British Journal of Middle Eastern Studies

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/cbjm20

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To cite this article: Moriel Ram & Haim Yacobi (2022): Zionism in a white coat: Israel's geopolitics of medical aid development assistance of health to Africa, British Journal of Middle Eastern Studies, DOI: 10.1080/13530194.2022.2038085

To link to this article: https://doi.org/10.1080/13530194.2022.2038085

Published online: 08 Feb 2022.

BRITISH JOURNAL OF MIDDLE EASTERN STUDIES
https://doi.org/10.1080/13530194.2022.2038085

Routledge
Taylor & Francis Group

Zionism in a white coat: Israel's geopolitics of medical aid development assistance of health to Africa

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ABSTRACT

This article focuses on Israel's export of medical knowledge to African states during the 1960s. Its aims are twofold. First, to evaluate and discuss the place of medical assistance and health aid within scholarship, examining the relationships between Israel and African states. Second, it will show how a discussion of Israel's medical and health projects are linked to the regional geopolitics that shape the movement of materials, individuals and knowledge between Africa and the Middle East. By exploring the themes of security and geopolitics, positionality towards Africa, and the movement of knowledge; resources and people this paper unravel how deployment of medical aid and development assistance of health were entwined into the effort to secure Israel's regional geopolitical objectives to position itself in proximity to different polities in Africa and interchangeably confirmed and challenged Israel's presence in the continent. Unpacking the place of health and medical knowledge, enables a better understanding of the reciprocal relations between medical knowledge, the spaces this knowledge shapes, and the sites where it is produced.

Introduction

This article discusses the medical aid that Israel provided to African countries. Based on extensive archival work in Israel's State and Military Archives, as well as the Zionist Central Archive, we suggest a reading that explores three main themes that underwrite Israel's intervention in Africa during the 1960s. These include: 1) Israel's arduous efforts to secure its geopolitical objectives in the continent; 2) the positioning of Israel politically and culturally towards, or away from, various African nations; 3) the connectivity and relations between Israel and different African polities through the movement of health professionals and medical knowledge.

Our aims are twofold. First, from an empirical perspective, we evaluate and discuss how medical aid and development assistance of health fits into the relationships between Israel and African states. Second, methodologically, we aim to show how a discussion of Israel's medical and health projects helps us to understand the relationship between these themes (security, positionality, connectivity and movement) to examine the trans-

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regional dimensions of medical activities that link Africa and the Middle East.[1]

We will argue that by discussing the themes of: security and geopolitics; positionality towards the continent; and the connectivity between Africa and Israel through the movement of knowledge, resources and people; we also help to unravel the place of medical aid and development assistance of health within the overall discussion around Israel's wider activities in the continent.

Like in other spheres of development aid, Israel struggled to provide medical aid and development assistance of health; and to compete with larger states involved in providing development aid to Africa. Israel's provision of medical aid was also informed by the perceived political proximity, and assumed distance, of Israel towards different locations in the continent. These practices were also entangled with an effort to disassociate Israel from legacies of colonial exploitation.

In the first section, we situate the case within the conceptual discussion about the geopolitics of Israel in Africa, and the politics of health and development in the Global South. The second section sketches how an analysis of medical aid illustrates the main themes underwriting Israel's involvement in the continent. We then explore Israel's dealings with Ethiopia to emphasize the need for a nuanced reading into the politics of medical aid and development assistance of health in Africa and the Middle East that evaluates the themes of security, positionality, connectivity, and movement. We conclude by focusing on Israel's medical aid to Ethiopia, to better illustrate the varying positions of politicians and professionals regarding the movement of people between Israel and Africa, and how this movement interchangeably confirmed and challenged Israel's presence in the continent.

Considering Israel's politics of development health aid in the Middle East and Africa

We situate our analysis within a discussion that has received significant scholarly attention: the myriad and complex activities of Israel in Africa. Towards the end of the 1950s, Israel decided to form strategic ties with African states as part of an overall effort to forge regional alliances with non-Arab countries.[2] Israeli experts offered military training, developed irrigation schemes, provided agricultural consulting, initiated commercial cooperation, carried out regional planning and established cultural programmes. By 1964, the Israeli ratio of experts to total population in Africa was twice that of all OECD countries; and in 1973 more than 3,017 Israeli experts worked on short or long-term projects in Africa.[3]

[1]Our discussion mainly revolves around Israel's involvement in Africa during the 1960s, when Africa witnessed considerate and expanded state-based interventions that offered development aid. Yet we also try to evaluate and acknowledge some activities which took place in the years that followed this period.

[2]Throughout the 1960s, Israel established diplomatic ties with over thirty African countries; several of these only gained independence (and established ties with Israel) in 1966–68. The decision to form strategic ties with African states and its aftereffects has been the focus of several works: Zach Levey, *Israel in Africa 1956–1976* (Dordrecht: Martinus Nijhoff Publishers, 2012); Samuel Decalo, *Israel & Africa: Forty Years, 1956–1996* (Miami: Florida Academic Press, 1998); Joel Peters, *Israel and Africa: The Problematic Friendship* (London: I. B. Tauris, 1992).

[3]'Model for Developing Countries', 25 March 1963 Israel State Archives (hereafter: ISA) Record Group CHETZ 1903/5. Peters, *Israel and Africa*, 4.

The literature discusses several themes arising from Israel's activities that help us to evaluate the place of medical aid and health assistance within Israel's overall activities in African countries. First is the consistent, and to a great extent unsuccessful, attempt to secure Israel's regional geopolitical objectives. As Yotam Gidron stresses, Israel's development projects in Africa were mainly aimed at achieving political and military alliances, as well as influence and leverage against its regional rivals.[4] Yet, as Zach Levey shows, the effort to gain the support of African states in the diplomatic arena was set back almost from the moment of its inception.[5]

The dynamics of securing Israel's geopolitical objectives influenced another theme in the literature relevant for our discussion, this is the positioning towards and away from other intervening states and African nations. Israel's various actions and activities in Africa were mired in varying vantage points on the specific African locations that the state should target. Haggai Erlich, Zack Levey and Yotam Gidron stress that Israel shifted its geopolitical weight from Western African and Sub Saharan states to East Africa, and particularly Ethiopia, in line with Israel's regional conflicts in the Middle East.[6] Other scholars, such as Sasha Polakow-Suransky, have pointed to how Israel's relationship with South Africa's apartheid regime constantly fluctuated, bringing the two closer together and further apart in line with the different geopolitical changes underwriting the dynamics of the Cold War.[7]

Political positioning was also entwined with the desire to disassociate Israel from colonial exploitation. Israeli leaders sought to appeal to African heads of state during the continent's decade of decolonization by accentuating Israel's position as a polity born out of a struggle against imperialism. At the same time, as Haim Yacobi and Eitan Bar Yosef show, Africa became entwined in Israel's politics of racialization, which are connected to the country's desire to be considered part of, or at the very least, in the orbit of, the Western block.

Finally, in discussing the politics of geopolitical (in)security and positionality, we also should consider Israel's protracted involvement in the affairs of African nations and societies. Some accounts mark 1957 as the beginning of Israel's activities in the continent, when it established an embassy in Ghana. 1967 is judged to be the 'beginning of the end' owing to the June War; culminating in 1973 when most African nations severed official ties with Israel. Yet as Gidron, Oulsola Ujo, Bar-Yosef and Yacobi show, Israel never 'left' Africa. The myriad relations between African countries and Israeli operatives, entrepreneurs, security 'advisors' and others, with Israel's tacit support, continued well into the decades following the 1973 October War.[8] Similarly, the perceptions of 'Africa' in Zionist thought have deeper roots than the initial diplomatic connections of the 1950s.[9]

[4]Yotam Gidron, *Israel in Africa: Security, Migration, Interstate Politics* (London: Zed Books, 2020), 6.
[5]Zach Levey, 'Israel's Strategy in Africa, 1961–67', *International Journal of Middle East Studies* 36, no. 1 (2004): 71–87.
[6]For a detailed discussion of Israel's activities in Ethiopia, Haggai Erlich, *Alliance and Alienation: Ethiopia and Israel in the Days of Haile Selassie* (New Jersey: Red Sea Press, 2013). See also, Scopas Poggo, *The First Sudanese Civil War: Africans, Arabs, and Israelis in the Southern Sudan, 1955–1972* (New York: Palgrave Macmillan, 2009).
[7]Sasha Polakow-Suransky, *The Unspoken Alliance: Israel's Secret Relationship with Apartheid South Africa* (London: Vintage, 2011).
[8]Olusola Ojo, *Africa and Israel: Relations in Perspective* (London: Routledge, 2020).
[9]Eitan Bar Yosef, *A Villa in the Jungle: Africa in Israeli Culture* (Jerusalem: Van Leer, Hakibbutz Hameuchad Publishing House, 2013).

