flipping to the very back of her now-thick medical file and seeing his own handwriting that he could confirm, with considerable embarrassment, her confident assertion. On reading her chart more carefully, Dr. Barkan was dismayed to learn that the patient had been treated for breast cancer, including the radiation that left her skin painfully dry, but that the cancer had returned and her prognosis was bleak. He also felt terrible guilt about his failure to follow up on her case.

After this second encounter, he stepped back from his clinical role to become what he called a kind of “total case manager”: supervising his former patient’s care, taking her out to a restaurant, buying toys for her small daughter. I asked how he would characterize their relationship. “What can I call this? I don’t know, compassion? If she needs a brain CAT scan at 3:00 A.M., I’ll take her. . . . Look, she’s going to die, she’s dying. She already can’t see out of one eye . . . and she’s in denial . . . and her daughter . . .” Clearly Dr. Barkan’s commitment to the Open Clinic, and particularly to this former patient and her young daughter, ran deep. Yet he had no interest in the political debates that raged at BZA about the broader implications of the clinic’s work. To him, these internal debates fell somewhere between the pedantic and the misguided. “I was at this meeting once of [BZA activists], a dinner party,” he explained,

and someone started making radical leftist statements, like “you shouldn’t give people care, that actually makes things worse, if you provide care then the state can wipe its hands of the matter.” That’s way too radical for me. I’d be very happy if there were services like that provided by the state, but they’d close down the same day. . . . That’s just not the right way to look at it. . . . you just have to do it [i.e., provide care voluntarily]. Period.

Although Dr. Barkan vaguely supported BZA’s efforts to advance unauthorized im/migrants’ right to health in the legislative and policy spheres, he expressed deep skepticism about the possibility of dramatic change. Rather than getting tangled up in such battles, he preferred to stay away from rights debates and instead pursue a humanitarian stance—to just “come in and do what I do.”

*Kobi Levy: “A Different Number One Goal”—Changing Immigration Policy*

Kobi Levy, the coordinator of BZA’s Project on Migrant Workers and Refugees, was drawn to BZA for different reasons from either Dr. Peled or Dr. Barkan; what attracted him was precisely the organization’s broad human rights agenda. A tall, soft-spoken man in his early thirties, Levy was among the only BZA activists I interviewed who drew a direct connection between family history—in his case, his parents’ immigration to Israel from North Africa—and a present-day commitment to migrant advocacy.

I'm a child of an immigrant family. That's a strong feature of my family. The transition, the very partial integration into Israeli society . . . these things are very present. Language, Arab culture—something which for a long time, even today, on one hand exists in my house, yet on the other hand there's always an effort on my parents' part to push it aside. . . . It's had a very significant influence on my choices.

When I interviewed him in 2007, less than a year after he had joined BZA's professional staff, Levy acknowledged that some board members saw his project as an ongoing distraction from BZA's core agenda.

I'm relatively new here, but I know how things were in the past, and I can still feel it among board members . . . we're not only interested in the rights of Palestinians in the Territories. That's one thing. Second, when we're talking about immigration policy, . . . there's a certain kind of opposition among board members. Maybe it's just something that's not entirely clear to them.

For Levy, unlike some of the organization's activist base, the right to health applies across the board—to Palestinians, to unauthorized im/migrants, to asylum seekers and refugees, and to other “status-less persons” (Hebrew: *khasrei ma'amad*; a term that came into use at BZA during his tenure as project coordinator)—and it is inextricably entwined with other human rights that are equally central to BZA's mission. Often, he explained,

[our] demand of the establishment, or whomever, isn't necessarily a demand for medical care but a demand to grant someone status . . . or to register someone at the Ministry of Interior, or to give a child a [government] ID card. That's a different kind of right . . . but it directly influences the right to health. . . . Actually the right to health is just one other way to look at things . . . but it's not all we do.

I was curious to know how this broadly construed human rights agenda influenced his strategic aims. “What,” I asked, “is the goal of your project?” His response: “To effect change in Israel's immigration policy *via the right to health*” (emphasis added).

Levy's answer caught me by surprise for reasons that will become clearer in the section to come, where I analyze a turbulent moment that occurred well before he joined BZA in which this goal—changing Israeli immigration policy—was effectively written off as an idea unworthy of serious consideration. Intrigued, I asked for clarification: “So basically the number one goal supersedes the right to health?” His response: “There's a different number one goal.”

It's to somehow advance the idea of becoming a state that's Jewish—which is fine, it can stay Jewish—but to become a state that has room for other kinds of people. Yes, definitely, immigration policy and the rights of immigrants: that's where I'm trying to achieve change. Of course if I can make changes there, it'll also have an influence on their right to health.



