

## Chapter 4

# Health and Education

There is no way out of what's fated  
—Clinton Bailey, *A Culture of Desert Survival:  
Bedouin Proverbs from Sinai and the Negev*

Teaching the young is like carving in stone;  
Teaching the old is like carving in the air  
—Clinton Bailey, *A Culture of Desert Survival:  
Bedouin Proverbs from Sinai and the Negev*

As seen in Chapter 3, an analysis of planning in Segev Shalom and throughout the resettled bedouin sector reveals mixed outcomes. There is no question that some successes may be noted, and a failure to do so, or to condemn the state at every turn regardless of what the statistics show—though commonplace in the Negev today—is simply disingenuous.

On the other hand, like much of the change now under way in the Negev bedouin community, the planning has been inconsistent, spotty, haphazard, and at times implemented in such a poor and neglectful fashion that often any positive outcomes that do accrue are simply overshadowed by patterns of sheer negligence, which serve to reinforce a sense among the bedouin that even when they are gaining, they are in fact losing. There are no better social development areas that exemplify this sentiment more cogently than those of healthcare and educational services.

### Healthcare Issues—Three Steps Forward, Two Steps Back

There is little doubt that the bedouin of the Negev today have access to more healthcare opportunities than they have ever had in history. That, as the saying goes, is the good news. The bad news is that the resettlement initiative has fostered a situation in which the bedouin of the Negev now show a greater *need* for healthcare than at any time in their history as well—and much of that need can be traced to the resettlement initiative.

Historically, the forced sedentarization initiative was rationalized largely upon the need to provide, above all else, healthcare services to the Negev bedouin community. The state's argument for the settlement of the population, like so many other nomadic communities during the same period, was straightforward: "they are citizens, so it is incumbent upon the state to give them adequate healthcare ... [but] when they are spread out they are difficult to access" (Shapira, 24 November 1992). Moreover, Shapira notes, in the mid 1940s, prior to the creation of the State of Israel, there was only one road connecting Gaza, Be'er Sheva, and Hebron. By horse or camel, it took two to three days to secure medical assistance in Hebron, the site where many bedouin acquired care—if at all—at that time.

Infectious disease, malaria, and tuberculosis (TB), in particular, were common throughout Palestine during the 1930s and 1940s (Abu-Rabia 2005: 422). Soon after the creation of the *siyag*, however, a high incidence of TB was identified among the bedouin community; the state determined that all members should be inoculated as fully and as quickly as possible (Shvarts et al. 2003: 50). "Isolated" and "ignorant" (Abu-Rabia 2005: 424), the bedouin practiced a variety of home, nature-based remedies using traditional healers to treat malaria and other ailments, injuries, and infections.

In 1949, the first mobile health unit was created out of Soroka Hospital in Be'er Sheva, charged most especially with providing inoculations to the bedouin. In essence, the authorities blamed the living conditions for the spread of the disease; poor nutrition, poor hygiene, and the like were all attributed to living in what amounted to an unhealthy environment (Shvarts et al. 2003: 51). Moreover, there was fear that, in time, the disease would be spread throughout the Jewish population as well.

And yet the irony of the situation is that, at the very time that the state was contending that the inability to provide complete inoculations and to stop the spread of TB and other infectious diseases lay with the fact that the bedouin population was too dispersed and could not be reached, a root cause of the disease's very contraction and rapid spread was to be found in the fact that the community was concentrated into a confined geographic area maintained by the authorities for the purposes of securing and controlling this Arab Muslim population. Thus, Shvarts et al. reveal that it was largely confinement to the *siyag*—and not, ironically, the fact that the bedouin were too dispersed—that led to the spread of TB and to malnutrition (2003: 57–58).

Nonetheless, since the 1950s and 1960s, bedouin health policy has always been hampered by the ability successfully to provide needed services. Often, government officials, academics, doctors, and even social workers are quick to blame logistical constraints or, more broadly, "cultural issues" as the primary barriers to effective service delivery (Moshe, 15 February

2007; D. Cohen, 24 April 2007; Meir 1997: 183; Dreier, 14 March 2007; Shimshoni, 1 June 1993). And yet, there is evidence that shows that, when proper inducements are provided, bedouin healthcare has proven effective and successful, regardless of the logistical, cultural or other barriers at play.

One example reveals this well. In 1953, the Maternal Insurance Law was instituted. The maternity allowance was created to cover delivery costs and to pay for expenses associated with having a newborn, in order to encourage hospitalization for the delivery of babies, which to that point was virtually unheard of (Shvarts et al. 2003: 53). Four decades later, 95 percent of all bedouin babies were born in the hospital (Belmaker, 19 April 1993), and not the tent as had been the case going back in previous generations. Thus, given this sort of appropriate incentive, the bedouin were able to “overcome the cultural barriers and geographic concerns” often cited as hindrances to effective healthcare provision in the Negev community.

Limitations on the provision side of the equation have drawn less attention, although the lack of trained staff was in truth a “primary obstacle” to serving bedouin medical needs throughout the 1950s (Shvarts et al. 2003: 55), and many doctors resisted even living in the Negev, where their services were needed. A lack of doctors with the cultural sensitivities needed to work with such a special clientele was a problem then and, as will be seen below, remains a problem to the present day.

Nonetheless, the Ministry of Health developed a document in 1961 entitled “Development of medical services for the Bedouin,” which stressed that it was “impossible” to raise the health standards of the bedouin as long as they remained “scattered over a wide geographic area in transitory tent encampments affording insufficient shelter, lacking potable water, and adequate education facilities” (Shvarts et al. 2003: 60). The solution to the problem, the document contends, is to settle the bedouin in “solid stone structures in villages or cities in one or several locations and to integrate them into the economy of the country as farmers, unskilled laborers or skilled craftsmen.”

The creation then of Tel Sheva in the late 1960s was good medicine and, in fact, results were almost immediate. There is no question that, once the *siyag* was removed concomitant with the initiation of the planned town initiative, it “[brought] about an immediate improvement in the standard of living of the Bedouin and their economic situation” (Shvarts et al. 2003: 64). But was it the “traditional bedouin lifestyle” that was burdening the bedouin community, making it “sick,” “diseased,” economically weak, and untenable? Or rather, did the Israeli military presence that sought to concentrate and to control the bedouin community in an artificially controlled and confined space against their will, against their interests, and against their long-term health and well-being play a role? Regardless, it was this very pretense of economic and physical weakness that further fed into the

argument for the need to concentrate and settle the community still further, moving from the *siyag* environment to today's "healthy," modern stone homes in the planned "villages and cities."

As recently as the early 1990s, a considerable degree of concern in the medical community still placed its emphasis upon issues that are related to the largely nomadic, dispersed, non-urbanized nature of the bedouin community. Attempts to immunize bedouin children against various diseases (Hepatitis B, polio, measles, tetanus) were high on the list of healthcare professionals' priorities, as well as were efforts to encourage basic hygiene. Problems with nutrition, which were directly connected to stunting and Failure to Thrive syndrome (FTT), were also emphasized.

