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“Germs know no racial lines”
Health policies in British Palestine
(1930-1939)

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Abstract

In mandatory Palestine, Zionist civil society proved to be a powerful instrument for institution- and state-building. Civil society developed around four conditions: shared values, horizontal linkages of participation, boundary demarcation and interaction with the state. These four factors were created and/or enhanced by the provision of medical services and by the organization of public health. In Jewish Palestine, these were developed – especially in the 1930s – by two medical agencies: the Hadassah Medical Organization and *Kupat Cholim*. First of all, Zionist health developed autonomously from an administrative point of view. Secondly, it was organized in a network of horizontal participation which connected different sections of the (Jewish) population. In the third place, medical provision worked as a connecting element between territory, society and administration. Lastly, the construction of health in mandatory Palestine contributed to create a cultural uniformity which was implicitly nationalistic.

Zionist medical provision in mandatory Palestine also responded to two of the main ideological strongholds of Zionism. The Zionist movement saw the introduction of science and rationality into Palestine as a mission of civilization. Zionism also aimed at the regeneration of the Jews after centuries of physical and spiritual oppression in the Diaspora.

The introduction of medical provision along western standards during the mandatory years had a number of important consequences for the future of Palestine/Israel. It improved the country's sanitary, medical and hygienic standards. However, it also contributed to draw a boundary between the Jewish and the Arab communities. Different approaches to illness and disease, diverse availability of medical structures for the two population groups, distinct levels of sanitation between Arab and Jewish towns and separate attendance in medical structures were all indicators of the division which, by 1939, had drawn apart these two communities.

The 1930s stand out as the decade in which the Zionist network of medical provision consolidated the process of civil society formation, of institution- and of state-building. During this decade such civil society became gradually more exclusive, as it became healthier and stronger.

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List of Abbreviations

AJP	American Jewish Physicians Committee.
ATL	Anti-Tuberculosis League.
AZMU	American Zionist Medical Unit.
AUB	American University of Beirut.
AUC	American University of Cairo.
CBS	Central British Fund for German Jewry.
CO	Colonial Office.
CUL	Cambridge University Library, Cambridge.
CZA	Central Zionist Archives, Jerusalem.
FO	Foreign Office.
GDH	Government Department of Health.
HDS	Hadassah Medical Organization Archives, New York.
HMG	His Majesty's Government
HMO	Hadassah Medical Organization.
HNI	Histadrut Nashim Ivriot (also known as
HNZ	Histadrut Nashim Zionot).
HU	Hebrew University of Jerusalem.
IPCRI	Israel-Palestine Centre for Research and Information.
ISA	Israel State Archives, Jerusalem.
J&EM	Jerusalem and the East Mission
JDC	Jewish Joint Distribution Committee Archives, New York
KH	Kupat Cholim.
KHA	Kupat Cholim Amamit.
KHL	Kupat Cholim Leumit.
KHM	Kupat Cholim Maccabi.
KOSJ	Knight Order of St. John in Jerusalem, London.
MEC	Middle East Centre, Oxford.
OETA	Occupied Enemy Territory Administration.
OSJ	Order of St. John in Jerusalem.
PHR	Physicians for Human Rights
PMC	Permanent Mandates Commission.
PRO	Public Record Office, London.
PJWA	Palestine Jewish Women Equal Rights Association.
RH	Rhodes House, Oxford.
SMO	Senior Medical Officer.
SMU	Smuts Papers.
STD	Sexually Transmitted Disease.
US	United States.
WIZO	Women International Zionist Organization.

*Signori,
la vita è breve.
Ma se dobbiamo viverla,
camminiamo almeno sulle teste dei re.¹*

¹ On a wall, Livorno, summer 2003.

Introduction

In February 1930 the *Boston Post* published an article which summarized the activities of the Zionist movement in mandatory Palestine. A large section was dedicated to the Hadassah Medical Organization. The article focused on two elements in particular. It pointed at urban development – at the “Jewish city of Tel Aviv,” at the “pleasant new Jewish suburbs of Jerusalem, Tiberias and Haifa.” In the second place, it highlighted the national significance of “many Jewish, social welfare and cultural institutions scattered over the country - day nurseries, orphans’ settlements and asylums, community houses, hospitals, kindergartens, schools.” These in particular were praised as “tokens of the persistent and dramatic collective effort of the Jews to restore their ancestral home.” In this respect, the social and medical involvement of the Hadassah Medical Organization (HMO) was portrayed as a national undertaking. The article also underlined how medical and social provision had been envisaged in Palestine “in a spirit of friendship to all the inhabitants of the land, as germs know no racial lines.”¹ A few months later the very same concept was echoed in the words of Dr. Ephraim Mordechai Bluestone, director of the HMO. Writing in *The Palestine Bulletin*, he maintained that “sickness makes no distinction and all people alike are susceptible. In matters of health no community can afford to be partial.”²

These statements carry a number of cultural and political implications which go beyond the apparent Zionist readiness to provide medical services for all, regardless of religious or national affiliation. They in fact imply that drastic measures were necessary to isolate or re-educate those sections of the population among whom infections were believed to be more widespread. Disease would have otherwise continued to spread from one community to the

¹ Hadassah Medical Organization Archives, New York (henceforth HDS), box 57, folder 5, 11th February 1930.

² E. M. Bluestone, “Health and Homeland”, *The Palestine Bulletin*, 27th April 1930.

other. The notion that "uneducated or diseased Arabs are not an advantage to the Jewish National Home"³ was in fact also embedded in the Zionist medical discourse. These ideas found a tangible expression in the pattern of settlement on the land. The Zionist centres in rural Palestine were for example placed far away from Arab ones, because of their allegedly high rate of infection.⁴ The statements mentioned above also implied that Zionism would have a civilizing effect over a backward country, an assumption which brings it culturally very close to colonialism.

Zionism and colonialism are two historical phenomena which should be kept distinct for a whole set of historical, economic, political and social reasons.⁵ However, they shared a common European matrix in those Enlightenment values which celebrated science, rationality and progress. Both colonialism and Zionism conceived their historical role as that of bearers of civilization and progress. In this sense they perceived themselves as actors in a linear conception history which would necessarily lead to an enlightened modernity. The values of the Enlightenment exerted an extensive long-term influence on European political thinking - up to the legitimization of the major colonial undertakings of the 19th and 20th centuries. Its impact on the Jews of Europe was also extraordinary. It contributed to their Emancipation (both as an internal process and as a concession from above).⁶ It favoured the re-definition of the *'Am Israel* as a political entity, rather than as a religious group alone. It also led to the development of a specific form of Jewish Enlightenment, the *Haskala*. The influence of this literary movement in planting the first seeds of Jewish nationalism is well known.⁷

³ Central Zionist Archives, Jerusalem (henceforth CZA), Series A (henceforth A), box 187, folder 17, [1930?].

⁴ S. M. Sufian, *Healing the Land and the Nation. Malaria and the Zionist Project in Mandatory Palestine 1920-1947*, Unpublished Ph.D. thesis, New York University, New York, May 1999, p. 50.

⁵ The highly politicized debate on the alleged similarities or differences between colonialism, imperialism and Zionism finds vigorous advocates on both sides. For an analysis of the different modes of colonialism and their relevance to the Zionist pattern of settlement, see R. Shamir, *The Colonies of Law. Colonialism, Zionism and Law in Early Mandate Palestine*, Cambridge University Press, Cambridge, 2000. See also O. Yiftachel, "Ethnocracy: the Politics of Judaizing Israel/Palestine", *Constellations*, 6, (3), 1999, pp. 364-390.

⁶ C. Goldscheider and A. S. Zuckerman, *The Transformation of the Jews*, The University of Chicago Press, Chicago and London, 1984.

⁷ The literature on this subject is extremely vast. J. Katz, *Out of the Ghetto: the Social Background of Jewish Emancipation 1770-1870*, Schocken Books, New York, 1978. S. J.

The Enlightenment - and later the *Haskala* for the European Jews - conveyed the ideas that science and rationality could be universal tools of collective emancipation, in Europe as well as in other cultural and geographical spaces.⁸ In this framework - and maintaining the differences between the means and the ends of colonialism and Zionism - the introduction into Palestine of a system of medical provision organized on western standards⁹ at the turn of the 20th century can be seen an exercise in late colonialism, by both the British and the Zionists.¹⁰

The British and the Zionist approach to questions of health and disease were also similar. Health is in western perception a stereotyped signifier of civilization and progress, just as disease is associated with backwardness and primitive conditions of life. The image of Palestine as backward and unsanitary had been perpetuated in Europe through the extensive number of travelogues published during the 19th century.¹¹ Part and parcel of the Orientalistic discourse, these accounts, memoirs and reportages contributed to the idea that the West could bring health, education, development and progress to a disease-ridden Holy Land. The British government, the Zionist movement and numerous missions - the western agents providing medical services in Palestine at the time of the British mandate (1921-1948) - had all internalized this approach, each for its own purposes. For all three of them there holds true one of the central assumptions of colonial medicine, i.e., the idea that western

Zipperstein, "Haskalah, cultural change and nineteenth century Russian Jewry", *Journal of Jewish Studies*, 34 (2), Autumn 1983, pp. 191-207.

⁸ Theodor Herzl had imagined the Jewish state as "the vanguard of culture against barbarianism" for example. Max Nordau believed "the Jews would not loose their European culture, just as the British had not become Indians in America, Hottentots in Africa, or Papuans in Australia." Quoted in T. Segev, *One Palestine, Complete: Jews and Arabs under the Mandate*, Henry Holt and Company, New York, 2000, p. 150.

⁹ For an analysis of the different systems of medical provision operating in the various European countries, see D. Porter, *Health, Civilization and the State. A History of Public Health from Ancient to Modern Times*, Routledge, London and New York, 1999, pp. 97-162.

¹⁰ On the model of dual colonialism in Palestine, see R. Shamir, *The Colonies of Law...*, p. 19. The dual colonialism model sees Palestine as both a colony of the Zionist settlers and of the British Crown. While the former engaged in the practical aspects of colonization, the latter provided its political, legal and administrative umbrella. However, this does not imply that the British functioned as a super-structure of the Zionist movement or that they shared a common blueprint. Quite the opposite in fact, as the British-Zionist relationship during this period was marked by continuous animosity.

¹¹ A. Elon, *Jerusalem City of Mirrors*, Little, Brown and Company, Boston Toronto London, 1989, pp. 134-141. See also B. Melman, *Women's Orient: English Women and the Middle East, 1718-1919, Sexuality, Religion and Work*, Macmillan, London 1995.

medicine would have played a central role in transmitting western cultural values to distant lands and indigenous populations, acting both as a cultural agency in itself and as an agency of western expansion.¹²

This thesis is concerned with the political and national implications of the development of the Zionist system of medical provision during the British mandate. The construction of such system is seen as one of the main factors which favoured the formation of a civil society able to turn a heterogeneous nationalist movement into a coherent process of institution- and state-building. In order to be successful in such a complex undertaking, the Zionist medical agencies operated simultaneously at different levels: in administration, among the population, on the territory and on a more subtle cultural plane. They also had to engage with the British government from a political point of view.