This protracted involvement compels us to consider when and where Israel becomes 'connected' to Africa. The varying forms of Israel's involvement in Africa also generated a dynamic of political movement in which ideas, governance, technologies and people traversed between Israel and Africa. Yacobi, together with Chen Misgav and Smadar Sharon, recently delineated how the scheme to export the Nahal settlement model to Africa is entwined into Israel's own historical development and the governance of Jewish immigrants from North Africa, as well as the Palestinian population living in the occupied territories.[10] As Gidron states, the movement of asylum seekers and labour migrants from various African states is part of this continued motion of people and power which constantly connects Israel to Africa.[11]

The fluctuations of the elements of security, positionality, connectivity and movement stress the need to think about the dynamics through which Israel's position, location and objectives in the Middle East and Africa were determined and pursued. In this article we discuss the politics of development aid for medical and health assistance. Sandra Sufian's work on the Malaria Eradication Campaign in Palestine demonstrates that the deployment of medical knowledge is bound to the national imagination of the place itself, alongside narratives about the inseparable linkage between 'healing the land' and the establishment of national institutions.[12] Building on this argument, we examine how medical aid and development assistance of health—part of the Israeli national project—were entwined into the effort to secure Israel's regional geopolitical objectives to position itself in proximity to different polities in Africa.

We argue that medical aid and development assistance of health were technopolitical tools, used to further strategic interests that distinguished different regions of Africa in ways that both accommodated and conflicted with these interests; and a political platform that connected Africa to Israel's own state-building project dynamics. For these reasons it is important to reflect on the actual, multifaceted ways in which medical aid and development assistance of health came to fruition.

We thus locate our discussion within the politics of health care development, primarily within the Twentieth Century, Cold War dynamics and Africa, and more specifically within the context of health and development in Africa and the Middle East.[13] This is an expanding research field which explores how medical institutions are entrusted with providing sustainable healthcare, curtailing epidemic outbreaks, and treating chronic illness. It discusses how political power, medical knowledge and commercial interests

[10]Haim Yacobi, Smadar Sharon and Chen Misgav, 'Technopolitics, Development and the Colonial-Postcolonial Nexus: Revisiting Settlements Development Aid From Israel To Africa', *Middle Eastern Studies* 56, no. 6 (2020): 937–952.
[11]Gidron, *Israel in Africa*.
[12]Sandra Sufian, *Healing the Land and Nation: Malaria and the Zionist Project in Palestine, 1920–1947* (Chicago: University of Chicago Press, 2007).
[13]Katayoun Shafiee, 'Technopolitics Of A Concessionary Contract: How International Law Was Transformed By Its Encounter With Anglo-Iranian Oil', *International Journal of Middle East Studies* 50, no. 4 (2018): 627–48; Richard H. Adams, 'Evaluating The Process of Development In Egypt, 1980–97', *International Journal of Middle East Studies* 32 (2) (2000): 255–75; Gabrielle Hecht and Paul N. Edwards, 'History and the Technopolitics of Identity: The Case of Apartheid South Africa', *Journal of Southern African Studies* 36, no. 3 (September 2010): 619–639.

are formed, dispensed and challenged.[14] The literature demonstrates the need to unpack what Julia Shatz calls a 'politics of care', formed from constant interaction between a myriad of networks connecting nodes of governance, local initiatives and politics of race, class and gender.[15]

Our work builds on the effort to unravel the political, cultural and social edifices that predicate healthcare as a techno-political tool and trace its colonial, imperial and national lineages. A significant part of the literature focuses on the breaking points and continuities of epistemological, political and social encounters between 'West' and 'South'; between an era of colonial domination and post-colonial development. This is a movement from official state power to non-governmental organizations operating beyond the limits of the state; and throughout there is a transition from an international community to global regimes developing health as a tool of state, and non-state, power.[16]

However, these discussions tend to overlook interventions in the politics of development assistance of health that were generated beyond Western Europe and North America. We conjoin the discussion on the politics of medical knowledge with an exploration of Israel's activities in Africa to better understand the place given to health by a state that associates itself with an ascribed 'West', while at the same time aiming, with varying degrees of success, to eschew the accompanying colonial baggage. Also, while the discussion over Israel's development aid is bound to the strategic calculations that determined both the form and means of assistance, we utilize the body of knowledge on the politics of care to discuss how, eventually, the forms of techno-political assistance became bounded to the movement, or at the very least to the potential of movement, between Israel and certain African locations.

Anat Mooreville has shown how the work of Israeli medical experts is pivotal to the larger discussion on Israel's involvement in Africa.[17] Politically speaking, deploying doctors could have generated significant diplomatic effects, with relatively fewer costs than would be incurred investing militarily or erecting institutions. Medical and health investments also garnered significant attention as they directly related to the humanitarian aspects Israeli policy makers sought to emphasize in their activities. Such medical projects furthered the prospects of scientific advancement and the facilitation of medical professionalization.

[14]Myron Echenberg, *Black Death, White Medicine: Bubonic Plague and the politics of Public Health in Colonial Senegal, 1914–1945* (Portsmouth, N.H: Heinemann, 2002). Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900–1940* (Cambridge: Cambridge University Press 1992). Elisha Renne, *The Politics of Polio in Northern Nigeria* (Bloomington: Indiana University Press, 2010). Meredeth Turshen, *The Political Ecology of Disease in Tanzania* (New Jersey: Rutgers University Press, 1984). James McCann, *The Historical Ecology of Malaria in Ethiopia: Deposing the Spirits* (Athens: Ohio University Press, 2015). Randall Packard, *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa* (London: James Currey, 1989). Chris Rominger, 'Nursing Transgressions, Exploring Difference: North Africans In French Medical Spaces During World War I', *International Journal of Middle East Studies* 50, no. 4 (2018): 691–713.

[15]Julia R. Shatz, 'A Politics Of Care: Local Nurses In Mandate Palestine', *International Journal of Middle East Studies* 50, no. 4 (2018): 669–89. See also Jennifer Johnson-Onyedum, ' "Humanize the Conflict": Algerian Health Care Organisations and Propaganda Campaigns, 1954–62', *International Journal of Middle East Studies* 22, no. 4 (2012): 725.

[16]Nancy Gallagher 'Medicine and Modernity in The Middle East and North Africa', *International Journal of Middle East Studies* 44, no. 4 (2012): 799–807; Paul W. Geissler (ed.) *Para-States and Medical Science: Making African Global Health* (Durham: Duke University Press, 2015).

[17]Anat Mooreville, 'Eyeing Africa: The Politics of Israeli Ocular Expertise and International Aid, 1959–1973', *Jewish Social Studies* 21, no. 3 (2016): 31–71.

Besides Mooreville, who demonstrated the importance of discussing Israel's export of medical knowledge to Africa, the main bulk of the literature on the politics of medical knowledge and health focuses on the politics of care in Palestine and Israel, or towards the immigrants arriving into this space.[18] In this article we use the notions of security, positionality, connectivity and movement to consider the role that medical assistance and health aid played in shaping Israel's activities and actions in Africa; and how these, in turn, informed and impacted the shape and extent of medical and health aid.

To be clear, we do not suggest a sweeping account of Africa as a monolith. As Eitan Bar Yosef mentions, Israelis working in Africa were wary themselves of such sweeping characterizations.[19] Yet as Mark Langan recently argued, one must not ignore trends that affect collections of states, rather one must address each individually.[20] Accordingly, our aim is to show how medical knowledge deployed to achieve political ends is bound with multiple conceptions of Africa. This posed geopolitical opportunities to secure Israel's interests in the Cold War, and to attain variegated degrees of proximity to the West and to other states in which Israel operated. Hence, instead of discussing Africa as a whole, we aim to identify how the themes of security, positionality, connectivity and movement connect and distinguish between different parts of Africa and Israel, to understand the place of medical aid and development assistance of health in the overall discussion around Israel's activities in Africa.