Levy's approach to the Project he coordinated and to BZA's agenda overall, struck me as innovative and intriguing but also deeply controversial. Not only did he explicitly declare the right to health but one among many human rights on BZA's agenda, but he also rejected the humanitarian "Hippocratic bubble" that allowed some activists to focus on immediate health concerns while skirting larger questions of right. Instead, he was attentive to how structural violence and social exclusion (although he did not use these terms) produce migrant "illegality" and associated forms of vulnerability and health risk in the first place. Finally, by ranking immigration reform *above* health rights, his political stance diverged from the BZA mainstream, where most staff and activists identified reliable, affordable, quality health care for unauthorized im/migrants and others lacking status—*not* immigration reform or national self-redefinition—as the organization's number one goal. For Levy, immigration reform is how this ethical theory of global provenance—the notion of a right to health—ought to be translated into local-level social and political practice. How do others at BZA understand this translational task?

### Human Rights, Humanitarianism, and Realpolitik: Competing Idioms of Social Justice Mobilization

MSF [Médecins Sans Frontières, or Doctors Without Borders] limits its agenda with a humanitarian sensibility, resists the responsibility of any claim to power, and offers no general platform for an alternative social order.

—Peter Redfield, 2006

According to Peter Redfield, Médecins Sans Frontières, the archetype of global medical humanitarianism, "embodies the *moral insistence* of a human right to health" (2005:333; emphasis added). It has developed a sophisticated "technical apparatus" for providing medical care in crisis situations, but the organization "almost never claims to represent a comprehensive solution" (Redfield 2005:330). Rather, MSF tends to choose the "seductive clarity of denunciation" (Redfield 2005:349) over the path of courts-based advocacy or political lobbying in the messy world of realpolitik. BZA, in contrast, is a small grassroots organization and not a major global NGO; it explicitly self-identifies as a human rights group, not a humanitarian organization; and its team is well acquainted with the nitty-gritty of legal casework and parliamentary lobbying. In certain respects, however, the institutional inclinations Redfield attributes to MSF are also characteristic of BZA. In this final section, I explore one moment in which these inclinations found clear expression: a heated intraorganizational debate convened in spring 2002 to chart a path forward for the organization's Project on Migrant Workers. Two issues proved especially contentious during this debate, which involved five and a half hours of discussion spanning two meetings<sup>18</sup>: first, conflicting interpretations of the proposition that unauthorized im/migrants have a right to health, and second, disagreement about whether BZA should be in the business of influencing, or attempting to influence, public policy. On both counts, and to some activists' great dismay, the organization revealed itself to be teetering on the fence between human rights and humanitarianism.

According to BZA Executive Director Oded Blum, the goal of this discussion was “to develop first, our pure human rights objective, and second, [our] strategy.” Eran Moyal, inaugural coordinator of the project and a veteran staff member, refined this goal: “The question now is: what can be done in the [current] Israeli political atmosphere?” Widely viewed as a local expert, Moyal had by then successfully spearheaded a number of legal and policy campaigns leading to limited improvements in health care access for authorized migrant workers, children of transnational im/migrants and, to a certain extent, im/migrants living with HIV/AIDS. Moyal launched the discussion by presenting four possible action pathways:

- 1 A campaign to include all migrant workers in Israel’s nationalized health care system;
- 2 An enforcement campaign targeting employers, who already are legally obligated to confirm that all noncitizen employees, including unauthorized migrants, have health coverage;
- 3 A campaign to ensure a limited basket of “core services” provided by either the state or the municipality; or
- 4 A “legalization” campaign framed as a precondition for full realization of im/migrants’ right to health.

Below I briefly discuss the first three possibilities, followed by a more detailed discussion of the final, most contentious option.

The first proposal, integrating migrant workers into Israel’s nationalized health care system, garnered support even though it was deemed a radical proposition with little chance of success. Still, several staff members preferred it to any sort of humanitarian or charity-based alternative that would, as Oded Blum put it, convey the wrong message: “we would be saying it’s charity and they don’t have a right.” The second option, an enforcement campaign targeting employers, met with outright opposition. A handful of private insurance options already existed for “legal” workers, and most excluded preexisting conditions. Also, because employers, rather than employees, were typically named on such policies, any sign of illness or injury could leave workers vulnerable to losing both their jobs and, consequently, their legal status. Finally, activists roundly condemned the local insurance industry’s notorious “plane ticket policy,” whereby insured individuals with serious diagnoses do not receive full treatment in Israel but instead are flown “home” regardless of the availability, affordability, or quality of care in their communities of origin.

Some supported the third option, a limited basket of state- or municipally provided “core services,” suggesting it would finally hold the government accountable for ensuring a minimum level of health care to *all* transnational im/migrants. Although the proposal on the table called for only primary care, Blum predicted it would offer more. “The moment you offer primary care, you can’t impose any limits,” he argued. “You can’t refuse to deal with a cancer patient.” To my ears, this option sounded like a recycled version of the original, failed agenda of BZA’s own Open Clinic: a primary care clinic with an equally open heart but a somewhat larger purse and a Ministry of Health address.