Two mobile health units operated out of Soroka Hospital in Be'er Sheva, serving 9,000 households in the *pezurah* in an attempt to address these concerns. From Regional Medical Officer Ilana Belmaker's perspective, six units might have been adequate, though the process, she noted, of using the jeeps was simply not cost-effective. (Having gone out with the unit a number of times in 1992, I personally saw that it was a time-consuming process as well.) And yet, she suggested, the service had a positive side to it: "The use of the mobile units gives the message of door-to-door service. If we're to face problems of diabetes during pregnancy, premature births, and stunting, we have to go to them if they won't come to us." She concluded by again noting the need for more mobile units. "There are so many problems. We just can't attack them all at once" (Belmaker, 19 April 1993). Significantly, there were *Tipot Halav* (Hebrew: mother/child clinics) and full service *Kupot Holim* (Hebrew: public clinics) in all of the planned bedouin towns at the time, as well as nearby Jewish communities where the bedouin might seek out medical help. Yet also at this time, the Emergency Room at Soroka Hospital in Be'er Sheva served as the primary medical facility for the bedouin community's healthcare needs.

Over the past two decades, there is no question that one now sees a substantial improvement in the health of the Negev bedouin community. That said, as will be seen below, there is in truth a difference between healthcare provision and access for those who live in the towns and those who resist relocation and remain in the *pezurah*. But what is also true is that within the community as a whole, a variety of problems exist that all bedouin share. Moreover, there are a number of medical concerns in the *pezurah* that are less common in the towns (such as accidental injury); in turn, as the bedouin urbanize, new healthcare concerns are arising in the towns that were, heretofore, previously nonexistent.

One particular issue that has attracted attention has been the occurrence of diabetes. Abou-Rbiah and Weitzman, for example, note that, "diabetes, virtually unknown among Bedouins in the Negev three decades ago,

has become a major health problem in this population” (2002: 689). More recent studies confirm this finding, noting that diabetes rates are significantly higher in the towns (5.5 percent) than in the *pezurah* (3.9 percent; A. Cohen et al. 2005: CR378). A. Cohen and his colleagues found that LDL cholesterol levels were also higher among urban town dwellers, findings that “imply that urbanization of nomadic Bedouins and the changes associated with it, increase the risk of cardiovascular diseases” (2005: CR379).

In other words, changing dietary habits and a reduction in physical activity due to lifestyle changes are largely to blame for these developments. These medical professionals also note that obesity rates are higher among those living in settled environments (i.e., the towns), and that women, who are significantly more obese than men (Abou-Rbiah and Weitzman 2002: 688–689), are also more prone to develop diseases such as diabetes. Dreier has also found that African/black bedouin women (i.e., the *Abid*), have twice the levels of hypertension as Arab women (14 March 2007).

Thus, throughout the past two decades, as the Negev bedouin community has become increasingly sedentary, healthcare issues related not to their level of dispersion, but rather to their concentration in urban agglomerations have increasingly become apparent. Below, I will turn to the specific case of Segev Shalom, in order to address three interconnected queries: 1) does the town’s citizenry manifest any particular healthcare needs?; 2) what provisions are being provided by the state to meet these needs, and to what extent are residents turning to private medical care as an alternative?; 3) overall, how have the services been utilized and viewed by the town’s residents during the 15 years that this study was under way?

### Segev Shalom: A Healthcare Profile

Looking specifically at Segev Shalom’s healthcare services, nearly all of those households surveyed in 2007, 99 percent, stated that they use the town’s healthcare services. In addition, 84 percent stated that they sometimes go to Soroka Hospital for healthcare, and 38 percent use private doctors, a handful of which have now begun opening their offices in Segev Shalom in recent years (see below). Still, for most, as was the case when the study was initiated in the early 1990s, healthcare services are publicly provided (as is the case for the majority of Jewish Israelis as well, though again, this is changing). Services are centered at a *Tipat Halav* clinic, which serves as a facility for pre-natal, maternity, and post-natal care to new mothers and is operated by the Ministry of Health, and a *Kupat Holim* family clinic. All of these facilities are located in the town center.

The *Kupat Holim* is in truth where most town residents go for their initial care. A new, state-of-the-art building opened in the town in January 2007 (see Illustration 4.1); the old building (not shown) houses office and storage space. Notably, approximately 60 percent of the 15,000 patients enrolled in the Segev Shalom *Kupat Holim* membership come from communities in the *pezurah*. As noted, Soroka Hospital's Emergency Room has served as the bedouin community's primary "clinic," and has been used, in the words of some observers, "excessively" for decades. But this use has begun to decline since 2000, most especially among bedouin from the *pezurah* (A. Cohen et al. 2007: 332). While some attribute this to the opening of *Kupat Holim* clinics in the periphery to meet the needs there (A. Cohen et al. 2007: 334) (over 20 *Kupat Holim Clalit* (Hebrew: General Public Clinics) have opened in the *pezurah* in the 2000s; nearby Wadi Na'am had 1,000 subscribers alone as of mid 2007), the use of clinics in the nearby bedouin towns such as Segev Shalom clearly plays a role as well.

The Segev Shalom *Kupat Holim* clinic is staffed by 6 doctors per day, each seeing about 30–50 patients, averaging about 250 patients/day. The facility is open Sunday–Friday (which is a half day); it is closed on Saturday, the Jewish Sabbath.

Dr. Jacob Dreihier, who has worked as an internist in the clinic for four years, notes that in general, patients tend to be women bringing children, especially young children, in for various ailments. While this was true back in the early 1990s, his elaboration of the state of healthcare in the town as well as the surrounding post-nomadic *pezurah*, where more than half of his patients now originate, well informs the situation today. I quote Dreihier here (14 March 2007) at length:

Many of our patients have diabetes, they adopt bad habits very quickly like not walking and driving everywhere, not exercising, eating junk food and so on. They are less likely to adopt good habits like physical activity, sport—they don't have a sports center here in Segev, and women are not allowed to jog or walk in the streets on their own so they sit at home.

Even the sheep they eat, the lamb, in the past would graze and eat the grass that is growing. Now they have a special mixture which is artificially made, enriched with all these growth hormones and vitamins. The lambs don't get much exercise and the meat is very high in fat. So even if they eat the same amount as before the meat itself has much more fat content than before. They also eat a lot of bread, and drink a lot of tea with sugar.

Doctors who treated the bedouin in the 1960s had ten patients with diabetes, and less than five had hypertension in the whole Negev. It wasn't

recognized at all. Today we have an epidemic of diabetes and hypertension, more than the Jewish sector.

Although it is clear that detection and treatment of these sorts of ailments was also likely to be of a lower level and quality 50 years ago, the doctor's



**Illustration 4.1.** The Segev Shalom *Kupot Holim* in 2007.

Source: Photo by Steven C. Dinero.

point is a significant one. Dreier also notes that in the *pezurah*, there are healthcare issues that are not as common in town: high accident rates, including accidentally drinking of dangerous liquids because they are stored in transparent bottles, home injuries due to open fires, and so on are all common events outside of the towns (14 March 2007).