Health aid diplomacy and the politics of regional (in)security

Israel's medical projects were part of the effort to secure the state's position in Africa, in the light of its regional conflict with Middle Eastern adversaries. It seems only natural that medical assistance would become a cornerstone of Israel's 'expansion' into Africa. Already in 1950, WHO recognized Israel as a potential contributor to health schemes as the state had a high number of physicians. In 1966, this translated into a ratio of 2.4 physicians per 1,000 people. In comparison, for most African states the average ratio stood at about 0.05 per 1,000 people.[21] The agreements that Israel signed with Liberia (1959), Gambia, Central African Republic [CAR] (1962), Gabon (1963) and Chad (1964), designated medical assistance as a pivotal part of the cooperation between Israel and the respective African polities.[22] In 1960 there were 157 Israeli experts operating in developing countries around

[18]Dafna Hirsch, '"We Are Here To Bring The West, Not Only To Ourselves": Zionist Occidentalism and the Discourse of Hygiene in Mandate Palestine', *International Journal of Middle East Studies* 4 (2009): 577–94.
[19]Bar Yosef, *A Villa in the Jungle*, 20.
[20]Mark Langan, *Neo-Colonialism and the Poverty of 'Development' in Africa* (London: Palgrave Macmillan, 2018). See also: William Brown, 'A Question of Agency: Africa in international politics', *Third World Quarterly* 33, no. 10 (2012): 1889–1908.
[21]'Rofi'im Yisraelim Le-Avoda Be-Chul' (Israeli physicians to work abroad), *Davar*, 23 January 1950; 'Yisrael Tzoedet Ba-Makaom Ha-Rishon' (Israel is located in the first place), *Herut*, 6 December 1961; 'Ha-T'naim Ha-Yerudim Le-Chaey Harefua Be- Yisrael' (the poor conditions of medical life in Israel), *Davar*, July 29, 1966. For WHO estimates see http://data.worldbank.org/indicator/SH.MED.PHYS.ZS?year_high_desc=false last accessed 15/07/2021.
[22]'Yisrael Tesayea Le-Gambia Be-Tchum Ha-Refua Ve-Hachaklaut' (Israel will assist Gambia in the fields of medicine and agriculture), *Davar*, 16 December 1962; ISA CHETZ 1938/5, Treaty between CAR and Israel, 13 June 1962.

the world (including Cyprus, Argentina, Nepal, Burma, Mexico, Ceylon, and Singapore); forty-two (30%) were medical, and all but two were engaged in several modes of intervention in Africa.[23]

Expeditions and surveys immersed Israeli medical experts within global health networks in Africa. In July 1960, an expedition of Israeli doctors flew to the Congo to advise on the construction of a medical infrastructure network. The expedition was part of a series of international interventions that dovetailed with Congo's independence.[24]

Israel deployed senior physicians and head nurses that managed hospitals or clinical wards. Israeli doctors and nurses were invited to fill senior managerial roles in a hospital in Tema, Ghana as part of a larger expedition force which included naval instructors, investment bankers, engineers, construction supervisors, agronomists and academics.[25] Israel deployed medical staff to Nigeria, Liberia and Uganda, and performed medical surveys in Gabon in 1962, Malawi and Ghana in 1963, and Madagascar in 1965.[26] The deployed teams were entrusted with a third field of activity: training local medicks to establish a professional cadre that would manage hospital departments.

In November 1961, two leading Israeli physicians pushed for Israeli involvement in medical schemes. Prof. Yitzhak Michelson, an ophthalmological expert from the Hebrew University; and Prof. Zeev Gjebin, the Head of the Israeli Medical Association, who also headed the expedition to the Congo and was asked by the Congolese government to draft a document for setting up medical institutions. The pair established an eye clinic in Monrovia, Liberia to combat Onchocerciasis.[27] Next, they set up a 25-bed ophthalmological clinic in St. Margaret Hospital at Dar-es-Salaam, Tanzania that was run by an Israeli physician and local doctors trained in Israel.[28] From October 1962 to October 1963, Israeli doctors at the eye clinic ward treated 20,400 patients.[29] Israel also sent a general surgeon, two nurses, a radiologist and a psychiatrist to the hospital.[30]

[23]ISA CHETZ 2029/12, report 1 January 1960. Israeli state institutions repeatedly sought to receive assistance from the state's military medical corps, Magen David Adom (Israel's national emergency medical services) HMOs and hospitals. The latter would award different concessions to medical personnel going to Africa, but with limited success. ISA CHETZ 2123/3, letter to Dr Haenosh, Chief Surgeon in Menelik Hospital, Addis Ababa, 4 December 1963. Abel Jacobs, 'Israel's Military Aid to Africa, 1960–66', *The Journal of Modern African Studies* 9 2 (1971): 165–187. The forms of assistance were funnelled through Israel's Ministry of Foreign Affairs Division of International Cooperation (the acronym in Hebrew was Mashav). Established in 1958, Mashav linked Israeli embassies that transmitted the requests of African policymakers and the foreign ministry in charge of recruiting experts.

[24]ISA CHETZ 1937/16, 'Kongo Ha-Belgit, Mishlahot Refuiyot' (Medical expeditions to the Belgian Congo). 'Hamoney Miztrim Mitrozezim Ba-Congo' (Egyptian running around in droves in the Congo), *Maariv*, 9 September 1960.

[25]ISA CHETZ 1903/5, Letter from Mashav official Giora Sigal, detailing recent activities, 4 January 1963.

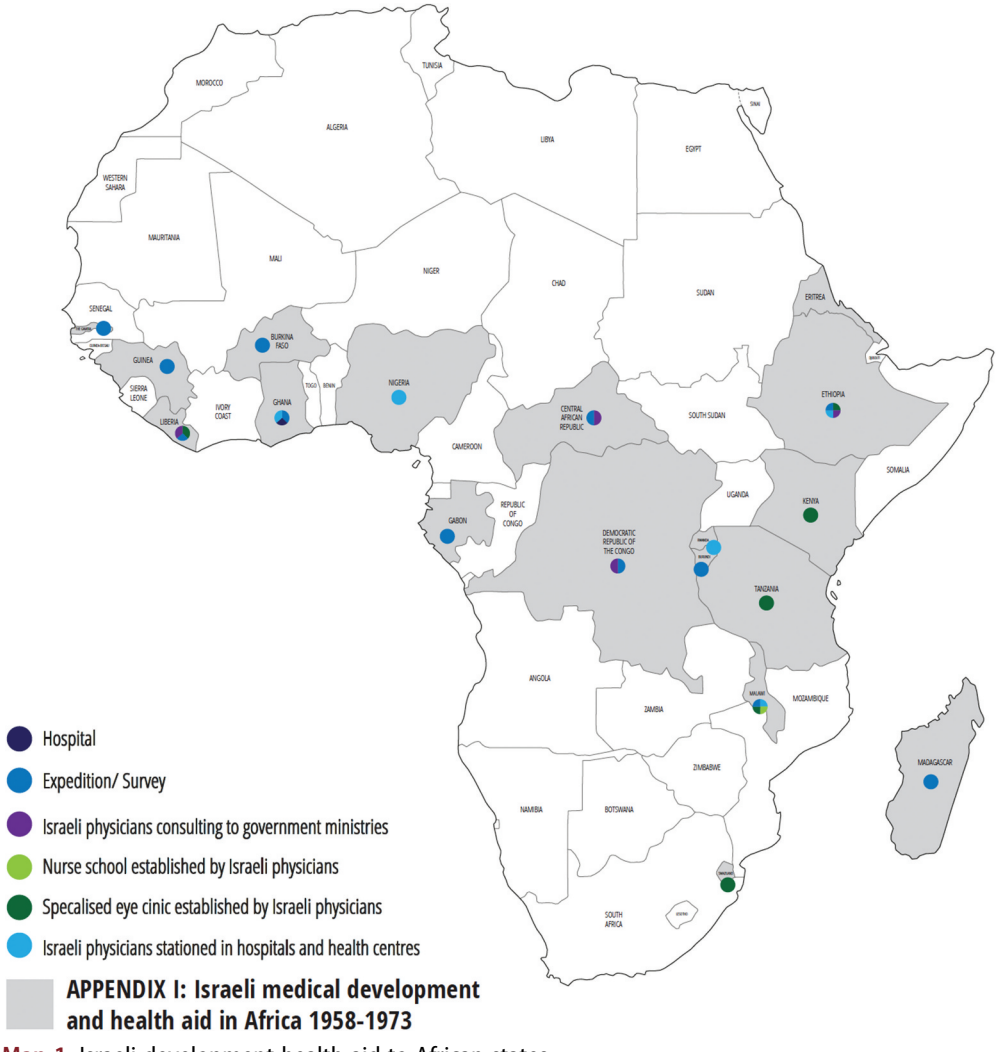
[26]ISA CHETZ 1903/5, 'Peulut Yisrael BeAfrica' (Israel's activities in Africa), 30 December 1962. ISA CHETZ 2739/21, Letter from Israeli embassy: request for medical equipment for a maternity ward in a field hospital in the Congo. ISA CHETZ 929/26, 'Seker Refui Be-Madagascar' (Medical survey in Madagascar), 8 December 1969.