*Is “legalization” a right to health issue?*

The fourth option, “legalization” as a pathway toward full inclusion in the national health care system, revealed the deepest and most significant differences of opinion among BZA activists. Several points proved especially controversial. The first hinged on Israel’s “Law of Return.” Crafted in the wake of World War II and the Shoah (Holocaust), the Law of Return inverts Nazi law by offering Israeli citizenship to anyone who might have fallen victim to the Nazis—that is, anyone with one or more Jewish grandparents and their immediate relatives. Virtually all others—transnational migrant workers, asylum seekers, Palestinian spouses of Israeli citizens, children born in Israel to members of these groups, and others who cannot demonstrate a bureaucratically legible connection to the Jewish people—are excluded. One longtime staff member, Noa Goldman, argued that the real problem lies in the exclusionary nature of Israel’s migration regime, and that the only real remedy would involve eliminating the Law of Return altogether. Only a tiny minority at BZA, and an even smaller minority of the Israeli public, would likely have supported Goldman’s proposal.

Another topic of disagreement revolved around the question that eventually topped Kobi Levy’s agenda five years later: the question of whether “legalization” was a necessary precondition for the realization of unauthorized im/migrants’ right to health. A number of physicians on the executive board opposed legalization on practical grounds, ideological grounds, or both. Dr. Green, for instance, argued that growing neoliberal influences and creeping privatization had created complicated ethical dilemmas for the Israeli health care system, and for Israeli physicians, and that the needs of Israeli patients had to take ethical precedence. “I try to be very pragmatic,” he said,

There are huge forces working against these objectives, like the huge numbers of unemployed people. First, to expect things from a government that’s supposedly trying to encourage Israelis to work is very unrealistic. Second: the rights of Israeli patients. Every day I deal with situations where I have to refuse care to people without money. I don’t know if you realize it, but the situation of the Israeli taxpayer is very bad right now. The Sick Funds [nationalized HMOs] are refusing to cover such basic things as follow-up care after surgery. Covering [unauthorized migrants] would be hugely expensive.

At this point Dr. Berger, a senior board member known for not mincing words, retorted, “it would cost less than one bypass road.” The expensive, well-designed roads to which she referred are constructed in the OPT for the exclusive use of Israeli settlers and, because they are off limits to Palestinians, they are sometimes dubbed “apartheid roads” by the government’s strongest critics.

Several board members spoke in support of Dr. Green. For instance Dr. Hussein, one of the only Palestinian–Israeli members of the board, said, “we’re wasting a lot of energy, time, and maybe money looking for a law or running to courts without giving primary care, humanitarian aid, to people.” Before long, Dr. Mintz, Chairman of the Board, complained that the conversation was losing focus:

The State of Israel, which can barely define itself, is not about to absorb another population. It's not going to happen. Therefore I—we always get into these global discussions—we're sort of astronauts in this department—therefore I think we should work on the humanitarian issues. Period.

Multiple lines of tension crosscut this lengthy, meandering conversation, but the deepest gulf divided board members with humanitarian inclinations from the human rights-oriented professional staff. By the end, Blum and Moyal wanted to shoot for the max and wage a rights-focused campaign that might, if successful, radically transform how migrant “illegality” is configured in Israel—essentially by eliminating it altogether. The chairman and several board members, in contrast, leaned toward a more modest agenda inspired, but not driven, by human rights principles.

This fundamental division became even clearer when Blum tried to steer the conversation toward closure. Moyal asked, “Do we start with ‘every person living here is entitled to all health rights?’” A board member, Dr. Feierstein, said, “we should start with a practical first step toward the ideology.” At that point, Dr. Mintz, drew the line:

There's a problem with our approach. Our project is not legalization. We're doctors. We don't know anything about this. Let's set limits. My number one concern is health, that all people who need health care will get it from the state.

Ultimately, then, five and a half hours of debate yielded neither clarity nor consensus about the specific content of unauthorized im/migrants' right to health or about the optimal, or even most realistic, pathway through which this right might be realized.

Multiple factors contributed to this lack of consensus including, in particular, the inherent difficulty of translating global configurations of ethical theory into concrete, consensually agreed-on forms of social and political practice. Ostensibly, the staff and volunteers at BZA were aligned behind a common set of principles and goals enshrined in the organization's eponymous commitment to health and human rights. Yet when activists began talking about the right to health, whether individually or in relation to broader questions of organizational mission and strategy, each seemed to have a different meaning in mind. Throughout the debate, no one quoted international human rights instruments or invoked moral philosophers or bioethicists. Neither did anyone draw comparisons to counterpart organizations in other countries or world regions. Moreover, everyone was acutely aware of the myriad obstacles to policy change and legal reform: a strained national budget, conservative national leadership, divisive parliamentary politics, a nationwide preoccupation with “security,” an ongoing military occupation with devastating human consequences, an overburdened welfare state, an epidemic of compassion fatigue, and the stigmatization of “human rights” activism in Israel as politically tainted, naïve, or even traitorous.