Overall, there is a greater need for healthcare services in the bedouin sector than ever before and that, in general, these services are being used. Ironically, there are now studies that reveal that these services may in fact be “over-utilized” by the bedouin (A. Cohen et al. 2007; Groode & Dreier 2007), a trend suggesting potentially newly developing pathologies amongst a bedouin community that is chronically, for want of a better word, “sick.”

But effective healthcare service provision is, like all aspects of the resettlement initiative, wrought with political, cultural, and economic concerns that problematize effective delivery at virtually every level. While provision of the service, which is culturally sensitive and appropriate, offers one side of the equation, effective use provides the other equally significant side. In the Negev, the disconnection between healthcare service providers and users is profound.

It has been argued in the past that two primary issues stood in the way of effective service delivery in the bedouin community, namely, logistical considerations and “traditional” bedouin culture. In essence, the inability to access healthcare was the bedouin’s own fault. Their belief in supernatural forces, their lack of understanding of “modern medical methods,” and “tribal nature” (expressed through the desire that each community would have its own clinic), and lack of confidence in medical personnel have all been cited as barriers to effective service delivery (Meir 1997: 183–184).

Dreier’s comments on the challenges of providing effective care seem to reflect this sort of sentiment. Again, quoting him at length (14 March 2007):

They have a fatalistic attitude that everything is from Allah and it doesn’t matter whether you comply or not with the doctor, everything is written from above and you can’t do anything to change it. This affects efforts to stop bad habits such as smoking. If a cure helps, the assumption is that Allah intervened—“I got better because Allah wanted me to, not because of my doctor’s advice, physical activity, whatever.” So it doesn’t really matter what you do since everything is dictated from above. The result is low rates of compliance with taking medications, responding to doctor’s orders for physical activity, stopping smoking, difficulty in achieving educational goals ...

There is now greater awareness of problems that arise out of consanguineal marriage and genetic disease. They come to consult before get-



ting married, or during pregnancy. They have a nurse trained in genetic counseling. She's in the clinic once a week. In the first six months, there were 1,000 consultations. In next twelve months, 3,000. So the services are used. But what is done with the recommendations she provides to these couples?

Amniocentesis? Termination of pregnancy? Who complies with these suggestions? They don't always do what she tells them to do. Even when they have children at home with a disease, and the pregnancy tests positive for that same disease and they know how terrible it is, do they terminate? It's a problem because it goes against Islam—they have very strict rules on when an embryo is a living creature and you can't end a pregnancy and the cutoff is very early. And once you know [that a certain disease of problem is evident] it's still against the tradition to [end the pregnancy].

Dreihier concedes, however, that considerable changes have occurred only in the brief period since he first began working in the clinic:

I've seen a few couples that induced abortion just because they didn't want to have more children, where they didn't have any problems, but this is very rare. I was really amazed. But I said "ok, you have 10 kids, it's enough for you, go ahead, sign the papers, no one will question, go, do it." But I was shocked. [I thought] are you a bedouin!?

The frustration in Dreihier's tone is palpable as he discusses his efforts. And yet, there is a certain lack of cultural awareness or appreciation of bedouin society that also can be read between the lines of his thoughts. Other healthcare professionals working with the bedouin have viewed this perspective on medical care in a different manner, which is perhaps less judgmental (Sheiner et al. 2001: 457):

[The bedouin] view pregnancy and childbirth as natural events, which require medical attention only when there are medical problems. This attitude renders them quite suspicious of the health services available and in particular invasive procedures. This position may be emphasized by the low usage of epidural analgesia, although it was highly recommended by the medical staff.

A bedouin medic employed by the Soroka mobile unit, a resident of Laq-iyā, related a series of anecdotes to me in the early 1990s that places this "fatalistic" attitude toward healthcare in an alternative light (Al-Sana, 11 November 1992):

I went out with a social worker to a bedouin family. The man was blind and the wife was mildly retarded. They had four children, all genetically deaf, all mute. We suggested she stop having children. The wife said no; maybe if she kept having children, she would have a normal child who could take care of the rest of the family.

When he last heard, she had had two more children—both were deaf and mute.

A woman was pregnant, and when they did an ultrasound they determined that the child would be a Downs child, and would be missing an arm, and perhaps would have other problems. We suggested she abort. She refused, she had the child, and it was born totally healthy and normal.

There was another woman who was in labor. She had had two C-sections previously, but this time she refused a C-section. I went into the field to locate the husband, but it isn't so easy to find someone out there in the dark. I found him, brought him to Soroka, he and wife talked, and they decided to go home. The husband signed a release saying he knew of the danger to the mother and child alike. The following day, I went out to their tent, and there were the parents and child; the child had been born in the tent without problems.

And finally:

I heard of an old man who was dying. I went to help with the preparations for death; I took his pulse, his blood pressure, and I determined he was simply dehydrated. I wanted to take him to hospital, but his family refused. I went to Be'er Sheva, got an off-duty doctor friend to join me, went back to tent, but [by then] the man was already in a coffin.

These and other stories reveal the Azazmeh mentality, yes. All is in Allah's hands. What Allah wills is what will be. Only the parents of a child who died after we inoculated him refused to accept this submission to fate. They argued that it was the doctor—not Allah—who was to blame for the death of their son.

“Fatalistic” as the bedouin may be, they are using the clinics in record numbers. However, the growing use of private medical professionals, as opposed to the public healthcare system, is clearly a sign of growing wealth and class distinction in Segev Shalom. In January 2007, a new development, a privately created and run dental clinic, was also established in Segev Sha-

lom, housed in what all recognize to be a rather unique looking building built literally in the town's very center.

Not surprisingly, the divisions within the town with regard to the use of such services are economic and, as discussed previously (see Dinero 2006), tribal. The Azazmeh, for example, are more likely to use a private doctor ( $p=.05$ ), especially those under the age of 40 ( $p=.02$ ), as are the more educated ( $p=.04$ ) and those with more highly educated fathers ( $p=.03$ ). Those choosing the term "Israeli" as an identity label (see Chapter 5) are also more likely to access a private doctor for healthcare ( $p=.03$ ), especially those under the age of 40 ( $p=.02$ ). Those with higher incomes tend to use a private doctor as well ( $p=.03$ ).

In 1993, men were found to be more likely than women to use healthcare facilities other than those in Segev Shalom, a sign of their freedom and mobility, unlike their wives, sisters, and mothers, who are more confined within the town's city limits ( $p=.00$ ). In 2007, women were still more likely than men to use the local Segev Shalom clinics rather than outside medical facilities ( $p=.03$ ).

Use of a private doctor is one indication of the sense that, as the bedouin socially develop and progress, they will seek out alternative ways in which to address their healthcare needs. And yet, as Figure 4.1 reveals, satisfaction with the Segev Shalom healthcare provisions, which are used by virtually every household, has improved continuously over the past two decades. This is not surprising; in 1993, the *Kupat Holim* operated out of one of the larger houses in town, providing basic care; by 2007, healthcare services were provided in a modern, multi-floored facility.