[27]'Me-Hkatedra el Ha-Jungle' (from the cathedra to the Jungle), *Herut*, 16 November 1961.

[28]For a detailed discussion on Michaelson, see Mooreville, 'Eyeing Africa'.

[29]ISA CHETZ 136, 'Skirat Avoda' (review of work being carried), 12 November 1963.

[30]ISA CHETZ 52/1, 'Bikur Prof. Michaelosn ve Dr Jazbin' (Prof. Michaelson and Dr Jazbin's visit), 6 November 1961 1. Eye care initiatives steadily grew to become Israel's largest medical science export. Between 1959 and 1984, over 30 Israeli ophthalmologists examined approximately 500,000 outpatients and conducted 20,000 major eye surgeries with Ophthalmic aid programmes expanded from Liberia in 1959 to eight more African states: Kenya (1961), Tanzania (1962), Ethiopia (1962), Malawi (1965), Rwanda (1966), Lesotho (1974), and Swaziland (1974). See Mooreville, 'Eyeing Africa'.



Map 1. Israeli development health aid to African states.

Israeli projects strived to provide solutions to global medical challenges. They engaged to a certain degree in 'Humanitarian biomedicine': targeting epidemics afflicting underdeveloped polities.[31] However, the impetus to construct, operate and facilitate these initiatives was guided by political calculations inherent in the seemingly professional considerations of medical development.[32] Specifically, it formed part of the Israeli efforts to achieve, what Yotam Gidron designated as, a contrast and reaction to the presence and political activities of Middle Eastern adversaries in the continent.[33]

[31]Andrew Lakoff, 'Two Regimes of Global Health', *Humanity: An International Journal of Human Rights, Humanitarianism, and Development* 1, no. 1 (2010): 59–79.
[32]Levey, 'Israel's Strategy in Africa'.
[33]Gidron, *Israel in Africa*, 10.

The 1963 survey in Ghana to predict and evaluate TB was coordinated so that it would coincide with a regional conference in Addis Ababa that drew attention to Israel's efforts to procure health for African states.[34] That same year, Guinea requested that Israel set up the country's pharmaceutical sector and provide at least five pharmaceutical experts. The Israeli embassy recommended acknowledging the request, since Egypt and Lebanon were also offering such assistance.[35] Israel also deployed medical assistance to Biafra during the civil war in Nigeria from 1967 to 1970[36] and to South Sudan from 1969–1971.[37] In both cases, Israel utilized medical assistance as a humanitarian act to garner immediate results.

The role of medical agents was to operate in the battleground of the Cold War within hospitals, health centres and clinics, and to alert Israel of the presence of Middle Eastern colleague-adversaries and East European agents. It was also a quest to find the 'right' people for this role professionally and politically. When Israel managed to assign a personal doctor to the president of CAR in 1970, the ambassador suggested seeing whether the appointed physician could deem the president too physically unwell to travel for a meeting with the Egyptian president in Cairo.[38] As an Israeli foreign official wrote to the embassy in Addis Ababa, 'A candidate that is considered to be good in his profession might not be "diplomatically" suitable. Beyond professional experience the candidate needs to be a "good" Israeli, a people person and multilingual—especially Arabic'.[39]

The political impact that medical aid aimed to yield was influenced by the overall difficulty in translating development aid into diplomatic gains in the continent. Gidron and Levey stress that Israeli emissaries, advisors and diplomats constructed Israel's role and presence in Africa as a barrier to both 'Nasserist' and 'Communist' penetration of the continent, offering inducements to African leaders to side with the West in the Cold War and supplying them with military training and arms. Furthermore, as Gidron shows, the medical aid Israel offered to the rebels in South Sudan was part of Israel's politics of positionality, that differentiated Arab North Africa from the 'black' South. Yet as Levey argues, Israel failed to realize that Western powers remained almost entirely indifferent to its desire to act as 'contractor' for the West in Africa.[40] The ability to secure geopolitical gains was bound to the positionality of Israel within the matrix of power relations in the continent.

Medical aid, development assistance of health and the politics of positionality

In this section we discuss how the effort to fashion medical and health aid into political leverage was entwined with positioning Israel as a political proxy for the West, yet one that was unable to be fully included within the West. Israel's gaze towards Africa was

[34]ISA CHETZ 1025/2, Letter 28 April 1963.
[35]ISA CHETZ 1025/2, Letter to Mashav director in Israel from the Israeli embassy at Conakri, 16 August 1963.
[36]Zach Levey, 'Israel, Nigeria and the Biafra Civil War, 1967–70', *Journal of Genocide Research* 16, no. 2–3(2014): 263–280.
[37]Yotam Gidron ' "One People, One Struggle": Anya-Nya propaganda and the Israeli Mossad in Southern Sudan, 1969–197', *Journal of Eastern African Studies* 12, no. 3 (2018): 428–453.
[38]ISA CHETZ 4423/1, 'Gius Rofeh Ishi LaNasie' (recruiting a personal physician for the president), 20 February 1970.
[39]ISA CHETZ 16/472, Mashav to Israeli Embassy in Addis Ababa, 15 August 1967.
[40]Levey, 'Israel's Strategy in Africa', 84.

imbued in cultural affirmations of Israel's supposed modern identity. Itiel Amichay, an Israeli colonel in Abidjan, wrote to Israel's foreign ministry: 'We see our contribution to the developing countries in upgrading the human level and preparing [the population] for a better life'.[41]

Such assertions capture the underpinning principle behind the entirety of the Israeli geopolitics of development in Africa and its politics of positionality: to conjoin the strategic interests of procuring viable alliances with African states with the overall effort to influence, manage and affect the lives of those living in these countries. Unlike former Western colonial empires, Israel was perceived as a young, developing country. Like Yugoslavia, Cuba and Egypt, it took on the role of establishing a plethora of health aid schemes in several countries. Israel branded itself as an emerging, decolonizing power and through this gained significant influence in many African countries.

Yet to understand the challenges facing the deployment of medical and health aid in Africa, it is also important to understand how they were regarded in the debate over the continued colonial presence of the West. In other words, the deployment of medical teams became an issue of Israel's association with and positioning against the continued colonial exploitation of Africa. While trying to associate itself with the West, Israel's involvement in African medical projects distance the state from former colonial superpowers. Medical expeditions, such the Congo in 1960, were meant to forge a beneficent image of Israel as a nation that renders assistance to other developing countries. After spending a period in Leopoldville, the expedition relocated to Stanleyville to operate from some of the abandoned, ex-Belgian medical labs. The visiting doctors were stricken by the degree of racism employed by the Belgians who had abruptly left without leaving any kind of medical guidance, and with equipment which was highly sophisticated and abundant in quantity. 'I have one more thing to say', concluded one of the Israeli members in his personal report, 'in the labs assigned to me there were two bars of soap, one for blacks and the other for whites'Figure 1-2.[42]

These perspectives allude to a genuine aversion to colonial legacies that impacted on the condition of public health in Africa's de-colonized polities. Indeed, the degree of racist attitudes towards the population, evident by the leftover soap, was also reported by Israeli newspapers covering the expedition.[43] They attest to the ability of Israel to generate affinity with decolonized African states through cooperation in health-oriented projects, and the importance of development assistance of health in yielding political leverage.