The most striking feature of this protracted and circuitous debate was BZA activists' complete inability or, perhaps, refusal to acknowledge the elephant in the room: the fact that a number of board members, despite their deep commitment to a health and human rights organization with a long track record and a very public profile, simply would not commit themselves to a *rights-based* interpretation of the right to health—that is, as a universal principle, a legal instrument, or a policy framework. Instead, board members like Dr. Green, Dr. Hussein, and Dr. Mintz adopted a distinctly *humanitarian* interpretation of this right—an interpretation not unlike that of MSF, which, according to Redfield, “embodies the *moral insistence* of a right to health.” Seen in this light (and here we see the resonance between their views and those of Drs. Peled and Barkan), health is a meta-value, a rhetorical device, and a potent symbol of a particular mode of intersubjective attention. It is an ethical discourse of global provenance that can play a valuable role when expedient; when inexpedient, however, it is to be relinquished in favor of other *idioms of social justice mobilization* such as humanitarianism, Hippocratic obligation, a national commitment to health as a public good, or ethical imperatives derived from collective memory or historical experience. Throughout this heated and lengthy debate, BZA's ostensible core commitment—to the right to health—turned out to be very much a moving target.

### Conclusion: Rethinking “Illegality,” Bioinequality, and the Right to Health

So do “illegal” im/migrants have a right to health? Rather than offering a straightforward answer, BZA and its Open Clinic instead reveal the complexity of this question and suggest that it requires reframing along several lines. First, however objectionable or “obnoxious” (De Genova 2002:420) we may find the language of “illegal” migration and migrant “illegality,” this mode of classification emerges consistently across migration settings, and it bears powerful material consequences, especially in the health domain. As I have suggested elsewhere, migrant “illegality” demands in-depth and comparative ethnographic attention along three dimensions: as a form of juridical status, a sociopolitical condition, and a particular mode of being-in-the-world (Willen 2007c). This three-dimensional approach can help us grasp how “illegality” is locally configured, how it shapes and constrains im/migrants' life-worlds, and how it can “reach quite literally into illegal migrants' inward parts” by profoundly shaping their subjective experiences of time, space, embodiment, sociality, and self” (Willen 2007c:10).

Yet this model neglects a crucial fourth dimension: the relationship between “illegality” and what Fassin calls “bioinequality,” or the epidemiological consequences of exclusion from the moral community (2009). Bioinequality, Fassin suggests, is not a simple function of biopolitics, for Foucault's biopolitics has little to say about the questions of morality and judgment that lead to the erection of biosocial boundaries and the unequal valuation of human suffering and human lives. Rather, these health-related inequalities hinge on a largely neglected question of great consequence: the question of “biolegitimacy,” which, for Fassin, lays the foundation for what Petryna (2002) calls “biological citizenship.”

As a medical anthropologist who has worked for over a decade with unauthorized im/migrants, I have long found the language of biological citizenship and its variants

powerful but also troubling. A few discursive contortions may render plausible the claim that average unauthorized im/migrants possess a certain form of “citizenship” despite their (often-comprehensive) exclusion, yet such efforts have long struck me as somewhat overwrought. Fassin’s rereading of Foucault, and of Petryna, explains why. What drives unauthorized im/migrants’ social and political exclusion stems not from the realm of citizenship—that is, the realm of biopolitics and governmental practice—but, rather, from the realm of collective moral judgment, understood here in terms of biolegitimacy. In seeking causal arrows, then, we must look both at and beyond the state, for determinations of biolegitimacy are not made or enforced by states alone. Rather, they emerge in the public sphere, where social institutions, the media, public opinion, and civil society all play leading roles.

If we take Fassin’s question of biolegitimacy as starting point, then the idiomatic promiscuity of health activism on unauthorized im/migrants’ behalf—put differently, certain activists’ willingness to employ idioms of social justice mobilization strategically—makes good sense. Dr. Peled, Dr. Barkan and the senior physicians on BZA’s board, it turns out, are not motivated by a fundamental commitment to the notion that unauthorized im/migrants possess a basic right to health. In fact, theirs is not really a political claim at all, but, rather, a *moral* claim about how the Israeli state and Israeli society ought to reckon biolegitimacy. Ideological and personal differences notwithstanding, these BZA volunteers and their colleagues are linked by their refusal to deny unauthorized im/migrants biolegitimacy or exclude them from the population of human beings whose disease, injury, pain, and suffering are deserving of attention and concern. What attracts these particular volunteers to BZA, then, is not the organization’s commitment to human rights, but instead the opportunity it offers to translate a firm if inchoate ethical impulse into concrete forms of social practice. For card-carrying human rights activists like Eran Moyal, Oded Blum, and Kobi Levy, these volunteers’ willingness to interpret the juridical notion of a right to health rhetorically—that is, to treat it only, or even primarily, as a strategically valuable symbolic statement anchored in a moral insistence on health as meta-value—is a major problem indeed. And yet it is not within staff members’ power to simply pull away from their volunteers, or their executive board, and craft a more universalist, orthodox, or internationally recognizable human rights agenda. As an organization, the notion of a human right to health is BZA’s strongest tool, and its concomitant messiness or “mushiness” is their lot.