Still, Segev Shalom residents are more than willing to voice a variety of criticisms of the town's healthcare facilities, not, as some might contend, because they expect miracles, but rather, because they view the provisions as unacceptable or inadequate. Significantly too, a number of correlations can be found that suggest that who one is, one's economic success, how one views oneself, and so on all play a role in one's experiences and attitudes toward Segev Shalom's healthcare facilities and provisions.

In general, older residents in the 1993 survey were more satisfied than younger residents under the age of 40 with the town's healthcare services ( $p=.03$ ). This was not found to be true in later surveys. What was found in the 2007 data, however, was that those living in the town the longest rated the clinics higher than the others ( $p=.00$ ). This was especially true of those with low incomes ( $p=.00$ ), those *under* the age of 40 ( $p=.00$ ), and members of the Azazmeh tribe ( $p=.00$ ). Residents with less education rated the medical facilities in town higher than those with higher levels of education ( $p=.03$ ), especially women ( $p=.01$ ), Azazmeh respondents ( $p=.05$ ), and those over the age of 40 ( $p=.02$ ). The low income Tarabeen

also tended to rate the town doctor higher than those Tarabeen tribe members with higher incomes ( $p=.02$ ). In other words, those in the town who are the *least* educated, poorest, and “traditional”—i.e., they who fit the stereotypical bedouin profile that lends to a fatalistic worldview—are most satisfied with the town’s healthcare provisions. Those who expect *more* and who are better off financially are seeking out in increasing numbers what they perceive to be higher quality privatized care.

As for the problems and concerns that are cited by town residents, many that were voiced as far back as the early 1990s were still being repeated in the 2007 survey. All appear to suggest that the services remain inaccessible to patients, even if the providers do not view them as such. Inconvenient hours of operation continue to be a complaint, cited in 1993 (Dinero 1996: 113), and is still an issue of concern today. The lack of adequate personnel (both quantity and quality) to meet the demands of the Segev Shalom population and its periphery has even made the national news (“Beduin complain...,” 13 April 2000).

In addition, a new phenomenon, never voiced in previous surveys, was found among the 2007 findings. A small but notable number of respondents (9 percent of those who responded) complained about the existence of “only one” dermatologist on staff at the *Kupat Holim*, who is available for consultations “only once a week.” The medical staff found these findings somewhat bewildering, insofar as there are no waiting lists for the dermatologist, and “usually, skin disorders don’t have many emergencies in which we feel the need to consult more often than once a week.” (Dreihier, 3 June 2007). As for why this is even considered a concern, Dreihier suggests that, “we can only speculate that skin problems are an especially sensitive issue in bedouin culture, as it [is] related to the appearance of the patient, rather than some hidden internal disease. After consulting with the clinic’s staff, it does appear that skin problems are conceived as bothering as they provoke questions by neighbors and friends and are interpreted as a sign of being unclean and of lower socioeconomic status.”

The other most commonly voiced complaint, which was cited in the 1993 survey (7 percent) and has been noted in every survey thereafter, including the 2007 study (26 percent of those who responded, and it is even noted as a concern by Shvarts et al. in the 1950s in the Negev [2003: 56]), is the lack of Arabic-speaking nurses, doctors, and other medical personnel in the Segev Shalom healthcare facilities. And, yet, this view is disputed by those working in the clinics. “This is highly imprecise; of eighteen people working in the clinic (physicians, nurses and clerks), five are of Arabic origin [sic] and speak Arabic as a native language. These include two nurses, two clerks and a physician. Most of the others speak Arabic to various degrees. If a doctor or a nurse does not understand the patient (or vice versa) he usually

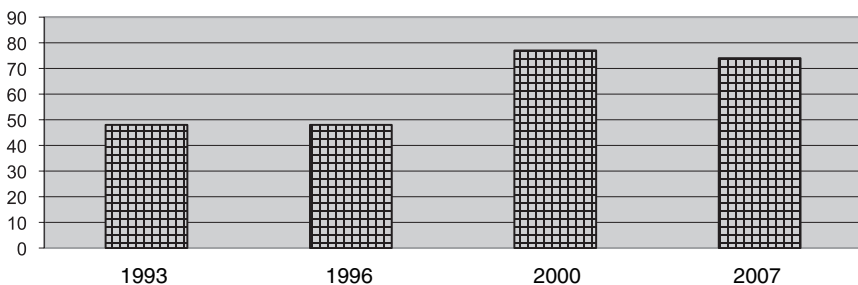
asks for translation by his/her Arab-speaking colleagues. We believe that the professionalism [sic] of the healthcare worker is more important than his/her ethnic background” (Dreihier, 3 June 2007).

Such a gap between the perspective of the service provider and the user prevails throughout virtually every aspect of healthcare provision. The bedouin community’s perceptions and the medical community’s perceptions repeatedly appear to be at odds. This not only serves to compromise effective provision, but also causes further stresses and anxiety for service users and providers alike.

Psychological health and welfare services also require increased attention in the sedentarized environment. Though few studies have been undertaken to make such comparisons, one significant work by Hays and Zouari compared village, urban, and sedentarized bedouin women in Tunisia. They found that the bedouin were significantly more likely to experience higher levels of psychological distress and depression than village or urban women (Hays and Zouari 1995: 84), and that these differences were largely related to stresses brought on by multiple child bearing and economic difficulties, which were new to the settled bedouin community.

Indicators in the Negev similarly suggest that the demand and need for social welfare services is high (see Dinero 1998a). And yet, Lubetzky et al. suggest that despite the presumed need of the resettled Negev bedouin to utilize social welfare services, they often go unused due to a “clash of cultures” in which they “appraise the value of health ... in different ways” (2004: 187). They note that Western medicine is premised upon “logic” and that rehabilitation, therapy, and the like are all crucial to rehabilitation.

Here again, trust and understanding are central to this service delivery effort, for if one does not believe in a certain approach or therapy, this does not mean that the parent of a disabled child, for example, does not under-



**Figure 4.1.** Percentage of Survey Respondents Expressing Satisfaction with Healthcare Service Provisions in Segev Shalom (by Survey Year).

Sources: 1993, 1996, 2000, 2007 Surveys.

stand or appreciate the “wonders of modern medicine,” but possibly, that they simply do not trust those delivering the service or do not feel that those providing the service genuinely wish to make a difference. Curiously, Lubetzky et al. suggest that the fact that the bedouin’s use of speech and language therapy services in the Negev is significantly less consistent and reliable than Jewish patients on average “*could* be due to the fact that the Hebrew language is the main therapy tool of this sector” (2004: 190, emphasis added). That such a question must even be posed is bewildering, for it again places the onus of service delivery failure upon the user, without taking note of the dysfunction of the service provision itself.

Meir provides a more sobering approach to the issue. He notes that by turning to social welfare services, the bedouin often lose tribal and family support (Meir 1997: 185). Moreover, as a people that has long functioned on its own under harsh conditions, such dependency is also a sign of lost respect and pride. As he notes, social workers in the bedouin sector have historically relied upon Western ideas and methods. Even the bedouin social workers use such methods given their educational background, and thus, such approaches typically do not meet bedouin needs, or respect bedouin culture. Thus, a tension mounts between the desire to intervene, and the willingness of this society to allow it to occur (Meir 1997: 191; Dinero 1998a: 31–32).