The expanding body of knowledge dealing with Israel's intervention in Africa's development reveals that Israel sought to fend off fears that the development schemes might be part of a global bid to gain control in the name of Western imperialism or an eastern, Soviet power.[44] Medical aid and development assistance of health became part of this

[41]ISA CHETZ 1903/5, Letter from Itay Amichay, Israeli colonel assigned to the Israeli embassy in Abidjan to Israel's foreign ministry, January 23,1963.
[42]ISA CHETZ 16/1937, 'Kongo Ha-Belgit, Mishlahot Refuiyot' (Medical expeditions to the Belgian Congo), July-August 1960.
[43]'Sabon Yarok La-Levanim, Sabon Adom La-Kushim' (Green soap for the whites, red soap for the blacks), *Maariv*, 31 August 1960.
[44]Haim Yacobi and Chen Misgav 'The Geo-Biographies of Spatial Knowledge: Regional Planning from Israel to Sierra Leone and Back', *GeoJournal* 84 (2019): 1383–1401; Levin, 'South African "know-how" and Israeli "Facts of Life": the Planning of Afridar, Ashkelon, 1949–1956', *Planning Perspectives* 34, no. 2 (2019): 285–309.

Figure 1. Israel medical mission departing for congo, Lod Airport, July 1960. Credit: Fritz Cohen, National Photo Collection.

effort. In 1960, Israel convened an international conference dedicated to the exploration of medical and scientific relations with African states and the role of science in developing new countries. Fourteen African states sent delegates, including ten high-ranking ministers and medical personnel,[45] to explore how science and technology could become 'instruments for guiding and promoting the development of newly-liberated states, specifically in Asia and Africa'. The conference was part of Israel's effort to construe itself as an ally of decolonized African nations, and as both a recently decolonized state and a developed Western society that was willing to provide aid.

Medical projects and development assistance of health combined in the effort to achieve regional security and to position Israel favourably in Africa. A polity that can be associated with the West, but is not part of the colonial endeavours of Europe in Africa. Yet the recruitment of doctors for development projects was not met with great enthusiasm by the doctors themselves, leading Israeli ambassadors to 'whiten' several parts of the continent, i.e. to present them as places that might be susceptible to Israeli visitors, since they were more inclined to a 'Western presence'. Tzvi Lokcer, the ambassador to Madagascar, explained that Mauritius could become an attractive location for Israeli doctors since 'the nature here is lovely and the "human landscape" is quite pleasant and of high quality. This isn't Africa at all though some African elements exist in the diverse prism that comprises the Island's population'.[46]

The Israeli embassy in Tanzania requested that Mashav recruit doctors who were not intimidated by Africa's 'wild landscape'. When Raphael Rupin corresponded with Mashav about possible candidates for Tanzania, he emphasized that those who came would serve

[45]Representatives came from Mali, Chad, Sierra Leone, French Congo, Belgian Congo, Ivory Coast, Liberia, Ghana, Nigeria, Kenya, Tanganyika, Ethiopia, Togo and Cameron. ISA CHETZ 920/20, 'Ha-Ve'eida Ha-Bein-Leumit Be-Rechovot' (The international conference in Rechovot) 23 August 1960.
[46]ISA CHETZ 2936/10, Tzvi Locker, Israel's ambassador in Tananarive to Mashav, 29 September 1968.

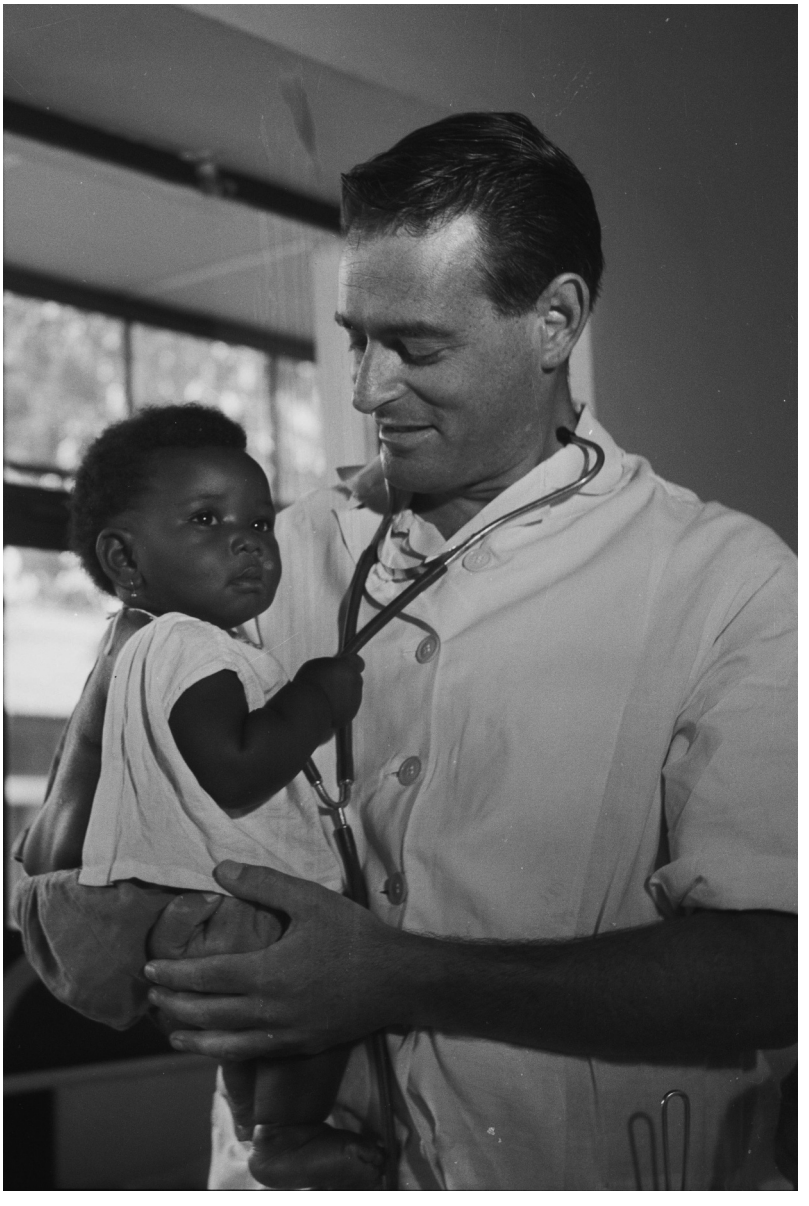


Figure 2. Dr O. Better, with patient In Kitambo hospital at Leopoldville, July 1960) Credit: Joe Fallett/ National Photo Collection.

in Dar es Salaam and also that Tanganyika [i.e. Tanzania] 'is in no way in the bush or the jungle—this usually means pleasant little country towns with climates generally far better than that of Dar es Salaam and possessing the usual characteristics of civilisation'.[47] In fact, Rupin wrote, the living standards in Tanzania 'exceeds that of Israel'. Rupin's position

[47]ISA CHETZ 52/1, Letter from Rafael Rupin, 27 June 1961.

problematizes an imagined divide between a 'developed' Israel and an under-developed Africa as it hints that Israel itself is still behind 'Western' norms and that, in some cases, African states were better equipped.

The struggle to send medical teams to Africa stressed how the positioning of health aid was also an issue of cultural and political proximity. Within this position, health aid not only secured Israel's geopolitical interest *in* Africa, but also becomes a safe space *from* Africa, which is presented as a wild country. An article in *Maariv* detailed the activities of an Israeli doctor in Ethiopia by recounting how, during his travels, he encountered 'hyenas, venomous snakes, and crocodiles' in the name of training local health personnel. Thus, the account re-enacts the pioneering efforts of Jewish doctors traversing the Yishuv during the Mandate-era anti-trachoma campaign.[48] However, Africa's 'un-safeness' mired the health aid with uncertainties, specifically, about the possibility of Israeli doctors operating in Africa's environment. Much like Israeli experts who advised on issues relating to agriculture, commerce and the military, so did the medical teams eschew staying in locations associated with harsh environments.