My introduction has been conceived as a presentation of the main elements which concurred to the realization of this process. These will then emerge throughout the work. In part one of the introduction I compare the British and Zionist approaches and finalities to the provision of medical services. In part two, I delineate the setting where the bulk of these operations took place, the cities of Palestine. I also explain my choice of concentrating on urban Palestine from a methodological and historiographical point of view. Part three provides a schematic framework to understand the features of Zionist civil society. A concise review of the literature published on the mandate and a brief outline of the thesis conclude the introduction.

1. The British and the Zionists in Palestine. Different implications of medical provision and public health.

From 1922 the Colonial Office (CO) was responsible for the administration of Palestine. Palestine was however not considered a real

¹² R. MacLeod and M. Lewis, *Disease, Medicine and Empire. Perspectives on Western Medicine and the Experience of European Expansion*, Routledge, London and New York, 1988, p. 7.

colony.¹³ In the words of General Smuts - one of the architects of the mandates system - Palestine was "a colony *sui generis*."¹⁴ At a geo-political level, it fulfilled a number of imperial functions: it constituted a buffer zone in the Middle East.¹⁵ It represented an element of continuity in the commercial and strategic routes towards India.¹⁶ It also offered an easily accessible terminus for oil¹⁷ and an important British stronghold (almost unchallenged until 1935) in the Mediterranean.¹⁸

At a more practical level however, Palestine could not be dealt with *only* as a colony. At different times during the thirty years of the mandate, it could count on a number of powerful advocates in both Houses to defend its particular status: Colonel Josiah Wedgewood,¹⁹ Winston Churchill,²⁰ Lloyd George, Lord Curzon,²¹ Lord Balfour and several others. For different reasons, they all placed the interests of Palestine above imperial considerations.²² Moreover, Great Britain had to report on the development of Palestine to the Permanent Mandates Commission (PMC) of the League of Nations on a yearly

¹³ The altogether fruitless debate on whether or not Palestine was administered as a colony despite the existence of the Mandate has been addressed by almost all historians who have written on mandatory Palestine. An extensive bibliography is given in part four of this introduction.

¹⁴ Cambridge University Library (henceforth CUL), Smuts Paper (henceforth SMU), Microfilm 690, vol. 25, 1922, letter n. 279; microfilm 696, vol. 31, 1925, letter n. 12; microfilm 697, vol. 32, paper n. 71.

¹⁵ Public Record Office (henceforth PRO), Colonial Office Series (henceforth CO) 732/40/9, PRO, CO 732/42/19, PRO, CO 732/42/22.

¹⁶ PRO, CO 732/60/6, PRO, CO 732/74/2.

¹⁷ PRO, CO 732/46/2, PRO, CO 732/48/6, PRO, CO 732/48/7, PRO, CO 732/54/6, PRO, CO 732/64/1, PRO, CO 732/65/6, PRO, CO 732/66/6, PRO, CO 732/69/2, PRO, CO 732/69/3, PRO, CO 732/71/3, PRO, CO 732/72/6, PRO, CO 732/74/6.

¹⁸ R. Quartararo, "L'altra faccia della crisi mediterranea (1935-1936)", *Storia Contemporanea*, Vol. 13-(4-5), 1982, pp. 759-820; see also M. J. Cohen and M. Kolinsky (eds.), *Britain and the Middle East in the 1930s*, Macmillan in association with King's College London, London, 1992.

¹⁹ PRO, CO 733/134/12, 1927, see also J. C. Wedgewood, "The Seventh Dominion. Palestine the Clapham Junction of the Empire", *The Referee*, 16th January 1927 in *Ibid*.

²⁰ M. J. Cohen, *Churchill and the Jews*, Frank-Cass, London 1985.

²¹ On Curzon see, D. Gilmour, "The unregarded prophet: Lord Curzon and the Palestine question", *Journal of Palestine Studies*, 25 (3), Spring 1996, pp. 60-68.

²² As in the case of the postponement of the debt due by Palestine to HMG, in PRO, CO 733/137/11. Also in PRO, CO 732/42/6, PRO, CO, 732/42/7, PRO, CO 732/42/8, PRO, CO 732/46/6. As in the case of the extension of the Imperial Preference to Palestine, in PRO, CO 733/137/17; as in the case of the loans to the Palestinian banks, in PRO, CO 733/223/14, 1932. The controversy which developed over who should pay for the maintenance of the Trans-Jordan Frontier Force, whether Palestine or the CO, represents an important exception to this pattern. In PRO, CO 733/133/11, 1927.

basis.²³ The PMC was in charge of supervising the country's progress towards social, economic and political maturity. In this context, the British delegations at Geneva periodically confronted the PMC's diverse committees which dealt - and increasingly so after the First World War - with health, with education, with the rights of children and women, with labour legislation, etc.²⁴

Health provision was in fact considered in the mandatory charter as one of the institutional obligations of the mandatory power in order for the mandate to fulfil its political mission, i.e., leading the mandated country to such a degree of maturity as to allow its ultimate independence. Because of economic stringencies and because of an increasingly complicated political situation within Palestine, the British government offered a minimal interpretation of this obligation.

As an institutional framework, the mandate allowed the permanence in the country of most agencies which had been dispensing health and education previous to British arrival.²⁵ It also allowed them to continue their work and to grow independently under British administration. Civilization through welfare appeared then as both a neutral and a natural element to legitimate the British presence in the area. However, the British taxpayer could no longer be asked at the end of the First World War to contribute indiscriminately to the costs of the empire. The British government therefore made use of those medical agencies which had the financial means to promote this undertaking. It reserved for itself the tasks of surveying,²⁶ legislating and coordinating public health, while it delegated actual medical provision to private medical and welfare institutions. It relied upon missions to provide medical services to the Arabs. As for medical services to the Jews, the British administration left them

²³ PRO, CO, 733/131/5, 1926; PRO, CO 733/204/3, 1931; PRO, CO 733/223/9, 1932; PRO, CO 733/240/9, 1933; PRO, CO 733/257/3, 1934; PRO, CO 733/284/1, 1935; PRO, CO 733/287/4, and PRO, CO 733/287/5, 1936.

²⁴ PRO, CO 733/136/10, 1927; PRO, CO 733/220/7, 1931.

²⁵ With the initial exception of the German ones, expelled from Palestine soon after the British conquest in 1917. See Middle East Centre Archives, St. Antony's College, Oxford, (henceforth MEC), Jerusalem and the East Mission Collection (henceforth J&EM), box 45, folder 5, 1. Also PRO CO 733/184/8.

²⁶ The set up of a governmental medical service in Palestine relied upon accurate surveys of the territory and of the population. This wide-ranging assessment of the country's health disguised the "great object of surveillance, analysis, intervention, modification" of the British in Palestine. B. S. Turner, *Regulating Bodies. Essays in Medical Sociology*, Routledge, London and New York, 1992, p. 130.

increasingly in the hands of the two existing Zionist medical agencies, the HMO and *Kupat Cholim*, the Labour Sick Fund (KH).

The Zionist movement understood its civilizing mission in the broadest possible terms. It turned the establishment of a system of medical provision and public health into one of the main means to realize its national goals. In its social and political dimensions, the perception of disease and the provision of health care are both shaping and shaped by the cultural circumstances which surround it.²⁷ Medicine is in fact not only the knowledge of healing techniques. It is also a complex *corpus* of cultural and social theories and political practices. Health provision represented for the Zionist movement much more than a way to deal with the unsanitary conditions of the land, with the recurrent epidemics and with endemic disease. Behind the organization of a health system stand in fact administrative arrangements, cultural approaches, social structures, political interests and, in the case of mandatory Palestine, also national finalities. In the context of a national movement in the process of establishing the foundations of its would-be state, medical provision and public health embodied a number of important social and political functions.

At a geographical level, they favoured first of all the re-mapping of the territory according to medical criteria. This process entailed the re-definition of the social and cultural space within which national construction could take place. Secondly, at an administrative level, measures of public health and provision of medical services contributed to detach towns with a Jewish majority (Tel Aviv, Haifa, Jerusalem, Tiberias, Safed) from dependence upon the British government, both from a political and economic point of view. At a social level, they defined the healthy individual as opposed to the sick one, the 'normal' as opposed to the 'pathological'. This process was translated into norms of acceptance into - or rejection from - society. In political terms, medical provision and public health favoured the creation of a network of institutions able to speak with one voice. This unity of the Zionist civil society was forged at a cultural level. Medical categories played here a relevant role in providing an ideological background to make Zionist civil society

²⁷ B. S. Turner, *Medical Power and Social Knowledge*, Sage Publications, London, 1987, p. 2.

homogeneous. The drive for compacting civil society was founded on the idea that a regenerated and healthy Jew had to be constructed in order for a new state to be established.

All these elements gave a fundamental impulse to the creation and the consolidation of a civil society able to translate national aspirations into organizational terms. In this respect, the provision of health and medical services contributed extensively to write in a new way that social contract between government and citizenry, which has been analyzed so well by Gosta Esping Andersen in a different context.²⁸ The cities of Palestine represented the stage on which the terms of this contract were to be drawn up.

2. Urban Palestine.

Zionist historiography has celebrated Galilee and the rural setting where the pioneers worked as the physical space of Jewish national re-birth.²⁹ Manual work in the *kibbutzim* has been represented as the spiritual and practical instrument for this individual and collective regeneration.³⁰ The study of Zionist settlement in rural Palestine has been crucial to understand the ideological foundations of the Zionist national project. It has disclosed its territorial strategies. It has also added an important dimension to our understanding of the roots of the domination of Labour over Palestinian (and later Israeli) politics.³¹ However, by focusing on rural Palestine as an

²⁸ G. Esping-Andersen, *Social Foundations of Postindustrial Economies*, Oxford University Press, Oxford, 1999, p. 33.

²⁹ Such an interpretation was drawn from the ideas of the first pioneers of the Second *alyia*. They were later called the founding fathers of the State of Israel, a definition they themselves encouraged and protected. The tilling of the soil - as one of the most important ways to bring about the individual and collective redemption of the Jews and of the land itself - was part of their cultural background. The secular prophet of this religion of work was Aharon D. Gordon. A. D. Gordon, *Kirvet*, [n.p.h.], Tel Aviv, 1930 [*Collected Works*, Hebrew]. The theme of the redemption of the land has been added of an important new dimension in the analysis of the measures undertaken by the Zionist agencies in their fight against malaria by S. M. Sufian, *Healing the Land...*

³⁰ H. Near, *The Kibbutz Movement. A History. Origins and Growth*, Vol. I, Oxford University Press, Oxford University Press; Washington DC, 1992; Id., *The Kibbutz Movement: a History. Crisis and achievement, 1939-1995*, Vol. II, Oxford University Press, 1997. W. Laqueur, *A History of Zionism*, Schocken Books, New York, 1972.