The same applies, I contend, to us as medical anthropologists. In *Pathologies of Power*, Paul Farmer decried the myopia that long prevented anthropologists and physicians, among others, from perceiving or responding to health-related human rights violations. Now, unlike in 1994, no one can say that “The phrase ‘right to health’ is not a familiar one” (Leary 1994:24). Medical anthropologists are particularly attuned to such violations, to their roots in structured systems of inequality and violence, and to the social suffering they produce. In fact, we tend to home in on such violations, sometimes to the neglect of other important angles or avenues of research. Yet in addressing one blind spot, we seem to have developed another; we have not maintained the “skeptical distance from the exalted claims of human rights” (Goodale 2006:32) that might help us unpack its manifold, conflicting, even contradictory meanings. Neither have we taken the right to health itself as an ethnographic object or critically examined how it is invoked, engaged, and promoted in

real-life forms of social practice. This right, it turns out, is perpetually in motion. It is in constant dialogue, and often tension, with other forms of rights discourse and other idioms of social justice mobilization. Its interpretation and implementation are shaped by local attitudes both toward health (i.e., as a common good or a commodity) and toward human rights (e.g., as “pro-Palestinian” or “anti-Zionist”). Furthermore, as the BZA activists introduced here clearly demonstrate, interpretations of the specific content and the potential for realizing this right, especially as it applies to biopolitically excluded groups like unauthorized im/migrants, often depend less on formal points of national or international law than on vernacular assessments of “deservingness”—that is, on questions of morality, ethics, and biolegitimacy bearing a distinctly local cast.

As medical anthropologists, we need to pay careful attention to these local meanings, movements, and tensions. Certainly, it is not our role to decide which interpretation is most authentic or correct. Rather, our task is to capture ethnographically both the power and the limits of this increasingly popular idiom of social justice mobilization in all its phases and forms. However attractive it may be to deconstruct right to health claims as utopian, nonjusticiable, or imprecise (among other possible critiques), the “seductive clarity of denunciation” (Redfield 2005:349) is not an option, for the right to health is as indispensable to im/migrant health activists, and to medical anthropologists, as it is mushy. Even when invoked in its weakest mode, or when its potential for realization is next to nil, the notion of a right to health remains a powerful tool for all who reject commonsense assertions that certain people’s diseases, sufferings, and lives are less important, less valuable, or less deserving of concern, than others’.

## Notes

*Acknowledgments.* This research was conducted with generous support from Fulbright-Hayes, Lady Davis Fellowship Trust at the Hebrew University of Jerusalem, National Science Foundation (No. 0135425), Social Science Research Council, and the Wenner Gren Foundation. Any opinions, findings, conclusions, or recommendations expressed are those of the author and do not necessarily reflect the view of funding agencies. I am deeply grateful to the staff and volunteers at “BZA” for allowing me to become so intimately, and critically, engaged with their work. Thanks are also due to Peter Brown, Heide Castañeda, Svea Closser, Erin Finley, Dani Filc, Mark Luborsky, Anat Rosenthal, Anahí Viladrich, Carol Kleiner Willen, Sebastian Wogenstein, and four anonymous MAQ reviewers for their generous and constructive feedback on earlier drafts.

1. Pseudonym.

2. Two notes on terminology are in order. First, rather than eschewing the language of “illegal” migration and migrant “illegality,” I join a growing group of scholars who insist on treating “illegality” as an object of analysis in itself (Coutin 2003; De Genova 2002; De Genova and Peutz 2010; Willen 2007c; see also Willen et al. this issue). For this reason, I retain the term but keep it in quotes. Second, I use the terms *im/migrants* and *im/migration* to indicate that the boundary

between migration and migrants, on one hand, and immigration and immigrants, on the other, is both porous and shifting.

3. For example, Gross 2007; Ruger 2006; Toebes 1999; Yamin 1996.

4. For example, Cole 2009; Dwyer 2004; Sen 2008.

5. For example, Gruskin et al. 2005; Hunt 2007; Hunt and Backman 2008; Mann et al. 1994.

6. For example, Lancet 2007a, 2007b, 2008a, 2008b.

7. For example, Baer et al. 2003; Biehl 2007; Biehl et al. 2009; Farmer 2005, 2008; Kim et al. 2000; Shell-Duncan 2008.

8. Scholarly idioms of social justice mobilization include, for instance, social medicine, social epidemiology (Yamin and Irwin 2010), and, arguably, public health itself (Krieger and Birn 1998).