Put simply, the twenty-first century Negev bedouin resident of Segev Shalom has needs and demands that are not being met, or that are barely being satisfied, due to this sort of cultural gap between provider and user. Until 2007, Segev Shalom did not, in truth, even have social welfare services and aid dedicated solely to its residents; they were offered “the minimum of the minimum” out of the offices in Be’er Sheva, which were later relocated to the town. Moreover, financial aid to needy families—one of the primary services of the bedouin social welfare agencies—was extremely limited; “they got very little, and in time they would stop coming” (Goren, 7 May 2007).

Today, suggests social worker Tsofit Goren, the Office of Social Welfare and its services are far more visible, and are being utilized at a far higher level than ever before. As she notes (7 May 2007):

The major change we see [today] is that the population is demanding more services. They want more quality services here in Segev Shalom. But they don’t want a special needs school for example, they want a school with qualified teachers which is specialized, which looks more like that in the Jewish system. There’s greater knowledge now. There are people now who say “we moved to the town”—this is especially true if they have kid with special needs—“for something better.”

This well sums up why so many have moved to the town—and why so many today are so disenchanting. So much of the resentment and frustration comes down to an issue of expectations, that is, the belief and assumption that town living would provide what living in the *pezurah* could not. Nowhere is this truer than in the area of providing for one's children, most especially, in the area of accessing the educational services offered by the state. Like healthcare, it has traditionally been one of, if not the primary motivations for relocating to a planned bedouin town. It is to educational service provision that I now turn.

### **Educational Services—A Case of Unintended Consequences**

If there is one area of service provision in the bedouin sector that has been critiqued the most—and yet, has shown the most success and promise—it is the area of education. As numerous scholars continue to show how inadequate educational service provision is in the bedouin sector (Abu-Saad 1991; 1995), what is rarely said but should be noted clearly at the outset is that today's Negev bedouin community as a whole is the most formally educated community in its history, and perhaps, is the most educated bedouin population in the entire Middle East.

And yet, despite this, the provision and use of educational services is, like healthcare services, highly controversial (see Dinero 2009). The Compulsory Education Law was created soon after the creation of the state, though early on, few bedouin students actually attended school and the state made little effort to enforce the ruling (Abu-Saad 1997: 25–26). By the mid 1950s, roughly 17 percent of the school-aged population was actually enrolled, though this figure refers only to boys. A dropout rate of 37 percent before graduation (Abu-Rubiyya et al. 1996: 2) led to a very low level of bedouin education overall. Only after the *siyag* was removed (which, incidentally, coincided with the aftermath of the 1967 war, when marriage with more educated women from the West Bank and Gaza brought new views of education to the Negev) did enrollment begin to rise (Abu-Rubiyya et al. 1996: 3).

In part, the tensions associated with the implementation of education in bedouin society are connected to the role of children in the household. As Abu-Rabia discusses at length (2006: 867), children played, and still play, a key role in household activities connected to the raising of and caring for livestock. Sending children to school is a luxury few could afford historically, and in truth for many in the *pezurah*, the value of having a child working at home still outweighs the value of sending a child off to pursue a formal education, which will surely train him (or her) for activities that, at

least in the short term, have little likelihood of contributing directly to the economic viability of the household.

By the 1990s when this study was initiated, the literature recognized a number of general problems in bedouin education. Negev bedouin schools are recognized for having the highest dropout rates in all of Israel (see Abu-Saad 1995). For example, according to one study, in 1995, 67 percent dropped out before graduating, compared with 43 percent in other Arab areas (Katz et al. 1998: 4). This was an improvement over previous years. While other studies quote even higher rates (Abu-Saad 1997: 33), perhaps to make a political point, a statistic of roughly 55 percent appears to be the most consistently cited (Abu-Rabia 2006: 879) and still, needless to say, is well beyond acceptable.

Regarding the nationally held matriculation exams, it has been argued that principals often seek to overcome the negative reputations that the bedouin schools experience by recommending only the best students take the exam, in order to make their schools look better, seeking to “enhance [their] prestige” (Abu-Rubiyya et al. 1996: 8). That said, in 1995, 6 percent of all bedouin high school students who took the national *Bagrut* exam successfully matriculated, compared to 22 percent in the rest of the Arab sector, and 40 percent in the Jewish sector (Katz et al. 1998: 5). The figure saw considerable improvement by 2002, with 26 percent of bedouin students matriculating. And yet, that same year, 34 percent matriculated in the rest of the Arab sector, and 52 percent in the Jewish sector, again revealing that the Negev bedouin remain behind the other sectors of Israeli society due to socioeconomic and other factors, directly impacting access to higher education (Abu-Rabia 2006: 877).

Other issues also play a role. Recent statistics, for example, reveal that only 60 percent of the regional teachers are Negev bedouin, the rest hailing from the north (Galilee), where there tends to be a surplus of teachers (Abu-Saad 1995: 156; Human Rights Watch 2001: 113). Yet this presents some issues as well, especially when single Arab women living far from home and teaching in bedouin culture are not fully comfortable with the situation (Abu-Saad & Isralovitch 1992: 778). Differences in dialects, dissimilarities in acceptable clothing, and other mores make teaching and learning a challenge for students and teachers alike (see Dinero 2009).

Most local bedouin elementary school teachers were men in the past, though this is slowly changing (Abu-Rubiyya et al. 1996: 4). A high proportion of the teachers who have taught in the bedouin schools, historically, were uncertified (Abu-Rubiyya et al. 1996: 17). This lack of role models is, of course, problematic and cyclical, and relates back to the fact that many bedouin students still do not complete their schooling, and very few see



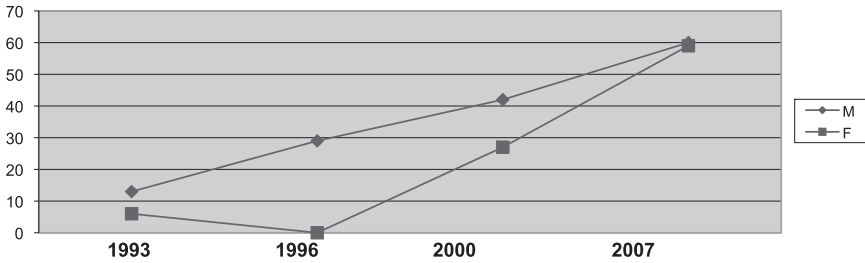
the value in pursuing an education as an attractive, viable career option (El-Farona, 19 February 2007).

Predictably, observers have again argued that problems in bedouin education, including high dropout rates and low scores on national tests, are due to bedouin culture (Meir 1997: 176), rather than to the innumerable ways in which the bedouin educational system is inadequate and inferior to the Jewish one. The issue, it is argued, is “related to Bedouin society’s receptivity to modern and formal education ... from a cultural perspective—modern education is still irrelevant for a considerable proportion of the Bedouin population” (Meir 1997: 176–177). Based on such arguments, it has been concluded by some that “educators concerned with the Bedouin educational system need to be guided by a worldview that regards the school as a means of integrating the bedouin into the mainstream of Israeli society” (Abu-Rubiyya et al. 1996: 25).