Another source of worry was that some Israeli operatives were exhibiting an 'imperialistic' tendency and taking a patronizing stand with their local interlocutors. Further, there was concern that the involvement of Israel in Africa would be associated with colonial domination. Chanan Yavor, Israel's consul in Accra in 1958 and later ambassador to Nigeria, implored the agency to develop protocols and training programmes that would acculturate the Israeli experts to the societies they were going to impact. Another operative, Zeev Shatil, drafted guidelines for Israel's medical assistance explaining that his aim was to prevent Israeli action from appearing to 'resemble prior colonial intervention'.[49]

Anat Mooreville has argued that the prevailing position amongst Mashav operatives was that 'doctors in white coats' symbolized the urban bourgeoisie elite, while Israel sought to project an image of an agricultural nation pioneering in a modern and anti-urban social revolution. These reservations attest to the assumptions that Israeli officials held regarding the ostensible image Israel was attempting to project through its actions. It was the initiative of the physicians themselves, rather than a bilateral dynamic, that galvanized Israel into medical action in Africa. Chaim Sheba, the Director of Israel's Health Ministry and one of the principal founders of Israel's public health sector, openly called for Israel to send doctors to Africa as part of the former 'mission' to the continent.

The reluctance of the Israeli Foreign Office to commit to medical projects highlights how it occasionally contrasted with the image the state was trying to convey; one which positioned Israel as part of the West, but not a continuation of the colonial practices identified with the West. One reason for this reluctance was the concern that doctors were regarded as a bourgeoise elite, an image contrasting with Israel wanting to present itself as a socialist ally of newly decolonized states. Yet another, equally meaningful reason was the dire need for doctors in Israel, that exposed to an extent Israel's state as a developing nation.

[48]Mooreville, 'Eyeing Africa', note 151.

[49]ISA CHETZ 1903/5, 'Hearot Le-Siyua Techni Le-Africa' (comments on technical assistance to Africa), 23 January 1963. It is important to note that Mashav officials were also aware that several Israeli experts that were sent by Israel embarked on private schemes to enrich themselves while utilizing state resources. See Bar Yosef, *Villa*, 238–239.

Israel faced two main logistical difficulties in delivering health aid to Africa. First, it had limited financial resources. Every suggestion to initiate significant medical schemes in Africa was met with a 'cooling effect' by Mashav operatives who complained that they simply lacked the proper funding. Unlike other state-oriented development schemes, Israel lacked the capacity to offer significant material development assistance of health. Israeli officials were aware that they could not compete with the involvement of states like the Soviet Union, who constructed whole hospitals.[50] In a memo sent by the Israeli embassy in Addis Ababa, its officials wrote that, if even the local government promises that it has money for doctors, the Israeli Foreign Office ends up paying a significant portion of the bill.[51]

Second, Israel had insufficient personnel. Israel had one of the highest ratios of physicians per population, but struggled to develop a functioning public health sector. When the Congolese ambassador requested doctors, Mashav admitted that it simply did not have the manpower and suggested instead that it set up a clinic in which one Israeli expert would operate.[52] Similarly, Raphael Rupin's request to send 15–20 doctors to Tanzania was rejected. A team of three to five doctors, relayed Mashav's representatives, would be considered a success.[53]

Israel's health aid to Africa did not utilize a big chunk of Israeli medical personnel (only about 3–4%) but did attract its best professional doctors, while Israel experienced an acute shortage of medical experts in its own peripheries. In 1950, there were 2,801 doctors in Israel with 1,297 over 50 years old.[54] From 1963, Israel experienced a shortage of 80 general physicians and 40 experts, such as eye/ear specialists, neurologists and orthopediatricians.[55] In 1964, around 43% of the 5,950 doctors in Israel were over sixty-five years old.[56] By 1969, there were 6,200 doctors, but two out of every three were over sixty years old.[57]

When the medical expedition to Congo took off from Lod national airport, Israel's health minister openly admitted that he hoped Israeli doctors would be willing to go to Israel's southern localities, not just Africa.[58] The minister's remark is important for several reasons. First, it stresses that Israel's medical difficulties were not only biographic but also geographic. In 1954 there were 3,717 doctors and of them only 514 willing to operate in rural areas.[59] Second, they connect Israel's geopolitical interests in one African region to its internal makeup, that was linked with another region of the continent. About 40% of

[50]ISA CHETZ 2739/21, Letter from Israeli embassy, concerning a request for medical equipment for a maternity ward in a field hospital in the Congo, 8 December 1969.
[51]ISA CHETZ 2123/3, 'Siyua Be-Refuat Eynaim' (medical assistance in Ophthalmology), 20 September 1965.
[52]ISA CHETZ 905/1,'Sikum Yeshiva im Shagrir Congo-Brazzaville' (minutes of meeting with the ambassador in Congo-Brazzaville), 18 October 1963.
[53]ISA CHETZ 52/1, Letter from 14 June 1961.
[54]'Kayam Machsor Be-Rofi'im Mumchim' (there is a shortage in medical experts), *Kol Ha'am*, 5 May 1950.
[55]D. Goldstein, 'Nithapach Ha-Galgal: Chaserim Roffim' (the table have turned: physicians are missing), *Maariv*, 14 June 1963.
[56]Yitzhak Kang, 'Odef Ve Machsor Gam Yachad' (simultaneous shortage and abundance), *Davar*, 7 July 1964.
[57]Shimon Pines, 'Giyus Rofi'im Olim Le-Mosadot Refua'a Ba-Aretz' (recruitment of immigrant physicians for medical institutions in the country), *Davar*, 1 June 1969.
[58]Uri Dan, 'Heyu Ge'im Bshlihut Avoteyhem La-Kongo' (be proud in your father's mission to the Congo), *Ma'ariv*, 24 July 1960.
[59]Y. Berman, Yashurun, 'Madua Chaserin Roffim Ba-Kfar?' (Why are physicians missing in the countryside?), *Davar*, 26 September 1954.

Israeli society were immigrants from North Africa. Most of these lived in development towns, such as the ones referred to by the minister, and they had to settle with only one or two doctors per 10,000 people.[60]

At the same time that Israel absorbed Jewish immigrants from North Africa (that also bolstered the Jewish demographic majority), it was also thought to utilize the Sub-Saharan parts of Africa. Israeli ophthalmologists soon became a leading research cohort mainly due to their experience acquired while operating in African states.[61] Additionally, Israeli officials targeted African countries as markets for pharmaceutical products manufactured in Israel.[62] Rupin suggested that Israeli hospitals could supervise central hospitals in Africa and open research centres dedicated to the study of the healthcare problems of developing countries. By doing so, he explained, Israel would become a global centre for health studies.[63]

To sum up our discussion so far, we have shown how Israel's medical aid and health assistance in Africa enables us to discuss the contingent and complex web of political calculations, regional connections and cultural identities entangled with the constant, continuous movement of medical knowledge and health aid. Politically, Israel's use of medical aid and development assistance of health aligns itself with Cold War interests against its regional adversaries. Yet at the same time, medical knowledge was used to set apart Israel from the legacies of Western colonial superpowers. In addition, while in the sphere of development aid, medical knowledge was used to bring Israel 'closer' to Sub Saharan and East Africa who were deemed to be strategically important, Israel's inability to meet the demands it sought to fulfil were linked to its own status as a developing state that relied on immigration from North Africa.

Yet to disaggregate the patterns of movement of medical and health aid, and to better understand how it mattered, we need to think about the specific moments and places in which medical intervention took place. To develop this point, we focus in the next section on the relationships between Israel and Ethiopia to further understand the political dynamic of medical assistance and health aid, and how health aid became associated with an effort to arrest, or delay, the movement of communities from Africa to Israel, while connecting Israel to Africa.