³¹ M. J. Aronoff, *Power and Ritual in the Israeli Labor Party: a Study in Political Anthropology*, M. E. Sharpe, Armonk NY, 1993; A. Cordova and H. Herzog, "The cultural

ideological space, this approach has neglected two important aspects of the Zionist process of institution- and state-building. It has not addressed with the same completeness the developments taking place in the urban setting. Secondly, it has not covered the vast - and as yet quite unexplored - field of the relations between the Zionist movement and the Arabs during this period.

In this context, an analysis of the foundation and development of the Zionist medical policies starting from rural Palestine would essentially represent a methodological continuity. This theme has moreover been addressed already by Shifra Schvarts in her study of KH during the Mandate.³² In a less traditional way, Sandra M. Sufian too has started from the rural setting to disclose some of the cultural and ethnic implications of the Zionist medical project *vis-à-vis* both the colonization of the land and the Arab population.³³

Most Jews in British Palestine lived in towns. Tel Aviv counted 40,000 inhabitants already in 1924-25. In the same year 14,000 Jews lived in Haifa and more than 42,000 in Jerusalem.³⁴ The 1930s saw an increase in this urban trend. In 1933, 83 per cent of Jews who immigrated to Palestine were reported to have opted for urban living.³⁵ During this decade most Jewish immigrants came from the mitteleuropean educated and urbanized middle classes. They settled in Tel Aviv, in Haifa, in Tiberias, and to a lesser extent, in Jerusalem.³⁶

endeavour of the Labor Movement in Palestine: A study of the relationship between Intelligentsia and Intellectuals", *YIVO Annual of Social Science*, 17, 1978, pp. 238-259.

³² S. Schvarts, *The Workers' Health Fund in Eretz Israel. Kupat Holim, 1911-1937*, The University of Rochester Press, Rochester NY, 2002. [1st ed. Ben Gurion University of the Negev Press, Tel Aviv, 1997, Hebrew].

³³ S. M. Sufian, *Healing the Land...*

³⁴ Z. Sternhell, *The Founding Myths of Israel*, Princeton University Press, Princeton NJ, 1998, p. 25.

³⁵ D. Giladi, *The Yishuv at the Time of the Fourth Aliya (1924-1929): Economic and Political Analysis*, 'Am Oved, Tel Aviv, 1973, p. 7. [Hebrew]

³⁶ Most studies on urban Palestine have been written by geographers, historical geographers and urban planners. See Y. Ben-Arieh and M. Davis (eds.), *Jerusalem in the Mind of the Western World, 1800-1948, With Eyes towards Zion V*, Praeger, Westport, 1997; Y. Ben-Artzi, *Early Jewish Settlement Patterns in Palestine, 1882-1914*, Magnes Press, Hebrew University, Jerusalem, 1997; G. Biger, "European influence on town planning and town building in Palestine, 1850-1920" *Urbanism Past and Present*, 9, 1984, pp. 30-35; G. Herbert, "Crossroads: Imperial priorities and regional perspectives in the planning of Haifa 1918-1939", *Planning Perspectives*, 4, September 1989, pp. 313-331; R. Kark, *Jaffa. A City in Evolution 1799-1917*, Yad Itzhak Ben-Zvi Press, Jerusalem, 1990; Y. Katz, "Ideology and urban development: Zionism and the origins of Tel Aviv, 1906-1914", *Journal of Historical Geography*, 12, 1986, pp. 402-424; M. Levine, "Conquest through town planning: the case of Tel Aviv, 1921-1948", *Journal of Palestine Studies*, 28 (4), Summer 1998, pp. 36-52; J.

In 1931, Jews in the Southern District lived in Tel Aviv (69,789) and Ramle (8,469); in the Jerusalem District they were primarily concentrated in Jerusalem (54,538). Very few lived in Hebron (135). As for the Northern District - where the majority of the Jews lived with the exception of Tel Aviv - there were 23,367 Jews in Haifa. 3,678 lived in Safed; 296 in Acre; 7,785 had settled in Tiberias; 3,172 were concentrated in Nazareth and just 14 lived between Jenin and Nablus.³⁷

Towns with a Jewish majority were central spaces where the interaction between Zionist representative institutions, British authorities and the population as a whole dictated the pace of the Zionist expansion. Here began the process of emancipation of the Zionist system of administration. It was again here that the first extended network of services to the Jewish population developed. In the cities a large number of medical, welfare and educational associations came to interact from a social and political point of view. Here there emerged the first nucleus of Zionist civil society. It was moreover in the towns that the domination of Labour within Zionist politics was challenged by other political orientations - the Revisionist movement in particular. In those cities where these processes were under way, the ideological dimension of Zionism - so extensively shaped by Labour and by the *Histadrut*³⁸ in the countryside - could be partially diluted by daily politics.

The civil society which developed in the cities was also more complex and sophisticated than the network which emerged in the rural context. It was more flexible and multifaceted. It was also freer to expand in different directions and more ready to incorporate different sections of the (Jewish) population. While it maintained an ideological framework which kept it united for the realization of its national project, it was less subject to the comprehensive domination of the *Histadrut*. Civil society in towns was shaped by the economic and political compromises which the Zionist movement had to

Schlör, *Tel Aviv. From Dream to City*, Reaktion Books, London, 1999; I. S. Troen, "The transformation of Zionist planning policy: from agricultural settlements to urban network", *Planning Perspectives*, 3, January 1988, pp. 3-23; Id., "The transformation of Zionist planning policy, alternative approaches to building Tel Aviv", *Journal of Urban History*, 18, November 1991, pp. 10-36.

³⁷ Cmd. 5479, *Report of the Palestine Royal Commission Presented by the Secretary of State for the Colonies in Parliament by Command of His Majesty*, HMSO, London, 1937, p. 404.

³⁸ The Federation of Jewish Workers of Palestine; (1922)

stipulate with the British government. As civil society formation also entails a process of exclusion of those who do not share its overall values, the urban context can reveal some of the mechanisms which excluded the Arab population from this political process.

Urban Palestine appears therefore as a field of inquiry which offers a wide range of variables hitherto explored only partially.

The HMO was primarily an urban organization. During the 1930s its network of medical and welfare associations expanded to rural Palestine too; its cultural foundations and its practical engagements however place it among the associations rooted in an urban context. In towns the HMO brought together different sections of the population and united them within one social and national framework. The country-wide battle against the spread of disease launched by the Zionist medical agencies in the 1930s - and by the HMO in particular - could be better co-ordinated from urban centres. Here were concentrated laboratories for clinical analysis and major medical and public health structures. The first modern hospitals appeared in Tel Aviv, in Haifa, in Jerusalem, in Safad and in Tiberias. With the exception of the so-called Emek hospital - founded by KH in Afula in 1930 - all the others were established by the HMO. If - as Bryan S. Turner suggests - the existence of hospitals can be seen as a "significant statement about the structure of modern societies,"³⁹ medical provision and public health in Zionism can be viewed as an important assertion of its cultural and political determination. From the beginning of the 1920s until 1938 the HMO carried "the primary burden for hospitalization needs of the Yishuv."⁴⁰ As such, it took part to most of those administrative, social and political aspects which allowed the construction of a medical network in Palestine. In this respect, the influence of this medical agency in networking Zionist civil society was exceptional.

3. Civil society.

³⁹ B. S. Turner, *Medical Power...*, p. 21.

⁴⁰ S. Schwarts, *The Workers' Health Fund...*, p. 76. During these two decades, the HMO provided for the hospitalization of over 200,000 Jewish patients.

Civil society is a much used and abused term. As it is central to this thesis, I would like to explain as clearly as possible the way in which I intend to employ it here. Definitions of civil society usually make reference to two common usages of the term. The first is a spatial one, broad and relatively value-free, intended to cover all those activities, associations, institutions and relations which neither belong primarily to the domestic sphere, nor to that of the State. The second is more narrowly normative, intending to distinguish between 'civil' and 'uncivil' society. Normative content has differed greatly over time, and that which distinguished Adam Ferguson's 'civil society' in late 18th century Scotland is not the same as that of the Centre for Civil Society at the London School of Economics at the beginning of the 21st century. Nonetheless they have a common point of contact in their insistence that civil society usually consists in a network of associations organized by active citizens who take an interest in public affairs.⁴¹

The strength or weakness of the two great institutions which lie on either side of civil society - the Family and the State - obviously exercise a great influence upon it. Over-powerful families and kinship networks can suffocate the possibility of civil society, based as it is on the free meeting of individuals. As for the State, it can either aid civil society, offering it meeting places, resources and encouraging its activities, or else it can work to undermine it, stunt its growth, or simply destroy it.⁴² I would also like to stress that civil society cannot be understood without emphasizing the transient character of many of its manifestations, and the possible conflict between them.

In this thesis, therefore, I intend to use the term 'civil society' in both a spatial and a normative sense. In spatial terms, the particularity of the Jewish Palestinian situation consisted in the absence of a strong State, and in the desire to use civil society precisely in order to construct a new vision and eventually a new reality of state power. As for the family, the prevailing ideology of the Jewish settlers was in favour of the limitation of its previously over-arching

⁴¹ H. Anheier, M. Glasius, M. Kaldor, "Introducing global civil society", in Id.(eds.), *Global Civil Society 2001*, Oxford University Press, Oxford 2001, p.15.

⁴² P. Ginsborg, *History of Contemporary Italy, Society and Politics 1943-1988*, Penguin Books, London, New York, 1990, pp. 141-185.

role in Jewish culture. No situation symbolized this better than the experimentation in collective forms on the *kibbutzim*.

In normative terms, Jewish civil society made reference to four elements which very often characterise the founding process of a civil society: shared values, a certain horizontal quality of participation and organization; boundary demarcation; an interaction with a dialectical counterpart. I wish to describe these briefly in general terms before passing to the case in question.

Shared values: These are usually progressive values of reform and/or construction and lie at the heart of a community's identity. They can reflect collective anxiety about possible disruption.⁴³ They can emerge out of a process of political and/or armed resistance.⁴⁴ They can represent the needs of a group of individuals and/or private institutions which are engaged in the public sphere.⁴⁵ There can also be a conservative model of civil society within which tradition is defended.⁴⁶ In all cases the values of civil society are forged through horizontal linkages of participation.

Horizontal linkages of participation: Participation leads to the construction of a network which regulates the organization of the social structure. The network is more than an admixture of various forms of association.⁴⁷ It is in fact founded on shared and homogenous values which perpetuate the identity of civil society. Networks can be 'dense' when they are structured in a territorially compact mode. They can be 'loose' when they are

⁴³ As indeed in the case of the *yishuv*. See B. Kimmerling, *The Invention and Decline of Israeliness, State, Society and the Military*, University of California Press, Berkeley, Los Angeles, London, 2001, p. 91.