9. See, for instance, Fassin 2008, 2009; Feldman and Ticktin 2010; Redfield 2005, 2006; Ticktin 2006; and part 7 of Good et al. (2010).

10. For example, Barlow 1999; Godlee 2009; Jadad and O'Grady 2008.

11. For an overview of this literature, see the Working Bibliography at the blog "AccessDenied: A Conversation on Unauthorized Im/migration and Health": <http://accessdeniedblog.wordpress.com/working-bibliography/>.

12. Some philosophers and ethicists, for instance, contend that questions about unauthorized im/migrants' right to health hinge on the relationship among rights, duties, and priorities (Dwyer 2004). Others perceive a need to balance an ethics of rights and justice, on the one hand, with an ethics of care and responsibility, on the other hand (Benhabib 1992; see Gross 2007:329–330). For political sociologists interested in health policy, human rights logic interacts with other logics (e.g., citizenship, the labor market, public health, and cost containment) interacting within three different spheres (state, market, and civil society; Filc and Davidovitch 2007).

13. When the study began in 2000, these were two of the largest and most institutionally well-organized communities of undocumented im/migrants in Israel (South Americans were the third). Filipinos and West Africans had reached Israel via substantially different migration pathways. Whereas nearly all West Africans arrived via the "tourist loophole" (Willen 2003) in Israel's otherwise strict migration regime and overstayed tourist visas, most Filipinos living "illegally" in Israel were legally recruited in the Philippines and later lost their authorization status. Filipino migrants came from multiple areas of the Philippines. West Africans came primarily from Ghana (from the Asante, Fante, Ewe, and Ga ethnic groups) and Nigeria (primarily Igbo, Yoruba, and to a lesser extent Bini). Despite the linguistic and cultural variation within the Filipino and West African communities, each functioned in key ways as a single community, largely as a result of their shared Christian faith and, for the West Africans, their common use of English as a lingua franca.

14. All activists are identified using pseudonyms.

15. An unpublished study conducted by the clinic's medical director using a random sample of patient files ( $n = 92$ ) found the most common diagnoses to involve orthopedic problems (24 percent) followed by gynecological concerns (14 percent), infection (13 percent), dermatological conditions (12 percent), digestive problems (7 percent), heart disease (4 percent), hypertension (3 percent), neurological problems (2 percent), lung disease (1 percent), and sexually transmitted infection (1 percent). The remaining 19 percent were classified as "other."



16. Ynet, "MK Ben-Ari: Eradicate Treacherous Leftists," January 5, 2011, accessed July 3, 2011, at <http://www.ynetnews.com/articles/0,7340,L-4009642,00.html>.

17. For an overview of transnational migration to Israel since the mid-1990s, see Willen 2007b.

18. These included a three-hour staff meeting and a two-and-a-half hour executive board meeting held two days later, both of which I attended and audio-recorded in addition to taking copious notes.

## References Cited

Anteby-Yemini, Lisa

2009 Migrations africaines et nouveaux enjeux de la frontière israélo-égyptienne. *Cultures et Conflits* 72:77–99.

Baer, Hans A., Merrill Singer, and Ida Susser

2003 *Medical Anthropology and the World System*. Westport, CT: Praeger.

Barlow, Philip

1999 Health Care Is Not a Human Right. *British Medical Journal* 319(7205):321.

Benhabib, Seyla

1992 *Situating the Self*. New York: Routledge.

Biehl, João

2007 *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton: Princeton University Press.

Biehl, João, Adriana Petryna, Alex Gertner, Joseph J. Amon, and Paulo D. Picon

2009 Judicialisation of the Right to Health in Brazil. *The Lancet* 37(9682):2182–2184.

Cole, Phillip

2009 Migration and the Human Right to Health. *Cambridge Quarterly of Healthcare Ethics* 18:70–77.

Coutin, Susan Bibler

2003 *Legalizing Moves*. Ann Arbor: University of Michigan Press.

Das, Veena

1995 *Critical Events*. Delhi: Oxford University Press.

De Genova, Nicholas

2002 Migrant "Illegality" and Deportability in Everyday Life. *Annual Review of Anthropology* 31:419–447.

De Genova, Nicholas, and Nathalie Peutz, eds.

2010 *The Deportation Regime: Sovereignty, Space, and the Freedom of Movement*. Durham, NC: Duke University Press.

Desjarlais, Robert

1997 *Shelter Blues: Sanity and Selfhood among the Homeless*. Philadelphia: University of Pennsylvania.

Dwyer, James

2004 Illegal Immigrants, Health Care, and Social Responsibility. *Hastings Center Report* 34(5):34–41.

Farmer, Paul

2005[2003] *Pathologies of Power*. Berkeley: University of California Press.