Abu-Saad is one of very few scholars who has documented the ways in which bedouin education is jeopardized not, as so many wish to argue, because of culture, traditional mindsets, and the like, but, rather, due to the purposeful neglect and unequal treatment of Arabs in Israel in general, and of the bedouin in particular. He notes, for example, the disproportionate distribution of funding, noting that the “Israeli State Comptroller’s 1992 report comparing Jewish and Arab education in Israel reveals that school budgets, teaching hours, professional resources and facilities are not equitably distributed between these systems. In the 1990–1991 school year, the annual per capita expenditure of the Ministry of Education and Culture was 308 New Israeli Shekels (NIS) for Jewish students, and 168 NIS for Arab students” (Abu-Saad 1995: 150).

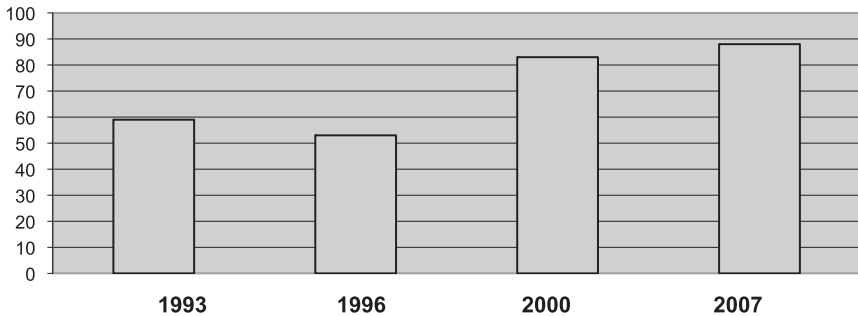
And yet, though it has been said that “Bedouin schooling is not a priority of the Israeli Ministry of Education” (Abu-Rabia 2006: 880), all statistics suggest that the bedouin are accessing educational opportunity, and at a relatively rapid rate. Not only is this true of the boys, but, increasingly, the bedouin girls as well; the educational gap between the genders that saw only one-half to three-quarters of the female student-aged population in school in relationship to similarly aged male peers in the 1980s and 1990s (Abu-Rubiyya et al. 1996: 10–11; Dinero 1996: 109) has all but disappeared as of 2007 (see Figure 4.2). Of related relevance, literacy rates have concurrently risen (Figure 4.3).

As will be seen below, educational level is a predictor of numerous social and economic development indices in Segev Shalom and throughout the Negev region, in the post-nomadic era. It is notable then that although the schools in town are educating more bedouin schoolchildren than ever before, there are a variety of difficulties that the educators must also face as the town continues to grow and to develop.



**Figure 4.2.** Percentage of High School Graduates in Segev Shalom (Male/Female).

Sources: 1993, 1996, 2000, 2007 Surveys.



**Figure 4.3.** Adult Literacy Rates (%), One or More Languages, Segev Shalom.

Sources: 1993, 1996, 2000, 2007 Surveys.

## Segev Shalom Education: Challenges and Successes

As of 2007, there were three elementary schools in Segev Shalom, with populations of at least 600, 750, and 1,000, totaling over 2,350 pupils. There is one high school in town that has 1,800 students, and the town now has a middle school with over 150 students (Illustrations 4.2, 4.3); adding a class each year, its expected population will also be 1,800 (Jirjawi, 7 February 2007). By way of comparison, in 1992, there was one elementary school and one high school (grades 7–12) in the town. The entire student body of the secondary school at that time was only 580 students (Hamamdi, 9 November 1992).

In addition to the growth of the town's population over the years, a substantial proportion of students are bussed to the town schools from the *pezurah*. The shortage of schools there is well known (Abu-Rabia 2006: 877) and is in part purposeful; after all, one of the primary goals of the resettlement initiative was to provide services in a concentrated environ-

ment, and if this were shown to be possible outside of a town, the rationale for resettlement would be further weakened. On the other hand, there are genuine logistical difficulties in building schools fast enough even in the planned towns to keep pace with the growing population (see below); this problem is compounded all the more so in the *pezurah*.

Regardless, only elementary schools are built in the *pezurah*; students must be bussed to the Segev Shalom High School (or one of the other town schools) at the secondary level, which plays a particularly central role in the dropout rates of high school-aged girls (Human Rights Watch 2001: 40), whose male relatives do not want them to travel too far from their homes and outside of the household influence in order to attend school. In most instances, these schools are viewed as “temporary” in any case (Abu-Saad 1997: 31), with designs reflecting the assumption (and purposeful intention) that, in time, the students and their families will relocate permanently to one of the planned settlements.

Be that as it may, in 1992, 20 percent of the elementary school population came from outside of the town (Dinero 1996: 109); in 2007, the figure at the elementary level is closer to 40–60 percent (Jirjawi, 7 February 2007; El-Farona, 19 February 2007). Sixty percent of the secondary school population hailed from the *pezurah* in 1992 (Hamamdi, 9 November 1992); that figure remained unchanged in 2007. Thus, new schools to accommodate this ever-growing student body are under construction in the town almost incessantly, as overcrowding and the use of “caravan” outbuildings lacking air conditioning or proper heating are a constant aspect of education delivery in this (and every other) bedouin town. A late 1990s government study determined that in order to keep up with demand, 146 additional classrooms would have to be built each year (Human Rights Watch 2001: 81), though this has not occurred. The overcrowding issue, which in truth is also of concern in the Jewish sector, is therefore a dominant feature of any bedouin classroom. The dynamic created by this fact is problematic not only for the pupils, but also for the bedouin faculty seeking to give the children the attention they believe they are due.

Let’s start with the number of students. Today the number of students has changed. Once there was a smaller, fewer students, and fewer numbers of schools. Now there are more students and more schools. Their needs—like computers and such—has grown. Once in education there wasn’t any. Once there were fewer students, fewer needs, but more achievements. For example, the class I taught, the whole class was 20 students, two left, and there were 18. That was enough for a teacher. Today in a class there are 39, and sometimes classes with 40, with 36. The minimum, no the average class is 36.

Even the teacher who really wants to give, he can't. It's like you've got a sandwich of bread and you need to divide it up to 4 or 10. So how much can you give from this? So it's a problem. (El-Farona, 19 February 2007)

But the issues impacting education delivery, according to bedouin educators, go beyond the question of the ongoing need for more facilities. That the schools in the bedouin towns are lacking in every material way in re-



**Illustrations 4.2. and 4.3.** The Segev Shalom Middle School and High School—2007.

*Source:* Photos by Steven C. Dinero.

lation to schools in nearby Jewish communities is blatantly obvious and recognized by most observers, including those working on behalf of the state (Katz et al. 1998). Unequal governmental expenditure leading to unequal opportunity is well documented throughout the literature (Abu-Saad 1991). But how this is translated and experienced on the ground, in the day-to-day lives of Negev bedouin educators, has gained little attention. Moreover, just as healthcare professionals see ways in which the bedouin appear to be “less than cooperative” in how they use healthcare, educators also see that making the transition to formalized education appears to some to be a generational process.