⁴⁴ As in the case of post-1945 Italy for example, or of post-1967 Palestine. See C. Pavone, *Una guerra civile. Saggio storico sulla moralità nella Resistenza*, Bollati Boringhieri, Torino, 1991. See D. Tuastad, *The social capital of Palestinian Refugees*, Paper presented at the Third Mediterranean Social and Political Research Meeting, EUI, RSC, 2002.

⁴⁵ R. D. Putnam, *Making Democracy Work*, Princeton University Press, Princeton, 1993. For civil society formation and the interests of donors see D. Williams and T. Young, "Governance, the World Bank and Liberal Theory", *Political Studies* 42, 1994, pp. 84-100, p. 87. See also P. R. Davis and J. A. McGregor, "Civil society, international donors and poverty in Bangladesh", *Commonwealth and Comparative Politics*, 38 (1), 2000, pp. 47-64; R. Jenkins, "Mistaking 'governance' for 'politics': foreign aid, democracy, and the construction of civil society", in S. Kaviraj and S. Khilnani (eds.), *Civil Society: History and Possibilities*, Cambridge University Press, Cambridge, 2001, pp. 250-268.

⁴⁶ As, for just one example, the controversial case of Algeria in all its complexity. See C. Lloyd, *Multi-causal Conflict in Algeria: National Identity, Inequality and Political Islam*, Queen Elizabeth House Working Paper Series - QEHWPS104, 2003.

⁴⁷ A. R. Norton (ed.), *Civil Society in the Middle East*, E. J. Brill, Leiden New York, Köln, 1995, p. 11.

spread in society. In the first case, they often have a political impact which is extended beyond the local dimension. In the second case they remain closely connected to the local reality out of which they emerge.⁴⁸

Boundary demarcation: Civil society does not represent the whole of society of a given historical or political context; it only includes that section which shares its values and which is culturally compatible. As Ernst Gellner has argued, cultural homogeneity permits the “modularity of men for each other” (or their “substitutability”) and therefore allows the growth of civil society.⁴⁹ Cultural homogeneity demarcates the cultural, social and political space of civil society.⁵⁰ It therefore establishes clear boundaries of inclusion or exclusion. From here also derives its embedded nationalism - which Gellner sees as an unescapable dimension of civil society⁵¹ - and the perpetuation of a selective concept of citizenship.

Interaction with the state: Civil society creates its own representative institutions and ultimately represents itself. It however needs a dialectical (and political) counterpart against which it defines itself and with which it can negotiate its political advancement. As in the Gramscian model - where civil society represents a space of conflict and negotiation where hegemony is contested⁵² - the dialectical and political counterpart of civil society is generally embodied by the state.⁵³

⁴⁸ F. Piselli (ed.), *Reti: L'analisi di network nelle scienze sociali*, Donzelli, Roma, 1995.

⁴⁹ E. Gellner, “The importance of being modular”, in J. A. Hall (ed.), *Civil society, Theory, History, Comparison*, Polity Press, Cambridge, 1995, pp. 32-55, pp. 43-50.

⁵⁰ Cultural affinity within a community is also considered one of the main factors for the development of popular sovereignty within democracies. See O. Yiftachel, “Homeland and Nationalism”, *Encyclopedia of Nationalism*, Vol. I, Academic Press, Boulder CO, 2001, pp. 359-383, p. 366.

⁵¹ E. Gellner, “The importance...”, p. 42.

⁵² N. Bobbio, *Saggi su Gramsci*, Feltrinelli, Milano, 1990.

⁵³ For an approach which sees the relationship between civil society and state as reciprocal and therefore overall balanced, see J. S. Migdal, *State in Society: Studying How States and Societies Transform and Constitute One Another*, Cambridge University Press, Cambridge, 2001. For a view which sees the growth of civil society as a result of the weakness of the state see J. Linz and A. Stepan, *Problems of Democratic Transition and Consolidation: Southern Europe and Post-Communist Europe*, John Hopkins University Press, Baltimore, 1996. Here civil society is presented as the space where cooperation is at work and where opposition to the state is built. In this sense the model of Linz and Stepan represents a simplified version of that of de Tocqueville where civil society is considered, among other things, also as the antechamber of political society.

Shared values, an extended network, cultural homogeneity, boundary delimitation and a dialectical counterpart are by no means the only elements which make a society civil. Nor are they the only elements which can turn civil society into a political process. However, they represent the necessary and sufficient conditions for it to be considered as such.

In the case of mandatory Palestine, these factors were all present within the Jewish community in Palestine (the *yishuv*). This is particularly true in for the post-1929 situation. Following the so-called Wailing Wall riots in fact, shared values, boundary demarcation and collective participation became the main instruments to consolidate a political process meant to be conducive to institution- and state-building.

The Zionist group in Palestine was kept united by a sense of national mission as well as by a feeling of impending danger. Despite talk of building a 'new and muscular Jew,' the *yishuv* saw itself as a weak minority, under siege from the Arabs, suffocated by the British *in loco*, and betrayed by the British government in London.⁵⁴ In the course of thirty years, it built an extensive network of educational, medical and welfare institutions; it connected, practically, politically and culturally, most Zionist settlements on the land; it also established the representative institutions to coordinate this constructive effort. It educated and forged a community which would identify with the same cultural and national values. After 1929 the *yishuv* became that modular community which Gellner sees as implicitly nationalistic. As a result, its process of boundary demarcation excluded all the other sectors of society which did not fit the cultural, social, educational, linguistic and national standards it had set, beginning with the Arab population.⁵⁵ Finally, it interacted dialectically – and politically – with the British authorities.⁵⁶

⁵⁴ B. Kimmerling, *The Invention and Decline of Israeliness...*, p. 91.

⁵⁵ R. Greenstein, *Genealogies of Conflict: Class, Identity and State in Palestine/Israel and South Africa*, Wesleyan University Press, University Press of New England, Hanover, N.H., 1995, p. 115.

⁵⁶ For purposes of simplification, I have here identified the state with the British government in Palestine. However, on a conceptual and institutional level, the state was absent and vacant in mandatory Palestine. According to the mandate system in fact, sovereignty resided with the League of Nations, while only administrative functions resided with the British government. As we shall see in chapter one, it was also because of the lack of correspondence between political sovereignty and the public sector that the private sector could triumph over the public one in the long term.

As we shall see in the course of this work, public health and medical provision played an important part in all these aspects of civil society formation.

4. *The British Mandate in historiography (1960-2002).*

The twilight zone that lies between living memory and written history is one of the favourite breeding places of mythology.⁵⁷

A large number of studies and historical works have investigated over the past fifty years the history of the British Mandate from many different angles. Historians, geographers, political scientists, anthropologists, sociologists and some journalists⁵⁸ have all recognized the significance of this period in laying the foundations for the development of the Arab-Israeli conflict. As a result, these thirty years have also been included retrospectively in that process of myth-making which has so extensively influenced the debate on 1948, that on its aftermath and the writing of the history of the conflict.

Both Zionist and Arab historiography on the Mandate have been respectively surveyed by Bernard Wasserstein and Kenneth Stein.⁵⁹ While the so-called New Israeli Historians have begun to deconstruct some of the myths of the Zionist historical narrative, the period of the Mandate still awaits to be addressed comprehensively in a critical perspective.⁶⁰ Simha Flapan, Benny Morris, Avi Shlaim, Ilan Pappé, Uri Ram and the other 'new historians' have in

⁵⁷ C. Vann Woodward quoted in B. Wasserstein, "The British in Palestine: Myths and Realities", in *Middle Eastern Lectures, Number One 1995*, The Moshe Dayan Center for Middle Eastern and African Studies, Tel Aviv University, 1995, p. 29.

⁵⁸ N. Shepherd, *Ploughing Sand. British rule in Palestine, 1917-1948*, John Murray, London 1999 and T. Segev, *One Palestine...*

⁵⁹ B. Wasserstein, "The British in Palestine..." and K. W. Stein, "A historiographic review of literature on the origins of the Arab-Israeli conflict", *The American Historical Review*, 96 (5), December 1991, pp. 1450-65. B. Doumani too gives precious indications on the different phases of the Palestinian historiography. In B. Doumani, "Rediscovering Ottoman Palestine: writing Palestinians into history", in I. Pappé (ed.), *The Israel/Palestine History*, Routledge, London and New York, 1999, pp. 11-40, pp. 20-24.

A comprehensive survey of the literature on the Mandate in its different phases is beyond the scope of this introduction. I have here limited the picture to the main historiographical trends emerged in the past fifty years.

⁶⁰ With the exception of the attempt by T. Segev, *One Palestine...*

fact addressed only some of the myths which belong to its last phase.⁶¹ After the 'new historians' work, the British government is therefore no longer seen as having tried to prevent the foundation of the State of Israel in 1948. Equally, the Arab population is no longer described as having fled Palestine spontaneously. Two other sets of myths are still waiting to be deconstructed: the ones connected to the beginning of the Mandate - the mechanism behind the Balfour Declaration and the implications of the separation of Trans-Jordan from Palestine in 1923 - and those which have stigmatized the British inconsistency towards the two populations as a simple policy of *divide et impera*.

This last myth especially has been perpetuated by the first wave of historical studies on the Mandate published in the 1970s, when the first British official documents were released. Yehuda Bauer, Musa Budeiri, Neil Caplan, Michael J. Cohen, Isaiah Friedman, Elie Kedourie, Rashid Khalidi, Uri Kupferschmidt, Ann Mosley Lesch, Philip Mattar, Joel Migdal, Ylana Miller, Moshe Mossek, Yehoshua Porath, Norman Rose Abdul Latif Tibawi, Mayir Vereté and Bernard Wassestein all wrote in this period. They focused on the first decade of the Mandate and most of them looked at it from a political and diplomatic point of view (with some exceptions).⁶² Their works analysed the

⁶¹ S. Flapan, *Zionism and the Palestinians*, Croom Helm, London, 1979. B. Morris, *The Birth of the Palestinian Refugee Problem. 1947-1949*, Cambridge University Press, Cambridge, New York, 1987; Id., *1948 and After. Israel and the Palestinians*, Clarendon Press, Oxford, 1994; U. Ram, "Postnationalist pasts. The case of Israel", *Social Science History*, 22 (4), Winter 1998, pp. 513-545; Id., "The Colonization Perspective in Israeli Sociology", in I. Pappé, *The Israel/Palestine Question*, Routledge, London and New York, 1999, pp. 55-80; A. Shlaim, *Collusion Across the Jordan: King Abdullah, the Zionist Movement, and the Partition of Palestine*, Columbia University Press, New York, 1988.