Medical aid and political connectivity between Ethiopia and Israel

Israel's health development schemes in Ethiopia, one of its central partners in Africa, illustrate how the deployment of medical assistance was bent on securing Israel's geo-political interests, based on relationships that preceded the formation of Israel. As Haggai

[60]Shimon Keren, 'Kiryat Gat Tova'at Rofi'im', (Kiryat Gat is demanding physicians) *Ma'ariv*, 14 February 1962; 'Kiryat Shmona Sovelet Me-Machsor Rofi'im Chamur' (Kiryat Shmona is suffering from acute shortage in Physicians) Al Ha-Mishmar, 4 May 1956; 'Shoa Refuit Tzfuya Le Toshvey Chevel HaNegev' (Residents of the Negev region are facing a medical calamity), *Herut*, 3 September 1957.
[61]Mooreville, 'Eyeing Africa', 33.
[62]ISA CHETZ 1938/5, document dealing with assistance to CAR, 13 November 1964.
[63]Raphael Rupin, 'Be-Tanganika Yesh Rak Shney Rofey Eynaim, Ve-Hem Me-Yisrael' (There are only two eye doctors Tanganyika—and both are from Israel), Ma'ariv, 13 March 1964.

Erlich's seminal work shows, the relations between the political leadership of Ethiopia and the Zionist movement predate the establishment of both countries, and evolved into a strategic and military alliance.[64]

In the early 1940s, following Ethiopia's liberation from Italian occupation, the British Mandatory Administration in Palestine arranged for a contingency of Jewish physicians and nurses to help set up Ethiopia's public health sector and offer immediate relief.[65] The activities of this team facilitated a foot hold in a country whose Christian majority, alongside its geographic proximity to Egypt and to the horn of Africa, made it a prime geopolitical target for Israel.[66] For the team the mission also signified a unique moment in which the Jewish polity in Palestine, which was on the brink of gaining independence, asserted the position of health aid provider. 'The problems of the medical services in Ethiopia' argued one team member, 'were only solved thanks to Palestine … [who was] the sole source of such doctors in the Middle East'.[67]

Yet while medical knowledge was fashioned as a geostrategic tool, it also became entwined with the political contestation over the immigration from Ethiopia to Israel of the Beta Israel communities, whose majority resided in Ethiopia's Gondar province. Resistance to Ethiopia's Jews immigrating to Israel came from several sources. First, the Ethiopian communities were not recognized as Jews by Israel's rabbinate administration; and second, the Ethiopian Emperor objected to any form of mass immigration that might destabilize social and political relations in Ethiopia.

While the Emperor's objections posed a significant barrier to any immigration attempt, Israeli officials developed additional objections. Saul Adler, a world-renowned epidemiologist and the head of the Parasitological Department of Hebrew University (who had found fame while conducting research in Sierra Leone during the 1920s under the auspice of the British colonial administration) wrote to Yosef Meir, then Director of the Israel's Ministry of Health: 'I read with terror that our emissaries are putting together a "magic carpet' from Abyssinia to Eretz Yisrael for the refugees'.[68] Adler argued that precedence should be given to the Jewish refugees still residing in camps in Europe. While this demand made sense, he followed it with the claim that the already known epidemiological problems incurred from the arrival of European immigrants would be dwarfed by the catastrophe that would be unleashed on Israel by immigration from Ethiopia: 'it is my opinion to postpone or delay the immigration of the Abyssinians until such time which will be suitable for us and for them [sic]'.

Israeli newspapers of the time reported rumours concerning a total immigration ban on Ethiopian Jews. During the period in question most immigration was organized by the concerted efforts of emissaries that represented Jewish philanthropic organizations operating on behalf of the Jewish Agency and the World Jewish Congress. The American Committee for Ethiopian Jews, and representatives of the Jewish Agency, demanded to know whether the Israeli government had denied the entry of Ethiopian Jews out of suspicion that they carry a 'hereditary contagious disease'.[69] Emannuel Timaret, a spiritual

[64]Haggai Elrich, *Alliance and Alienation*.
[65]Rivka Ashbel. *As Much as We Could Do: The Contribution Made by The Hebrew University of Jerusalem And Jewish Doctors And Scientists From Palestine During And After World War II* (Jerusalem: The Hebrew University Magnes Press, 1989).
[66]Elrich, *Alliance and Alienation*.
[67]Ashbel, *As Much as We Could Do*, 147.
[68]ISA G 10/5558, Letter from Saul Adler to Yosef Meir, Jerusalem 8 June 1949; Letter, Haim Sheeba, May 6.
[69]'Shmuo't al Issur Aliyat Ha-Falashim' (Rumours that there is an immigration ban on the Falasha). Herut, 9 April 1950.

leader and one of the more outspoken advocates of the Jewish community in Ethiopia, challenged arguments that the community might bear a medical threat to the body politic of Israel. He argued that the remoteness of the communities and their natural condition made them less susceptible to attracting diseases related to social decay. Indeed, emissaries of the Jewish Agency working with such communities in Ethiopia depicted a view that Ethiopian Jews were, overall, sound both physically and mentally.[70]

Relevant to our discussion is the correlation between the development assistance of health extended to Ethiopia by Jewish doctors from Palestine, and the development of a medical policy towards potential immigration from Ethiopia. Haggai Erlich speculates that the Jewish doctors who arrived from Palestine in the 1940s were the source of the dire estimations of the condition of Ethiopia's Jewish communities.[71] Even though no systematic appraisal ever evaluated whether these communities posed such a risk, the opinions of some of the physicians sent to Ethiopia as part of an evolving effort to export medical knowledge, seemed to contribute to the designation of these communities as a liability.

The topic of Ethiopia's Jews and their potential immigration continued to be entangled with Israel's activities in Ethiopia. During the 1960s, Israel had the second largest group of military consultants in Ethiopia. Israeli 'security advisers' became a channel of communication between the military's upper echelons and the lower ranks. During that time, Ethiopia constantly pressed for Israeli doctors.[72]

By the mid-1960s, Israeli doctors played key roles in eight Ethiopian hospitals.[73] The Israeli embassy in Addis Ababa allocated funds for the experimental medical schemes of Ethiopian doctors who applied. Dr Avraham Peeri, Tel Aviv's branch Director of Leumit Health Fund (one of Israel's main healthcare providers) was entrusted in 1960 with reconstructing the administrative functions of Massawa regional hospital in Eritrea. Eventually, he assumed full managerial responsibility over all Eritrea as part of Ethiopia's effort to consolidate control over the region.[74] Israeli experts took responsibility for the military hospital in Harar, where they took an active part in Ethiopia's conflict against insurgents in the Ogaden region.[75] Mashav and embassy diplomats were interested in maintaining a position in the Harar hospital as they regarded the military echelons in charge as a political group that had strong influence over Ethiopia's leadership.[76]

Yet securing geopolitical interests clashed with other concerns. During March 1965, the Ethiopian government suggested that Israeli officials would assume full medical supervision over health issues in the Gamo Gofa region.[77] The offer was based on a strategy of conferring medical responsibility to a foreign power in a specific region, rather than dispersing experts all over the country. Resistance to the offer came directly from the Israeli medical professionals operating in Ethiopia. Eliezer Mattan, a senior physician entrusted with evaluating the state of Ethiopia's health centres, vehemently objected to

[70]Meital Regev, *Deciding Not To Decide Israel Policy Towards The Falasha 1973–1948* Unpublished MA thesis. Ben Gurion University of the Negev, 2014, 35–38 (Hebrew).
[71]Elrich, *Alliance and Alienation*, 67.
[72]ISA CHETZ 2123, Letter from Israeli embassy in Addis Ababa to Mashav, 30 July 1965.
[73]ISA CHETZ 2123, Letter from Eliezer Mattan to Mashav, 14 February 1965.
[74]ISA CHETZ 2123/3, Letter from Israeli embassy in Addis Ababa to Mashav, 25 January 1965.
[75]ISA CHETZ 2123/3, Letter from Dr Razin to the head of Mashav, 12 July 1964.
[76]ISA CHETZ 2123/3, Letter to Mashav, 8 April 1964.
[77]ISA CHETZ 2123/3, Letter from Mashav, 6 April 1965. 'Hattzat Etyopia Le Achrayut Refuit Mechozit' (Ethiopia's offer for medical regional responsibility), 25 March 1965.

the proposal. Most of the people in Gamo Gofa, he wrote to the Israeli embassy, are either 'pagans' or Muslims and therefore the medical work will have little impact on the Christian majority nor on the major political players. Furthermore, he wrote, it would be difficult to find doctors that would go and 'sit in remote desolate 'non-places".[78]

Mattan's objections, which were eventually accepted, illustrate how the medical cadre was embroiled with strategic calculations that determined which parts of the population were worthy of medical aid and which were less so. Yet Israel's political mission, which was shaped by the physicians entrusted to dispense medical knowledge, also undermined the attempts to safeguard Ethiopian Jews in the country (Beta Israel).