For example, the role of parents who, though they may value formal education for their children, are unprepared to help them fully with their schooling, is one crucial element that few have discussed (see Abu-Saad 1995; Dinero 1996, as exceptions). As the aforementioned statistics reveal, formalized education is new to bedouin society. In 1993, only 1.2 percent of those surveyed in Segev Shalom stated that their fathers had graduated high school, while 78 percent had no formal education (Dinero 1996: 110); by 2007, 16 percent stated that their fathers had graduated high school, while only 49 percent stated that their fathers lacked formal education.

And yet, just as assumptions about healthcare access and satisfaction are not always born out by reality, attitudes toward education, and access to it, do not always follow patterns that modernization theorists might anticipate. Though admittedly some statistics appear to suggest that education levels reveal that the bedouin are in a period of transition from one generation to the next and from the nomadic phase to the planned town environment and that it will take time before this transition is complete, this does not mean that all of the players on the “continuum” (Meir 1988) are in fact following the progression from “traditional” to “modern” in an orderly fashion. Middle School Headmaster Ibn-Nasir explains (19 February 2007):

The problem is with the parents, yes. They don't always worry about their kids' education. The kids don't do their homework, they don't have the commitment. But the parents who *don't have* much education, they sometimes tend to have a *greater* commitment to get their kids educated than the others.

Headmaster El-Farona sees the issue similarly. He states (19 February 2007):

It doesn't matter if [a student] lives in the settlement or outside [in the *pezurah*], in connection to education. There's no connection. I see sometimes that there are children whose mother and father know how to read

and write and they help them, and they're better students than those who live in the settlement. It doesn't matter about the living conditions. Those who live in a tin shack—sometimes they have electricity, sometimes they don't have electricity—but it doesn't depend on those conditions, it depends on who is looking after the children. These things matter. Even if a child lives in a castle, he has everything, but who's looking after him?

...

(T)here are people in the town who don't want to raise their children. This one will have his house, he's got everything. But he doesn't want to look after his children. There are people outside [in the *pezurah*] who don't have anything, but they invest all their energy in their children. That's the difference.

Another “difference” that plays a significant role is the question of student motivation and commitment to the educational enterprise. For most people, formal education amounts to a means to an end, the end being a better job, financial security, and so on. To suggest to a post-nomadic indigenous population that formal education is a worthwhile endeavor in and of itself is not only naïve, but fails to consider the economic foundation of this classic social development measure.

In Negev bedouin society, economic success does correlate statistically with educational achievement (see below). But as with the case of healthcare, perception plays a key role here as well; if the perception in the bedouin community is that educational success will not lead to economic success, then it should be no wonder that teachers will continue to struggle in the classroom to convince their charges that their scholastic endeavors are worthwhile. El-Farona, who was a classroom teacher for 12 years before taking on his new role of the past 8 years as Headmaster of one of the town's elementary schools, states (19 February 2007):

If we take a boy who has completed 12<sup>th</sup> grade and has his matriculation exams but he doesn't have any money, he won't go on to study ... He'll think, “For what?” His brother did it, he completed it, and for what? To be unemployed? The father sits at home, the brothers sit at home, [and] they get unemployment payments. Today, what will the boy think? They're sitting and sitting every day getting unemployment checks. He won't even make an attempt. Once, we all went out to work. Everyone went out to work. Today, no. Now the father explains to him, “Look, I get money from the State.” The child, what does he think? “Why should I even make an effort?”

...

Sometimes there's a job notice in the paper, and we're sitting around, and there's folks who say, "Listen, [it's not for me], I'm an automobile technician, or whatever." They say that because since they didn't do the army, or because they're bedouin, they fear they won't take them. So I say, "Look, try. Go. Show them that you're capable." So, he's thinking he's screwed from the start. He won't even put himself out as a candidate. There's also that thinking. "Go, try to change it. You may not succeed, but go, try." These are the things you have to try to change. But that's the outlook of our young people.

Despite such perceptions, there is no question that educational level is a primary indicator—if not, *the* primary indicator—through which much of the nature of social and economic development and political change now occurring in Segev Shalom can be examined, measured, and traced. Education is central to the process of moving the bedouin community from an ascriptive-oriented society to an achievement-oriented one (Abu-Saad 1995). This has been true since data was first gathered in Segev Shalom in 1993, when it was found that education levels correlated with reasons for relocating to the planned town. Less educated bedouin were more likely to state that they relocated seeking the development opportunities that town life had to offer, while the more educated were more likely to cite other reasons for relocating, such as government force ( $p=.04$ ). In the same survey, it was also found that those living in the town for 5 or fewer years, the "newcomers," tended to be less educated than those living in the town more than 5 years ( $p=.03$ ). Lastly, education and employment correlated ( $p=.00$ ) as did education and gender ( $p=.00$ ); the more educated were male and had a greater likelihood of being employed.

By 2007, several additional factors correlated with educational levels. More educated residents tended to be under 40 years of age and were single/never married ( $p=.00$ ). As suggested by the educators' sentiments above, parents' educational levels played a role in one's own ability to access scholastic achievement. The more educated bedouin were found to be more likely to have more educated fathers ( $p=.00$ ) and mothers ( $p=.00$ ). The father's education also played a role in one's economic status. Curiously, an inverse relationship was found between the father's education and the possibility of owning a stone/permanent house, although the relationship was not strong ( $p=.05$ ). Perhaps more predictably, those with less educated fathers were less likely to own a phone, ( $p=.01$ ), a TV ( $p=.00$ ), or a VCR/DVD player ( $p=.00$ ).

As one would expect, younger residents (under the age of 40) tend to be more educated than older residents ( $p=.00$ ). This impacts dynamics in the town; those who came to the town longer ago, the "veterans," and "found-

ing fathers,” are less educated than the recent arrivals ( $p=.00$ ), especially those in-migrants under the age of 40 ( $p=.02$ ). The Azazmeh newcomers are more educated than the Azazmeh veterans ( $p=.00$ )—that is, they who founded the town in the early 1980s and who feel a particularly vested interest in the planning and development of “their” town. In general though, members of the Azazmeh tribe are more educated than the Tarabeen ( $p=.05$ ). Lastly, lower income newcomers are more educated than veterans ( $p=.00$ ); they may come to the town with limited financial resources, but the one thing they have that many low income town residents still lack is education.

As for the role of education in Segev Shalom’s economic development, the ramifications from a statistical viewpoint appear to be clear. And yet factors such as age and tribe play a role in one’s ability—beyond educational level—to access economic resources in bedouin society today. When looking at the labor force as a whole, for example, the more educated residents of Segev Shalom are more likely to be employed ( $p=.00$ ). And yet, this is especially true for women ( $p=.00$ ), though not for men; for those under 40 ( $p=.01$ ), but not over 40; for Tarabeen members ( $p=.00$ ), but not the Azazmeh; for those with lower incomes ( $p=.00$ ), but not for those with higher incomes.