2008 Challenging Orthodoxies in Health and Human Rights. *Health and Human Rights* 10(1):5–19.

- 2010 *Partner to the Poor: A Paul Farmer Reader*. Haun Saussy, ed. Berkeley: University of California Press.
- Fassin, Didier  
2008 *The Humanitarian Politics of Testimony*. *Cultural Anthropology* 23(3):531–558.  
2009 *Another Politics of Life Is Possible*. *Theory, Culture, and Society* 26(5): 44–60.
- Feldman, Ilana, and Miriam Ticktin, eds.  
2010 *In the Name of Humanity: The Government of Threat and Care*. Durham, NC: Duke University Press.
- Filc, Dani  
2009 *Circles of Exclusion: Citizenship, Occupation, and the Americanization of the Israeli Health Care System*. Ithaca, NY: Cornell University Press.
- Filc, Dani, and Nadav Davidovitch  
2007 *Rights, Citizenship and the National State*. In *Transnational Migration to Israel in Global Comparative Context*. S. Willen, ed. Lanham, MD: Lexington Books.
- Fried, Mordechai  
2003 *The Israeli Health Care System's Treatment of Migrant Workers [Hebrew]*. *HaRefuah* 142:430–432.
- Godlee, Fiona  
2009 *Health Is a Human Right*. *British Medical Journal* 338:b136.
- Good, Byron J., Michael M. J. Fischer, Sarah S. Willen, and Mary-Jo DelVecchio Good  
2010 *A Reader in Medical Anthropology: Theoretical Trajectories, Emergent Realities*. Malden, MA: Wiley-Blackwell.
- Goodale, Mark  
2006 *Ethical Theory as Social Practice*. *American Anthropologist* 108(1):25–37.
- Gostin, Lawrence O.  
2002 *Public Health Law, Ethics, and Human Rights*. In *Public Health Law and Ethics: A Reader*. L. O. Gostin, ed. Berkeley: University of California Press.
- Greco, Monica  
2004 *The Politics of Indeterminacy and the Right to Health*. *Theory, Culture and Society* 21(6):1–22.
- Gross, Aeyal  
2007 *The Right to Health in an Era of Privatisation and Globalisation*. In *Exploring Social Rights*. D. Barak-Erez and A. Gross, eds. Oxford: Hart.
- Gruskin, Sofia, Michael A. Grodin, George J. Annas, and Stephen P. Marks  
2005 *Perspectives on Health and Human Rights*. New York: Routledge.
- Hunt, Paul  
2007 *Right to the Highest Attainable Standard of Health*. *Lancet* 370(9585):369–371.
- Hunt, Paul, and Gunilla Backman  
2008 *Health Systems and the Right to the Highest Attainable Standard of Health*. *Health and Human Rights* 10(1):81–92.
- Jadad, Alejandro, and Laura O'Grady  
2008 *How Should Health Be Defined?* *British Medical Journal* 337:a2900.
- Kashti, Or  
2010 *Poll: Majority of Israel's Jews Back Gag on Rights Groups*. Ha'aretz. April 28. <http://www.haaretz.com/news/national/poll-majority-of-israel-s-jews-back-gag-on-rights-groups-1.285120>, accessed July 3, 2011.
- Kemp, Adriana  
2004 *Labour Migration and Racialisation*. *Social Identities* 10(2):267–292.
- Khan, Irene  
2009 *The Unheard Truth: Poverty and Human Rights*. New York: W. W. Norton.