In July 1963, Shlomo Hillel, Director of the Department of Africa in the Israeli Foreign Office, acknowledged that the World Jewish Congress was in charge of overseeing the condition of the Ethiopian Jewish community. Hillel explained that Israel could not arrange for the immigration of Ethiopia's Jews for the reasons established a decade before: i.e. doubts over whether they conformed to the definition of Judaism that Israel recognized. Delicate relationships existed between Israel and Ethiopia's Emperor, and the public health hazards that an immigration from Ethiopia (and Africa for that matter) might pose. Hillel stressed the importance of emphasizing the general Jewish attributes of the assistance, and of playing down the fact that Israel was taking an active part in this assistance.[79]

Israel, reluctantly, agreed to assist the Ethiopian Jews as long as Jewish philanthropic organizations would provide most of the funding and would be the official sponsors of the operation.[80] The cooperation between these organizations and the Israeli state vis-à-vis the Ethiopian officials produced a fragmented political action where state and non-state actors operated to achieve different and sometimes diametrically opposed objectives. Israel eventually established its connection and affirmed its ascribed responsibility to the Jewish communities in Ethiopia via medical aid. In 1962, an Israeli medical physician was sent to the Gondar region (where Beta Israel communities resided) earning a salary that was funnelled through funds from Jewish organizations, such as World Jewish Congress (WJC) and the Central British Fund.[81] The physician, Dan Harel, finished his work in August 1964. The Israeli Foreign Office was not keen on maintaining a medical presence, but eventually conceded to send a replacement, Dr Mario Felzer, who was asked by Jewish philanthropic organizations to provide a professional opinion on the possibility of organizing the immigration of Ethiopia's Jews to Israel. In his response, Felzer built upon his experience working both with the Ethiopian community in Gondar as well as his past professional experience in Israel's development towns where he treated Jewish immigrants from North Africa. The physician suggested selective immigration, particularly oriented towards bringing the younger generation to Israel.[82]

When the Israeli embassy in Addis Ababa heard of the correspondence between the Israeli physician stationed in Gondar and the Jewish organizations, it demanded that any plans to facilitate the arrival of Ethiopian Jews in Israel be scrapped, on the basis that such

[78]ISA CHETZ 2123/3, Letter from Eliezer Mattan in Ethiopia to Dr Jazbin, March 31, 1965.
[79]ISA CHETZ 2123/3, Hillel's Letter, 9 July 1963.
[80]ISA Chetz 1921/1, Letter from Norman Bentwich to Ministry of Health, Israel, 21 June 1961. Letter from Mashav to ministry of Health 26 September 1961.
[81]ISA CHETZ 472/15; Mooreville, 'Eyeing Africa', 53.
[82]ISA CHETZ 3406/26, Letter from Mario Felszer to Arie Tartakover. 18 November 1962.

schemes would jeopardize the overall mission of Israel in Ethiopia. A short time after, the Israeli Foreign Office officially asked to be relieved of providing assistance to the Ethiopian community. Much like Gamo-Goffa, it became unwise to invest in Gondar.[83]

It is remarkable that while Israel's involvement in Ethiopia's frontier wars in the Harar region, or its later efforts to consolidate its control of Eritrea, were not deemed to be problematic interferences in Africa's regional and Ethiopia's inner affairs; support for Jewish communities was considered a potential intrusion into the domestic sphere of the Emperor. This demonstrates how an analysis of medical aid and development assistance of health can flesh out the relations between the need to secure geopolitical regional interests and the conflicts that Israel's positionality produces. However, the assumed different positions vis-à-vis Ethiopia's frontier wars and its Jewish community were both based on a notion of state sovereignty. The war in the Ogaden and the conflict over Eritrea were part of the struggle to unify the empire. Support for Beta Israel immigration was considered support for the empire's disintegration, thus politically problematic.[84] In other words, while Israel set out to position itself as regional ally of Ethiopia as part of the Cold War waging in Africa, it struggled with its ascribed commitment to Jewish communities in the diaspora. Adding to this conflict was the fierce internal debate in Israel about the validity of the Ethiopian Jewish community to be considered Jews in the first place.

Felzer was not the only Israeli doctor working in Ethiopia that had 'experience' with immigration from Africa and its vicinity to Israel. In the early 1950s, Israel sent doctors to Casablanca and Marseille (where transient camps for North African Jews were set up) tasked with developing strict selection processes that would determine who from the immigrants were physically able to arrive in Israel. Before his mission in Ethiopia, the aforementioned Eliezer Mattan was sent to Khashed in Yemen where he supervised Jews awaiting immigration to Israel. Later he oversaw the applications from North African youth in Casablanca, participating in a selection process that prevented a significant number from immigrating to Israel.[85] The selection process was part of a larger campaign bent on forming a human resource by categorizing Jewish identities in accordance with their geographic locations and medical conditions.

Felzer's response captures how Israeli involvement in Ethiopia and Africa for the sake of development (to achieve strategic gain) echoed the state's inner political attitudes towards immigrants from Africa. Like Eliezer Mattan, who was sent to oversee the immigration of Yemenite and North African Jews, and then to Ethiopia to supervise the development of its public health sector, Felzer's recommendation was based on his own experience with immigrants having lived in Israel's development towns.

We do not suggest, however, equating the movement of Jewish communities from various locations in Africa (in this case from North Africa and Ethiopia). Rather, we seek to emphasize the political, professional positioning of medical personnel in relation to Israel's various objectives in Africa, and how this positioning became linked to various forms of movement. One type of movement involved the arrival of medical personnel to

[83]ISA CHETZ 3406/26, Letter to Nina Haviv, office for international cooperation from Meir Yaffe, Israel's Embassy in Addis Ababa.
[84]We want to thank the article's reviewer for this insight.
[85]Avi Picard, *Cut to Measure: Israel's Policies Regarding the Aliyah of North African Jews, 1951–1956* (Ben-Gurion Research Institute: Ben Gurion University Press, 2013) (Hebrew).

provide development assistance of health to African states such as Ethiopia. Another was the control of immigration from Ethiopia to Israel. In both dynamics, the positioning of Israeli doctors was pivotal to the strategic effort to secure Israel's geopolitical goals, while also being connected to the internal demographic dynamic within Israel. Hence, medical aid and development assistance of health produced different positions for different regions in Africa towards governing and controlling the movement of people and knowledge that connected them with Israel.

Conclusion

The materialization of Israel's health aid to states in Africa underscored the former's conflicted proximity to Western powers within the movement from colonial to national governance. Furthermore, Israel's commitment to development projects created an ambivalent geopolitical imagination of Israel as a polity that was part of the developed,

Western world on one hand; and a developing nation which had recently undergone a process of decolonization, on the other.

The discussion around producing health as viable development knowledge thus illustrates how African states, immigrants, sources and knowledge played vital roles in the formation of Israel's own public medical sector. Medical and health aid were immersed in and informed by regional geopolitical dynamics derived from Israel's security issues and positionality towards different regimes in the continent.

The discussion on Israel's development assistance of health to African states emphasizes how, instead of thinking about a unilateral dynamic of knowledge, i.e. materials and human resources moving from a developed polity to several developing loci, we need to look at the ways in which medical knowledge, in the form of development health projects, is deployed in multiple conflictual ways. Unpacking the place of health and medical knowledge, both of Israel in Africa and that of Africa in Israel, enables a better understanding of the reciprocal relations between medical knowledge, the spaces this knowledge shapes, and the sites where it is produced.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Wellcome Trust [Small Grant in Humanities and Social Sciences].