In other words, those in Segev Shalom who could be referred to historically as the strongest, proudest, ablest community members—namely, through the ascribed status as “True” Azazmeh bedouin men who have come of age and have wealth and means to prove it—now are able to express these same ideals through the obtainment of education. But when they do so, there is no statistical correlation between this achievement and whether they will ever acquire a wage-labor position compatible with their educational accomplishments.

When, however, the data that includes all of the town’s sectors are considered, the findings do confirm what one might anticipate about the connections between educational achievement and economic well being and behavior. Those with more education, for example, also were found to have higher family incomes ( $p=.02$ ). They were less likely to raise animals in town ( $p=.00$ ) to supplement their incomes, especially those with young households ( $p=.01$ ). The more educated were also less likely to raise crops or fruit-bearing trees in town ( $p=.00$ ), another sign of both social and economic transition away from a subsistence economy. Again, this was found to be especially true of young families ( $p=.02$ ) and the Tarabeen ( $p=.03$ ).

Education levels also were found to play a role in goods ownership. While this was true to a limited degree in the 1993 findings, by 2007, several correlations could be found within the data. The more educated residents, for example, were more likely to own a phone ( $p=.00$ ), especially the young



( $p=.01$ ) and those with *low* incomes ( $p=.00$ ). The same was true of those owning VCR/DVD players ( $p=.00$ ,  $.01$ , and  $.00$ , respectively).

The more educated were more likely to own a car ( $p=.02$ ), especially those with low incomes ( $p=.01$ ). Among those under 40, the more educated were more likely to own a satellite dish for their TVs ( $p=.03$ ); this was also true of those with low incomes ( $p=.04$ ). Among the Azazmeh, the more educated residents were more likely to own a washing machine ( $p=.04$ ); this was also true of those with low incomes ( $p=.01$ ). And lastly, those bedouin in town who were more educated were more likely to own a computer ( $p=.00$ ), and again, this was especially true of those under the age of 40 ( $p=.00$ ), the Azazmeh ( $p=.00$ )—and, of course, those with low incomes ( $p=.00$ ).

Once again, the bedouin seem to be following a classic model of socioeconomic development, and yet once again, they appear to be diverting from it in unique and significant ways. For while it is to be expected that higher educational rates might yield exposure to new ideas, interests, changed tastes, and so on, all of which would lead to new patterns of material consumption, what stands out here is the factor that should play the biggest role—can one afford to buy all these consumer products—is an inverse variable. Rather than finding that those with higher incomes are the standard bearers of early bedouin consumerism, it appears that those with *lower incomes*, but who have achieved *higher levels of education* are by far the most likely to wish to acquire the material accoutrements of twenty-first century Israeli society.

The picture becomes cloudier still when one considers political attitudes, both local and national, and how educational levels influence these views. In previous data sets, correlations were found between one's educational achievement, and one's views and satisfaction with local services, national governance, and the state of bedouin society as a whole. As but one example, in 1993, more educated male respondents were more likely to be critical of Segev Shalom's sanitary services than the less educated ( $p=.01$ ).

The 2007 data set provided similar findings. Those residents, men and women, with higher incomes and who were more educated tended to rate the local water service lower than the less educated ( $p=.04$ ). Although, in general, more educated residents tend to be more critical of town services as these examples reveal, there are exceptions. More educated men, for example, rate the electrical service in town higher than those with less education ( $p=.01$ ). But perhaps of greater relevance and significance to the long-term growth and development of Segev Shalom and to the urbanizing bedouin community as a whole is the role of education as it informs the increasingly politicizing nature of the community (see Chapter 6), for it is

these findings which may provide a window into better understanding the direction in which the community is now heading.

For example, the more educated residents of Segev Shalom were found to be *less* likely to have participated in voting in the most recent national elections ( $p=.01$ ). This group, which presumably represents a significant alienated sub-population of today's most informed Negev bedouin, tend to be under 40 ( $p=.05$ ), Tarabeen ( $p=.00$ ), and with overall higher incomes ( $p=.03$ ) in the town.

The pattern is reinforced still further by the fact that those with more educated fathers were also less likely to have voted ( $p=.02$ ), especially the Tarabeen ( $p=.00$ ). Those with more educated mothers also were less likely to have voted ( $p=.05$ ), especially those with lower incomes ( $p=.05$ ), the Tarabeen ( $p=.03$ ), and women ( $p=.01$ ). The more educated bedouin also were more likely to choose an option on the survey stating that the national government is "failing to serve the needs of the bedouin community" ( $p=.05$ ) than those with less education. This is especially true of those under 40 ( $p=.04$ ). Those who are more educated with higher incomes are more likely to express that they "feel unequal with other Israelis" ( $p=.02$ ), another survey option. Further, those who are more educated with fathers who also are more educated are more likely to say that they feel less equal with other Israelis ( $p=.04$ ).

In other words, these statistics suggest that those who are more educated and are on top of the bedouin socioeconomic ladder have a better idea than anyone else (or so they believe) that their political situation is unequal, and, one might conjecture, apparently with little promise.

If there is any solace to be found in their situation, it is clearly not in the maintenance of the political status quo, but in seeking a viable alternative. Thus, the 2007 data reveal that more educated men are more likely to favor the Islamic parties over the Jewish/Zionist parties than the less educated ( $p=.02$ ). Again, what is notable here is that this is especially true of those in Segev Shalom coming from households enjoying *higher* incomes ( $p=.00$ ). The Islamic party option need not be viewed as wholly indicative of an increasing level of Muslim orthodoxy in Segev Shalom, although this is, in part, occurring. It should be noted, for example, that more educated residents under 40 are *less* likely to state that they frequent the mosque ( $p=.01$ ), especially more educated women ( $p=.04$ ).

It does, however, suggest that as the bedouin residents of Segev Shalom become more formally versed in the Israeli educational system, they are not merely learning the "3 Rs." Rather, the aforementioned statistics appear to suggest that today's Negev bedouin, as he or she becomes more educated, is also becoming all the more aware of the social, political, and

economic inadequacies and injustices that are a part of daily bedouin life in Israel. The more they learn, the more they see of Jewish society, then the more they realize just how much Segev Shalom and the neighboring areas are truly lacking and are victims of neglect. As the above has introduced and as the following chapter will allow for further extrapolation and exploration, more educational opportunities for the bedouin is a double-edged sword, exposing them ever increasingly to new ideas and modes of perceiving their newly developing identities within a globalizing Israeli context.

As their formal educational experiences expand, so too do their expectations—expectations that are, to this point at least, largely unmet. Moreover, no sector of bedouin society has been impacted more profoundly by the changes brought on by the expansion of educational opportunity than bedouin women (see Chapter 6). As each new class entering school each year is now 50 percent female, Negev bedouin girls' and women's expectations, hopes, and dreams for the future bare little resemblance to their mothers' and grandmothers' lives. And yet, a variety of barriers and limitations remain, which are not easily resolved outside of a modernization-minded, Orientalist framework. It is to these issues and challenges that I now turn.