⁶² Y. Bauer, *From Diplomacy to Resistance: A History of Jewish Palestine 1939-1945*, Jewish Publication Society of America, Philadelphia, 1973; N. B. Bethnall, *The Palestine Triangle. The Struggle Between the British the Jews and the Arabs 1935-48*, Futura Publications, London, 1980; M. Budeiri, *The Palestine Communist Party 1919-1948: Arabs and Jews in the Struggle for Internationalism*, Ithaca Press, London, 1979; N. Caplan, *Futile Diplomacy*, 2 vols., Frank Cass, 1983 and 1986; M. J. Cohen, *Palestine, Retreat from the Mandate. The Making of British Policy, 1936-45*, Elek, London, 1978; I. Friedman, *The Question of Palestine, 1914-1918*, Schocken Books, New York, 1973; R. Khalidi, *British Policy Towards Syria and Palestine 1906-1914*, Ithaca Press, London, 1980; E. Kedourie, *The Chatham House and Other Middle-Eastern Studies*, University Press of New England, London, 1970; Id., *In the Anglo-Arab Labyrinth: The MacMahon-Hussein Correspondence and Its Interpretations*, Cambridge University Press, Cambridge, 1976; U. M. Kupferschmidt, *The Supreme Muslim Council. Islam Under the British Mandate for Palestine*, E. J. Brill, Leiden New York, 1987; A. M. Lesch, *Arab Politics in Palestine, 1917-1939. The Frustration of a Nationalist Movement*, Cornell University Press, Ithaca London, 1979; P. Mattar, *The Mufti of Jerusalem: Al-Haj Amin Al-Husayni and the Palestinian National Movement*, Columbia University Press,

development of the Zionist and the Arab national movements as separate, therefore transferring into historical analysis the paradigm of conflict which was shaping the contemporary political reality.

The studies published in the 1970s can also be seen as a reply to the publication of numerous books, memoirs, diaries, collection of letters etc. which the former British administrators of Palestine had published from the 1960s onwards, generating what could be defined today as a literary phenomenon in itself. Writing at a time when the Anglo-Israeli relationship was still strained by the bitter memory of the Mandate's last phase and by the late recognition of the State of Israel by Great Britain (1950), this class of former imperial administrators offered a self-serving and partial answer to their contradictory experiences. Joshua Sherman has rightly stressed the peculiarity of a whole class of British rulers and administrators who felt the internal urge to make sense of their extraordinary experience by writing books (Norman and Helen Bentwich, Hugh Foot, Thomas Hodgkin, A. S. Kirkbride, Edwin Samuel, etc.),⁶³ letters (sent home on a regular basis) and/or by filling diaries with frequent entries.⁶⁴

New York, 1988; J. Migdal, *Palestinian Society and Politics*, Princeton University Press, Princeton NJ, 1980; Y. Miller, *Government and Society in Rural Palestine, 1920-1948*, University of Texas Press, Austin, 1985; M. Mossek, *Palestine Immigration Policy under Sir Herbert Samuel, British, Zionist and Arab Attitudes*, Frank Cass, London, 1978; Y. Porath, *The Emergence of the Palestinian National Movement: From Riots to Rebellion, 1929-1939*, Frank Cass, London, 1977; Id., *In Search of Arab Unity, 1930-1945*, Frank Cass, London, 1986; N. Rose, The debate on partition 1937-38: the Anglo-Zionist aspect. I - The proposal", *Middle Eastern Studies*, 6 (3), October, 1970, pp. 297-318; Id., "The debate on partition 1937-38: the Anglo-Zionist aspect. II - The withdrawal", *Middle Eastern Studies* 7 (1), January, 1971, pp. 3-24; Id., *The Gentile Zionists*, Frank Cass, London, 1973; A. L. Tibawi, *Anglo-Arab Relations and the Question of Palestine 1914-1921*, Luzac, London 1977; M. Vereté, "Palestine and Israel in the 19th and 20th centuries", *Middle Eastern Studies*, 6 (1), January 1970, pp. 48-76; B. Wasserstein, *The British in Palestine. The Mandatory Government and the Arab-Jewish Conflict 1917-1929*, Royal Historical Society, Oxford 1978.

⁶³ N. and H. Bentwich, *Mandate Memoirs*, Hogarth Press, London, 1965; H. Foot, *A Start in Freedom*, Harper & Row, New York, [1964]; Id., *The Future of Jerusalem: A Review of Proposals for the Future of the City*, Research Directorate, National Defense University, Washington, DC, 1980; G. Glynn, (ed.), *Tidings from Zion. Helen Bentwich's Letters from Jerusalem 1919-1931*, I. B. Tauris Publishers, London New York, 2000; E. C. Hodgkin (ed.), *Thomas Hodgkin. Letters from Palestine 1932-36*, Quartet, London, 1986; E. Keith-Roach, *Pasha of Jerusalem. Memoirs of a District Commissioner Under the British Mandate*, Edited by Paul Eedle, Radcliffe Press, London 1994; A. S. Kirkbride, *A Cradle of Thorns. Experiences in the Middle East*, J. Murray, London, 1956; D. Quickfall, *Shadows over Scopus. Reflections of an ex Palestine Policeman*, Cromwell, Manchester, 1999; E. Samuel, *Handbook of the Jewish Communal Villages in Palestine*, Zionist Organization Youth Dept., Jerusalem,

The works of Ted Swedenburg and, later, of Zachary Lockman opened a new phase of history writing in the 1980s. From different perspectives, they in fact began to analyze the role of non-elite groups in mandatory Palestine.⁶⁵ Following the path-breaking nature of Edward Said's study, the colonial paradigm was also introduced in the writing of the conflict's history and of its origins.⁶⁶ Gershon Shafir was one of the first Israeli scholars to examine Zionism as a colonialist phenomenon.⁶⁷

In the 1990s a new historiography on Palestine/Israel began to focus on those groups whose history had been ignored in the previous fifty years: the Arab population, peasants, workers, women and Mizrahi Jews. The effort to re-introduce Palestinians into history was also been essayed by the joint work of Baruch Kimmerling and Joel Migdal.⁶⁸

Post-Zionism began in the mid-1990s to look for alternative perspectives to analyse the consolidation of power and identity of Zionism in

1945; Id., *British Traditions in the Administration of Israel*, Mitchell, London, 1957; Id., *Britain's Legacy to Israel*, Leeds University Press, Leeds, 1962; Id., *A Lifetime in Jerusalem: The Memoirs of the Second Viscount Samuel*, Vallentine, Mitchell, London, 1970; R. Storrs, *The Memoirs of Sir Ronald Storrs*, G. P. Putnam's Sons, New York, 1937; Id., *Orientalisms*, Nicholson & Watson, London, 1943.

⁶⁴ MEC, Bowman; MEC, Emery; MEC, Norman; MEC, Perowne; Rhodes House, Oxford, (henceforth RH), Mss. Brit. Emp. S 284; RH, Mss. Brit. Emp. S 382.

⁶⁵ Z. Lockman, *Comrades and Enemies. Arab and Jewish Workers in Palestine, 1906-1948*, University of California Press, Berkeley London, 1996; Id., "Arab Workers and Arab Nationalism in Palestine: A View From Below", in J. Janowsky and I. Gershoni (eds.), *Rethinking Nationalism in the Arab Middle East*, Columbia University Press, New York, 1997, pp. 249-272; Id., "Railway workers and relational history. Arabs and Jews in British-ruled Palestine", in Pappé I. (ed.), *The Israel/Palestine...*, pp. 99-128; T. Swedenburg, *Memories of Revolt. The 1936-1939 Rebellion and the Palestinian National Past*, University of Minnesota Press, Minneapolis London, 1995; Id., "The role of the Palestinian Peasantry in the Great Revolt (1936-9)", in I. Pappé, *The Israel/Palestine...*, pp. 129-167.

⁶⁶ E. W. Said, *Orientalism, Western conceptions of the Orient*, Penguin Books, London, 1991.

⁶⁷ G. Shafir, *Land, Labor and the Origins of the Israeli-Palestinian Conflict, 1882-1914*, University of California Press, Berkeley Los Angeles London, 1996; Id., "Zionism and Colonialism. A Comparative Approach", in I. Pappé (ed.), *The Israel/Palestine...*, pp. 81-96.

⁶⁸ B. Kimmerling and J. S. Migdal, *The Palestinians, the Making of a People*, Harvard University Press, Cambridge MA, 1993. The re-inscription of Palestinians into history could not however begin from the Mandatory period. According to the Zionist narrative in fact, Palestinians had in this period already disappeared from the historical scene. Also in response to this approach Beshara Doumani and Butrus Abu-Manneh concentrated on the 18th and 19th centuries, the period which the dominating historiography had obscured in a sort of dark middle-ages. B. Doumani, *Rediscovering Palestine. Merchants and Peasants in Jabal-Nablus, 1700-1900*, University of California Press, Berkeley London, 1995; Id., "Rediscovering Ottoman Palestine..."; B. Abu-Manneh, "The Rise of the Sanjak of Jerusalem in the Late Nineteenth Century", in I. Pappé (ed.), *The Israel/Palestine...*, pp. 41-51.

its historical development.⁶⁹ It therefore privileged a thematic-horizontal approach in contrast to the national-vertical one which had predominated until then. The latter had taken for granted the cultural and social differences which had divided Arabs and Jews. The Post-Zionist perspective looked into these differences to discuss the ways in which the Zionist group came to assert its dominance over the country. The Post-Zionist thematic approach also put in relation various parts of a larger process of socio-political construction and of cultural homogenization. Zeev Sternhell, Laurence J. Silberstein – and in some respects also Uri Ben Eliezer – and other scholars therefore analysed different political, economic, social and cultural instruments: the *Histadrut*,⁷⁰ the army,⁷¹ schools,⁷² immigration policies⁷³ etc.

The organization of a medical system can also be considered as one of these instruments. It promoted national cohesion. It consolidated the Zionist presence over the land and among the population. It also contributed to a process of cultural and social normalization. In short, it brought the Zionist movement to erode the country's administrative structure, to redefine its geographical space and to transform its social system.

Medical history has so far been almost neglected in the vast literature on the Mandatory period, with three major exceptions: Manfred Waserman and Samuel Kottek have underlined the importance of this field to understand the history of the country. In their work on the history and sociology of medicine,

⁶⁹ L. J. Silberstein, *The Post-Zionism Debates. Knowledge and Power in Israeli Culture*, Routledge, New York London, 1999, "Like postmodernism, postzionism suggests the need to move beyond the prevailing (zionist) discourse in search of more adequate ways to talk about Israeli culture, identity and history. (...) The debates over postzionism are important on a number of levels. First of all, they concern relations of power that affect the lives of Israelis, Palestinians, and all others affected by events in the Middle East. In addition, they pertain to the unfolding character of the state and the place of democracy in it." (p. 9). See also G. Shafir e Y. Peled, *Being Israelis*, Cambridge University Press, Cambridge, 2002, pp. 37-46.

⁷⁰ Z. Sternhell, *The Founding Myths of Israel...*

⁷¹ U. Ben-Eliezer, *The Making of Israeli Militarism*, Indiana University Press, Bloomington and Indianapolis, 1998.

⁷² R. Elboim-Dror, "Israel Education Policy", in F. N. Bolotin (ed.), *International Public Policy Sourcebook. Vol. 2. Education and the Environment*, Greenwood Press, New York, Westport CT, London, 1989, pp. 79-96; Id., "British Educational policies in Palestine", *Middle Eastern Studies*, 36 (2), April 2000, pp. 28-47.