- Kim, Jim Yong, Joyce V. Millen, Alec Irwin, and John Gershman, eds.  
2000 *Dying for Growth*. Monroe, ME: Common Courage.
- Krieger, Nancy, and Anne-Emmanuelle Birn  
1998 A Vision of Social Justice as the Foundation of Public Health: Commemorating 150 Years of the Spirit of 1848. *American Journal of Public Health* 88(11):1603–1606.
- Kritzman-Amir, Tally  
2010 “Otherness” as the Underlying Principle in Israel’s Asylum Regime. *Israel Law Review* 42(3):603–627.
- Lancet  
2007a The Right to Health: More than Rhetoric. *Lancet* 369(9560):438.  
2007b Vulnerable Migrants Have a Right to Health. *Lancet* 370(9581):2.  
2008a Special Issue on the Right to Health. *Lancet* 372(9655).  
2008b The Right to Health: From Rhetoric to Reality. *Lancet* 372(9655):2001.
- Leary, Virginia A.  
1994 The Right to Health in International Human Rights Law. *Health and Human Rights* 1(1):24–56.
- Levitt, Peggy, and Sally Merry  
2009 Vernacularization on the Ground. *Global Networks* 9(4):441–461.
- Mann, Jonathan M., Lawrence O. Gostin, Sofia Gruskin, Troyen Brennan, Zita Lazzarini, and Harvey Fineberg  
1994 Health and Human Rights. *Health and Human Rights* 1(1):6–23.
- Office of the High Commissioner for Human Rights  
1976 Article 12, International Convention on Economic, Social, and Cultural Rights.
- Petryna, Adriana  
2002 *Life Exposed: Biological Citizenship after Chernobyl*. Princeton: Princeton University Press.
- Portes, Alejandro, Donald Light, and Patricia Fernandez-Kelly  
2009 The U.S. Health System and Immigration: An Institutional Interpretation. *Sociological Forum* 24(3):487–514.
- Redfield, Peter  
2005 Doctors, Borders, and Life in Crisis. *Cultural Anthropology* 20(3):328–361.  
2006 A Less Modest Witness: Collective Advocacy and Motivated Truth in a Medical Humanitarian Movement. *American Ethnologist* 33(1):3–26.
- Rosenthal, Anat  
2007 “Illegality” and Illness in the Everyday Struggles of Undocumented HIV+ Migrant Workers in Tel Aviv. *International Migration* 45(3):134–156.
- Ruger, Jennifer Prah  
2006 Toward a Theory of the Right to Health. *Yale Journal of Law and the Humanities* 17(2):273–326.
- Sen, Amartya  
2008 Why and How Is Health a Human Right? *Lancet* 372(9655):2010.  
2009 *The Idea of Justice*. Cambridge: Belknap Press of Harvard University Press.
- Shell-Duncan, Bettina  
2008 From Health to Human Rights: Female Genital Cutting and the Politics of Intervention. *American Anthropologist* 110(2):225–236.
- Singer, Merrill  
2009 *Introduction to Syndemics*. San Francisco: Jossey-Bass.
- Ticktin, Miriam  
2006 Where Ethics and Politics Meet: The Violence of Humanitarianism in France. *American Ethnologist* 33(1):33–49.

Toebes, Brigit

1999 Toward an Improved Understanding of the International Human Right to Health. *Human Rights Quarterly* 21(3):661–679.

United Nations

1966 General Comment 14 on the International Covenant on Economic, Social and Cultural Rights.

Willen, Sarah S.

2003 Perspectives on Transnational Labor Migration in Israel. *Revue Européenne des Migrations Internationales* 19(3):243–262.

2005 Birthing “Invisible” Children: State Power, NGO Activism, and Reproductive Health among Undocumented Migrant Workers in Tel Aviv, Israel. *Journal of Middle East Women’s Studies* 1(2):55–88.

2007a “Illegality,” Mass Deportation, and the Threat of Violent Arrest: Structural Violence and Social Suffering in the Lives of Undocumented Migrant Workers in Israel. *In* *Trauma and Memory*. A. Sarat, M. Alberstein, and N. Davidovitch, eds. Stanford: Stanford University Press.

2007b Introduction. *In* *Transnational Migration to Israel in Global Comparative Context*. S. Willen, ed. Lanham, MD: Lexington Books.

2007c Toward a Critical Phenomenology of “Illegality.” *International Migration* 45(3):8–36.

2010a Citizens, “Real” Others, and “Other” Others: The Biopolitics of Otherness and the Deportation of Undocumented Migrant Workers from Tel Aviv, Israel. *In* *The Deportation Regime*. N. De Genova and N. Peutz, eds. Durham, NC: Duke University Press.

2010b Darfur through a Shoah Lens: Sudanese Asylum Seekers, Unruly Biopolitical Dramas, and the Politics of Humanitarian Compassion in Israel. *In* *Medical Anthropology: Theoretical Trajectories, Emergent Realities*. B. J. Good, M. M. J. Fischer, S. S. Willen, and M.-J. D. Good, eds. Malden, MA: Blackwell.

Forthcoming-a How is Health-Related “Deservingness” Reckoned? Perspectives from Unauthorized Im/migrants in Tel Aviv. Special Issue: Migration, “Illegality,” and Health: Mapping Vulnerability and S. Willen, guest ed. *Social Science and Medicine*.

Forthcoming-b Special Issue: Migration, “Illegality,” and Health: Mapping Vulnerability and Debating “Deservingness.” *Social Science and Medicine*.

Wilson, Richard A.

2001 *The Politics of Truth and Reconciliation in South Africa*. Cambridge: Cambridge University Press.

Workers’ Hotline and Hotline for Migrant Workers

2007 Freedom Inc.: Binding Migrant Workers to Manpower Corporations in Israel. Tel Aviv, Israel. [http://hotline.org.il/english/pdf/Corporations\\_Report\\_072507\\_Eng.pdf](http://hotline.org.il/english/pdf/Corporations_Report_072507_Eng.pdf), accessed July 3, 2011.

Yamin, Alicia E.

1996 Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law. *Human Rights Quarterly* 18(2):398–438.

Yamin, Alicia Ely, and Alec Irwin

2010 Collaborative Imperatives, Elusive Dialogues. *Health and Human Rights: An International Journal* 12(2). <http://www.hhrjournal.org/index.php/hhr/article/view/364/554>, accessed July 3, 2011.