⁷³ P. Giordano, *Il principio di capacità economica di assorbimento. I Britannici e l'immigrazione ebraica in Palestina (1923-1937)*, Unpublished Ph.D. thesis, Università di Firenze, Firenze, June 1999.

they were the first to frame the medical discourse in a pattern of long-term historical continuity.⁷⁴ In that volume two authors in particular dealt with medical development in mandatory Palestine. Nira Reiss presented a narrow and controversial picture of the British system of medical provision.⁷⁵ Shifra Schvarts focused on KH.⁷⁶ However, the full national implications of the construction of a Zionist medical system in mandatory Palestine emerged in the two major works written on this topic. Shifra Schvarts has worked and published extensively on the history of KH.⁷⁷ Sandra M. Sufian has worked on the social, cultural, territorial and political impact of malaria on Zionist settlement.⁷⁸

The present study is different from theirs in that it concentrates specifically on the 1930s, making use of a wide variety of archival sources. It also concentrates primarily on the cities as opposed to the countryside. Above all, it uses health to study the process of Zionist civil society formation. In this respect, it tries to concentrate on the administrative, social and ideological aspects of medical provision. It tries to show how health could be instrumental to create a cultural uniformity based on shared values and codes of behaviour. It also tries to demonstrate how the organization of medical provision and of public health was founding of networks of horizontal participation which were both 'dense' and 'loose'. This work examines health as an instrument of boundary demarcation between communities. As such, the organization of medical services and of public health – as it developed in this period – is seen as having exerted a long-term influence on the cultural traits of Zionism,

⁷⁴ M. Waserman and S. Kottak, *Health and Disease in the Holy Land. Studies in the History and the Sociology of Medicine from Ancient Times to the Present*, Lewiston NY, 1996.

⁷⁵ Reiss N., "British Public Health Policy in Palestine, 1918-1947", in *Ibid.*, pp. 301-328.

⁷⁶ S. Schvarts, "Kupat Holim and Jewish health services during the Mandate", in *Ibid.*, pp. 329-360.

⁷⁷ *Id.*, *The Workers' Health Fund...*; *Id.*, "Kupat Holim and Jewish health services during the Mandate"...; *Id.*, "Health Reform in Israel: some aspects of seventy years of struggle (1925-1995)", *Social History of Medicine*, 11 (1), April 1998, pp. 73-88; *Id.*, "B'nai B'rith-Sha'Ar Zion Hospital in Jaffa (1891-1921): the first Jewish community hospital in Palestine," *Judaism: A Quarterly Journal of Jewish Life and Thought*, 47 (3), Summer 1998, pp. 358-371; *Id.*, L. A. de Leeuw and S. Granit, "The salaried model in Israel: from Socialist principles to motorcycle maintenance- A historical perspective", *American Journal of Public Health*, 89 (2), February 1999, pp. 248-259.

⁷⁸ S. M. Sufian, *Healing the Land...*

whether we consider the relationship of this movement to Judaism alone, or its controversial approach to the Arab population.

Outline of the dissertation.

This research is limited to the 1930s. This decade was crucial for the crystallization of a number of social, political and institutional processes which also affected the subsequent history of Palestine/Israel. In political life, the process of institutionalization which began in the 1930s set these two communities apart. During the 1930s, medical policies also became increasingly central as a political instrument in the country's life.

The main body of this dissertation is composed of three chapters. Chapter one focuses on administration and on its significance as a tool of civil society formation and of institution- and state-building. It therefore frames the Zionist administrative system within the British one in order to see the means through which the former emancipated itself from British control. Chapter one also explains the relevance of medical policies for this process. Chapter two explores how medical policies stood at the centre of the process of networking of Zionist civil society both over the territory and in society. Drawing on the differences between rural and urban Palestine, this chapter attests to the ultimate integration of these two worlds within one national project. Chapter three investigates the cultural and ideological dimension of health work. Here health is seen as a means to create a cultural homogeneity which united a *yishuv* that was progressively more diversified from several points of view.

As the boundaries *within* the *yishuv* gradually disappeared, those *between* communities in Palestine were strengthened.⁷⁹ Medical categories were instrumental to the weakening of differences within the Zionist group – and therefore also to the formation of civil society. They were also conducive to the progressive separation between national communities. The very same elements which brought the formation of Zionist civil society – cultural compatibility, shared values, networks of horizontal participation, boundary

⁷⁹ R. Greenstein, *Genealogies of Conflict...*, p. 115.

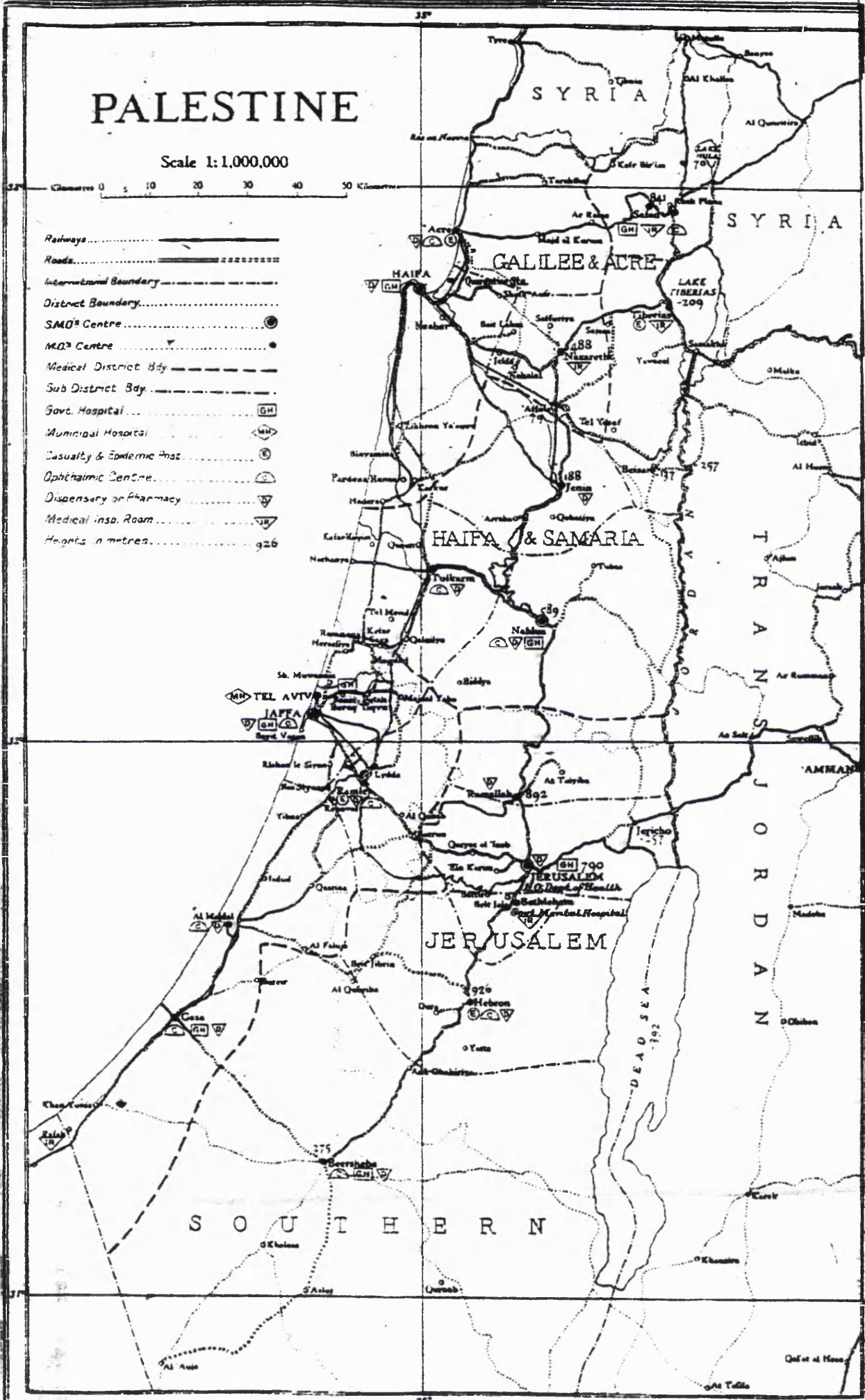
demarcation etc. - contributed to hinder the networking of the Arab society. They also excluded the emergence of a common civil society between Arab and Jews. Zionist civil society became cramped and exclusive, a peculiarity which was to be much accentuated in later decades. For these reasons the 1930s was a fundamental period in which the Arab and the Zionist national identities became mutually exclusive. The new conception of administration, territorial and social control, an ideological self-centred approach, represented in fact three of the elements which forced upon the country a process of normalization built upon western notions of citizenship. The new social contract being signed in mandatory Palestine between Zionist civil society and the state inevitably excluded the Arab population.

PALESTINE

Scale 1:1,000,000

0 10 20 30 40 50 Kilometres

- Railways.....
 Roads.....
 International Boundary.....
 District Boundary.....
 SMO's Centre.....
 M.O.'s Centre.....
 Medical District Bdy.....
 Sub District Bdy.....
 Govt. Hospital.....
 Municipal Hospital.....
 Casualty & Epidemic Hqs.....
 Ophthalmic Centre.....
 Dispensary or Pharmacy.....
 Medical Insp. Room.....
 Heights in metres.....



Administration

The construction of a system of medical provision and public health in mandatory Palestine, its development and its organization at different levels, was the result of a number of factors: the necessity of both the British and the Zionists to create the conditions for a healthier environment, the introduction of concepts of western medicine into the country,¹ the national commitment of the Zionist organizations, questions of financial availability, of administrative practice and of political arrangements. All these different elements converged to create a general administrative and political framework within which the relationship between the British authorities and the Zionist agencies developed and grew during the Mandate. It was in fact this relationship, rather than the work of each taken separately, which dictated the pace of the construction of the system of medical provision and of public health. It provided consistency and coherence and transformed it into a political and national project, particularly for the Zionist group.

Through the introduction of new ordinances, of administrative changes and of instruments of financial control – just to mention the three main subjects analysed in this chapter – Palestine's system of medical provision and of public health underwent a dramatic change during the 1930s. This transformation had precise long-term consequences for the country's cultural and political organization, ultimately leading to a change in the balance of power between the British administration and the Zionist agencies. If in 1929 the Zionist institutions still depended upon the British administrative framework, by the end of the 1930s the daily practice of administration and financial compromises reached between the two had successfully rendered the Zionist institutions autonomous. At the beginning of the decade the contract between

¹ On colonial medicine see R. MacLeod and M. Lewis, *Disease, Medicine and the Empire...*

citizenry and state was still being regulated through the provisions contained in the mandatory charter. By 1939 medical provision had emerged as that field which - together with welfare and education - determined who would have access to resources - and therefore to the benefits of citizenship broadly conceived. If in 1929 the Zionist medical system still had to rely upon British resources for its organization and functioning, by 1937 its efficiency, reliability and standards were acknowledged in the Peel Commission Report to be higher than those of the British Government Department of Health (GDH). This reality could also be inferred from an analysis of the decreased percentage of government expenditure on public health, from 4,8 per cent in 1929 to 3,3 in 1936-37.²

The beginning of Zionist medical work in Palestine dates back to the first years of the 20th century.³ However, the 1930s witnessed the opening of a constructive phase in which social work became one of the main instruments for the consolidation of the Zionist political and national project. Especially in this field, this decade saw an acceleration of the process of institutionalization. Concurrently, it also witnessed an intensification of political antagonism. Given this new context, the relationship between the British administration and the Zionist agencies changed considerably. It became more intense, and at times more troublesome, than it had been in the previous decade, but also more focused and direct. The situation sparked off the functioning of a co-ordinated system of medical provision which had its foundations in the autonomy of the municipalities, in the political representation of the religious communities and in the distribution of grants-in-aid to voluntary and private medical associations. The new administrative and legal framework, as well as the progressive networking of Zionist agencies, transformed the latter into one embryonic civil society capable of turning its social work into a process of institution- and state-building. The second part of chapter one explores the construction of this process from an administrative perspective.

² Cmd. 5479..., p. 313.

³ A. M. Kass, "Sir Moses Montefiore and medical philanthropy in the Holy Land", in M. Waserman and S. Kottek, *Health and Disease*, pp. 207-230 and N. Schwake, "Hospitals and European colonial policy in the 19th and early 20th centuries", in *Ibid.*, pp. 231-262.

In order to track these administrative and legal changes, to analyse their importance and influence on the networking of Zionist civil society and to understand how this process contributed to deepen the disparities between the Jewish and the Arab groups, I have divided this chapter into three parts.

In part one I delineate the organization and functioning of the British administration with reference to the relationship between the central administrative institutions and the GDH. Secondly, I discuss the administrative structure which the Zionist agencies constituted in this period and how they came both to interact and clash with the British ones. In this section I focus more specifically on the administrative measures adopted by the Zionist institutions and medical organizations *vis-à-vis* both the British administration and their own national project. While the British administration remained the primary reference point for legal and administrative questions because of its institutional role, the financial contribution of Diaspora Jewry to the health of the *yishuv* after the First World War – and of US-based organizations in particular – had contradictory implications. Facing a British administration which could no longer count on the previous level of financial availability,⁴ the new and growing Zionist financial access made the relationship between the two less conflictual on practical issues, but more confrontational on an ideological level. Such confrontation developed *pari passu* in a two-fold process which took place within the Zionist field: on the one hand the medical work of the Zionist organizations became more diversified in the number of the medical agencies involved, in their ideological orientation, and in the population groups they reached. On the other hand they were still able, for purposes of development and representation, to confront the British administration as a united entity.

In part three, I consider the administrative and political changes which occurred in the British-Zionist relationship and inside the Zionist field after

⁴ In the post-war scenario the British administration was caught between a tight financial situation and the paramount need to invest in security. The British in Palestine applied what was known as the 'Cromer System' of administration. It emphasized the importance of low taxation, efficient fiscal administration, careful expenditure on remunerative public work and a minimal interference in the internal and external traffic of goods. G. Biger, *An Empire in the Holy Land. Historical Geography of the British Administration in Palestine, 1917-1929*, St Martin's Press, New York, 1994, p. 20.

1935. This was a time when the rapidly changing international and domestic situation required an effort of adaptation for all the parties involved in the functioning of the Palestinian system of medical provision and public health. One of the most immediate results of such change was the reorganization of the Zionist medical and public health work along new and even more autonomous directives.

1. The British administrative structure of health provision.

The GDH was organized in 1920-21 along lines which remained substantially unchanged throughout the Mandate.⁵ Headed by Col. George Wykeham Heron between 1920 and 1944, it represented the centre of the organization of medical provision and public health in several respects. It oriented the government's policy, mediating between the local Palestinian reality and the financial requirements dictated by the Treasury and by the Colonial Office in London. It coordinated the decentralized work of its Senior Medical Officers (SMO) – key figures in the administrative chain. The GDH decided on the allocation of the available funds to the different religious communities. It also maintained and administered a number of government and municipal hospitals (Jerusalem, Haifa, Nablus, Jaffa, Safad, Beersheba and Gaza). In this scheme the more senior posts always remained in the hands of British officers of the colonial service. Their duties comprised the administration, organization and supervision of the system of medical provision and of public health, while positions of lesser responsibility – like the medical officer in charge of a clinic, for example – were usually assigned to Palestinians, considered responsible for the “detailed execution of duties.”⁶

The GDH consisted of a directorate in Jerusalem,⁷ a District Health Administration,⁸ a Railway Medical Service and an Endemic Diseases Service.

⁵ For an analysis of the institutional organization of the Mandate, in its relationship with the PMC and the CO and of its internal administrative functioning, see B. Wasserstein, *The British in Palestine ...*; see also P. Giordano, *Il principio ...*, Appendix I.

⁶ Colonial n. 133, *Palestine Royal Commission. Memoranda prepared by the Government of Palestine to the Palestine Royal Commission*, HMSO, London 1937, p. 131.

⁷ Ibid. This first branch of the British medical system was in turn divided into subsections: General (for administration, finance, personnel, medical stores, town planning and village water supplies), Medical (in charge of hospitals, dispensaries, schools for medical service, pharmacy and prisons), Sanitary and Epidemic (which dealt with urban and rural sanitation, the

Its first two branches constituted the backbone of a system whose salient features remained for thirty years the delegation of medical services to voluntary (private) institutions, the decentralization of services and the idea that medical provision and public health should be primarily regulated through legislative intervention rather than through direct involvement. I will now turn to a brief analysis of these three elements which shaped the British organization of medical provision and public health in Palestine.

a) *Delegation.* Economic difficulties constituted one of the main reasons for the delegation of medical work to private and/or charitable and voluntary agencies. Palestine's "precarious state of finance" always constituted one of the primary concerns of all the administrators involved in the country's development, both in London and in Jerusalem. In the words of Henry Stewart Perowne – one of the administration's most distinguished civil servants who remained in Palestine between 1927 and 1934 – "the blight of the whole administration is that we can't spend a penny, even on a typewriter, without asking the permission to the Secretary of State."⁹ The budget for Palestine was moreover severely restricted by the continuous "interference of the Treasury who insist on Palestine being (sic) a substantial proportion of its defence costs."¹⁰ Many reports to the PMC and to the CO from the GDH concluded with a recurrent statement: "it will be appreciated that the financial situation of the Government renders impossible any important development of social services at present."¹¹

After 1929, this constant complaint appeared justified. The riots of that year, the deteriorating political situation and the lack of financial resources

regulation of trades and industry and food-control), Endemic Disease (which included ophthalmic, tuberculosis and venereal diseases) and Laboratory.

⁸ Ibid. The District Health Administration consisted of four medical divisions under British SMOs. They controlled: a) 18 sub-districts, each under a Palestinian medical officer responsible for all medical, health, sanitary, epidemic, malarial, endemic and medico-legal duties in the main towns of the sub-district, in villages and settlements; b) most of the country's government and municipal hospitals, mental hospitals, maternity service, infant welfare stations, ophthalmic clinics, training centres for nurses, a school for midwives, antirabic treatment centres and quarantine service at the four ports. Colonial n. 133..., p. 131.

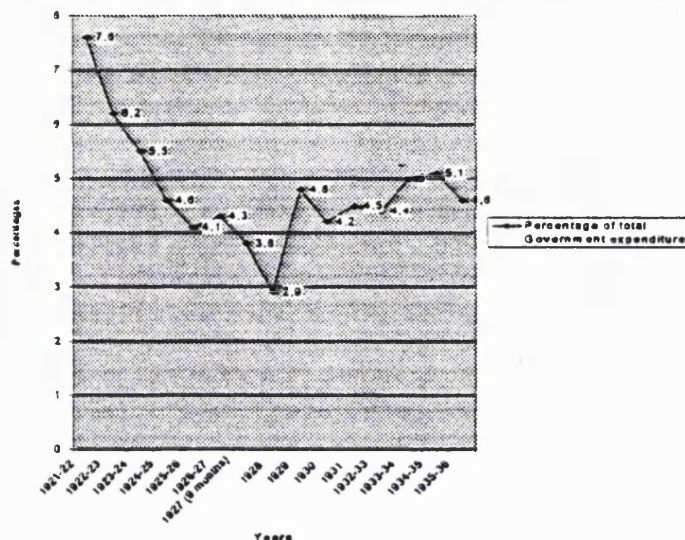
⁹ MEC, Perowne, b. 2, f. G, 1931

¹⁰ CUL, SMU Microfilm 705, vol. 40, letter n. 2 from J. S. Amery to J. C. Smuts, 1st May 1928.

¹¹ PRO, CO 733/174/3, 1928.

contributed to the British choice to invest primarily in security and in the building of infrastructures, rather than in social services. After 1929 the British administration devoted a very limited amount of its annual budget to general medical expenses: for instance, in 1930 it granted to medical services just below five per cent.¹²

1. Percentage of total Government expenditure
for medical expenses (1921-1936)¹³



Since 1925 the GDH had formulated its policy of concentrating on matters of public health importance rather than on general medical relief.¹⁴ This orientation was confirmed in 1928, when the government outlined the guidelines for the new decade, with the idea of leaving the treatment for the poorer classes of the population as far as possible to charitable and municipal enterprises and of channelling government funds to matters of more direct public health importance.¹⁵ These included very general tasks: the reduction of preventable diseases, the improvement of general sanitary and health conditions, medical supervision of school children and infant welfare. Direct

¹² HDS, b. 56, f. 3, Letter from H. Szold to Mrs Edward Jacobs, Jerusalem 26th March 1930.

¹³ Elaboration of data from Colonial n. 133..., p. 137. As this chart indicates, the percentage of government expenditure for medical provision decreased constantly until 1929, only to grow irregularly after this date. However, the values never went back to the first years of British presence in Palestine.

¹⁴ PRO, CO 733/130/5, 1927, Health Department, *Annual Report 1925*.

¹⁵ HDS, b. 79, f. 8, Letter from H. Yassky to Mrs Samuel Halperin, 18th June 1930.

involvement was envisaged only for infectious diseases, mental diseases and for medical service in prisons. In 1933 Heron confirmed and further specified this course.¹⁶ In each of these areas – epidemics, mental health and prisons – the British administration failed, as we shall see, from both a structural and an organizational point of view.¹⁷

General medical relief in most towns could in any case be obtained from private medical practitioners or charitable institutions. In different ways and with a different legal status,¹⁸ both the Zionist medical agencies and the numerous missionary societies present in Palestine¹⁹ were comprised in the category of private, charitable or voluntary institutions. This group of organizations supplied that medical provision which the British could not afford to offer. Missions worked for both rural and urban Arabs, for those sections of the population the government could not reach from a geographical and/or cultural point of view and for the country's poor. In general, they addressed the medical situation of those who were in the direst need to improve

¹⁶ PRO, CO 733/223/4, 1932, *Note on proposals to subsidize Jewish Medical Services*, by Director of Health. [n.d.]. In 1933 the Secretary of State established four categories of medical provision and public health where the government was expected to intervene directly. "a) To concentrate on public health and sanitation and the prevention of disease; b) to provide hospital accommodation for dangerous, infectious and communicable diseases and mental disease; c) to limit as far as possible hospital accommodation provided by the administration for general diseases to the requirements of government officers and employees, members of the police force, prisoners, medico-legal cases, accidents and the very poor; d) to provide hospitals, or to aid municipalities to provide hospitals for the needs of the general population in areas where no provision or inadequate provision was made by voluntary organisations."

¹⁷ On the failure of British direct involvement in these three fields see M. Simoni, "At the roots of division: a new perspective on Arabs and Jews", *Middle Eastern Studies*, 36 (3), July 2000, pp. 52-92.

¹⁸ "[Missionary] hospitals were subsidized by Government to the extent that they were exempted from import duties on certain articles and from various rates and taxes." PRO-FO 733/223/4, Minutes, 11th August 1932. See also PRO FO 371/15331, *Exemption of charitable and religious institutions and Government departments in Palestine from customs and taxation*.

¹⁹ R. Kark, *The Impact of Early Missionary Enterprise on Identity Formation in Palestine, 1820-1914*, draft circulated at the workshop on "Identity Formation and the Missionary Enterprise in the Middle East", 17-18 November 1999, Watson Institute, Brown University, p. 21. At the beginning of the British mandatory rule in Palestine over thirty missionary societies from different western nations were active in Palestine. Most of these were British, Scottish, American and German Protestant missions. The British presence among missionary institutions was not limited to the Anglican Church: "At the end of 1917 ten British Churches and Missionary Societies were active in Syria and Palestine were (sic); the London Society for Promoting Christianity among the Jews (commenced in 1823), the Presbyterian Church of Ireland (1843), Church Missionary Society (1851), British Syrian Mission (1860), Edinburgh Medical Missionary Society (1861), The Church of Scotland (1864), Friends Foreign Mission Association (1869), The United Free Church of Scotland (1884), Jerusalem & the East Mission (1889) (sic), The Presbyterian Church of England (1895)."

their hygienic and medical conditions. The Zionist medical agencies had encouraged the policy that no settlement or group of Jews resident in the country should be without medical assistance immediately available. While missions had adopted the criterion of providing according to creed, need or census, the Zionist agencies chose a religious-national framework to construct their system of medical provision.

Despite these results, which pointed at material and tangible signs of division between population groups along religious and national lines, reliance on such private institutions was considered by the government essential for both financial and practical reasons. Submitting its memorandum to the Peel Commission in 1937, the GDH wrote:

It is a fact that, had these institutions not existed in the country, Government would have been faced *ab initio* with a very much greater expenditure on hospital and medical services and, owing to the limits of the public purse, much that has been accomplished in public health and sanitary developments would perforce have been left to the general disadvantage of the community.²⁰

As a result of the British delegation of general medical services to private medical institutions, the British investment and involvement was generally limited to measures of public health. It was in part the realization that such a field was being covered by government's policy, that enabled the Zionist organizations to develop their medical services to the degree of co-ordination, sophistication and completeness attained during the 1930s. They would never have reached such a high level, however, if the British administration had not also favoured a decentralized system of health administration and introduced a large number of new pieces of legislation. It is to these further factors that I now turn.

b) Decentralization. Decentralized administration had not been conceived in Palestine as a basis for the establishment of local semi-autonomous governments as, for example, in the case of the French mandated

²⁰ Colonial n. 133..., p. 138.

Syria.²¹ With the exception of the Departments of Health and Education – whose decentralized work followed the division of the country in districts²² – the other departments (Regional Planning, Land, Legal, Police, Antiquities, Finance etc.) generally maintained a centralized and rather imposing working method. While formally proclaiming the importance of administrative decentralization, the British administration in Palestine remained substantially centralist. The country was considered too small and too divided to permit further subdivisions.²³

The two main means adopted to decentralize medical provision and public health were the encouragement of the autonomy of the municipalities and the work of the Senior Medical Officers *in loco*. The British administration viewed the municipalities as an important tool for the promotion of self-government in Palestine. As early as 1924, it had tried to combine the idea of local autonomy with that of delegating medical services. With a scheme that saw the municipalities ideally becoming responsible for the control over the prevention of disease, for the financial management of medical institutions and for the provision of services to the population,²⁴ the government tried to achieve a two-fold aim. In the first place, it tried to guarantee in the short-term the financial survival of the medical institutions through the revenue accruing locally from treatment fees. Secondly, in the long-run, it was hoped that local interest would be stimulated so as to gradually render autonomous the local system of medical provision. As in the case of other initiatives, the growing political antagonism between the different communities undermined the viability of the scheme.²⁵ Moreover, its implementation brought the British to

²¹ P. A. Shambrook, *French Imperialism in Syria, 1927-1936*, Cornell University Press, Ithaca, 1998. See also, S. Mardam Bey, *La Syrie et la France. Bilan d'une équivoque (1939-1945)*, Éditions L'Harmattan, Paris, 1994.

²² There were ten districts in 1920. With the shift from the Occupied Enemy Territory Administration (OETA) to the civil administration in 1922, they were reduced to seven, then to four and finally to three – Northern, Southern and Jerusalem. During the 1930s, Palestine remained divided in three districts directed by three District Commissioners, twelve Assistant District Commissioners and thirty-seven District Officers. All those belonging to the former two groups were British while all of the latter were Palestinian.

²³ G. Biger, *An Empire in the Holy Land...*, p. 103.

²⁴ Cmd. 5479..., p. 315.

²⁵ This became especially true in the 1930s, as in the cases of the medical centres of Haifa, Ramle, Jaffa, Nablus, Bethlehem, Gaza and Hebron. In PRO, CO, 733/144/12. See also Israel State Archives (henceforth ISA), M 839, 677.

confront the existence of different levels of administrative development between the Jewish and the Arab municipalities.

The decentralization of services had in fact favoured the autonomous development of those municipalities with a Jewish majority, which had promptly adapted their method of work to the new administrative framework. Health provision in areas of Arab cultural and numerical prevalence remained entangled between attempts towards local autonomy, reliance on traditional family-based agencies²⁶ and the existence of a new legislative framework.²⁷ In Jaffa and Nablus in fact, the government had to discontinue an experiment aimed at encouraging the "local communities to manage their own affairs" when it realized it still had to supply "all technical services and equipment" and to pay "fifty per cent of the total cost."²⁸

In this context the work of the Senior Medical Officer – the second instrument to promote the government's policy of decentralization – played a role of the greatest relevance. His role had originally been conceived as a liaison between the district administration and the Department of Health, between the population groups and the medical agencies working on the territory and between the latter and the government. The very presence and work of the SMO had allowed the government to establish a connection with those remotest villages where poor social conditions and the spread of illness went hand in hand. Intermediary between the government and the medical organisations, between its institutions and the people, playing the roles both of inspector and doctor, the SMO visited villages, inspected and supervised voluntary hospitals and dispensaries in his sub-districts, granted licenses for pharmacists, regulated water supply, tried to keep a registry of births and deaths, inspected public places (industries, prisons, schools etc.), supervised anti-malaria public works and emergency routine in times of epidemics. Ideally, the SMO was dynamic and his activity omni-comprehensive. On his

²⁶ For the role of the *waqf* in the provision of medical services to the Arab population see the study of Y. Reiter, *Islamic Endowments in Jerusalem under British Mandate*, Frank Cass, London, 1996.

²⁷ See also some remarks in N. Reiss, "British public health policy ...", pp. 301-328.

²⁸ PRO, CO 733/223/4, 1932.

shoulders rested the responsibility for the system's effective functioning locally and for its connection to the wider administrative context.

Despite the importance of such a post, its existence came under threat in 1931, following an investigation conducted by the O'Donnell Commission, one of the numerous commissions of enquiry sent from London from 1929 onwards.²⁹ With the intention of optimizing services while reducing expenses, the O'Donnell Commission suggested in its report a reduction of "the staff now maintained" as a necessary measure for improving the system "without any substantial loss of efficiency."³⁰ Its proposal called into question the way in which decentralization had been realized by suggesting the redefinition of a whole series of administrative roles: that of the District Officer, of the District Inspector, of the Municipal Officer and of the Surveyor. In this scheme the number and functions of the SMOs were also to be reduced. Had the O'Donnell commission's suggestions been adopted in a system where municipal autonomy had failed to achieve the creation of conditions of equality for different population groups, the reduction of the SMOs' tasks would have seriously undermined the whole British engagement in public health, the only field where the government had maintained its commitment to intervene. The work of prevention – and therefore the control over the spread of disease³¹ – would also have been seriously damaged.

As head of the GDH, Col. Heron's protested vigorously with the CO against the suggestions of the O'Donnell Commission. He was successful to the extent that this key post was not abolished, nor was the number of SMOs diminished. These concessions were however granted only in exchange for the reduction of LP 4,000 in the expenditure of the GDH's budget per year beginning in 1932-33. In the context of fewer government resources available, the greater financial availability of some of the Zionist medical agencies had

²⁹ Cmd. 3530, *Report of the Commission on the Palestine Disturbances of August 1929*, HMSO, London, 1930 (Shaw); Cmd. 3686, *Report on Immigration, Land Settlement and Development*, HMSO, London, 1930 (Hope-Simpson); Cmd. 3692, *Statement of Policy by His Britannic Majesty's Government in the United Kingdom, October 1930*, HMSO, London (Passfield); Government of Palestine, *First Report on Agricultural Development and Land Settlement in Palestine* by Lewis French, Jerusalem, 1931 (French Report); Cmd. 5479... (Peel).

³⁰ PRO, CO 733/208/9, 1931.

³¹ Ibid.

precise implications for the unlikely development of medical services for the Jewish and Arab communities along equal lines. The Zionist group continued in fact to expand its services and to develop autonomously thanks to the freedom that the British policy of decentralization had allowed to those who had the (cultural and financial) means to benefit from it. Instead, the Arab group became even more dependent upon the few resources and services offered by British and missionary systems.

The decentralization of health administration therefore worked against the often proclaimed adherence to the principle of the equal distribution of services to the different population groups. It also demonstrated the limits of the oft-repeated statement that the development of health (and education) along British lines would have led to the creation of a shared Arab-Jewish Palestinian identity.³²

c) *Legislation.* The British involvement in public health and their insistence on prevention was revealed most of all by the extraordinary high number of ordinances which were promulgated during the thirty years of British rule. This constant flurry of legislation was also repleted in other fields of administration, to the point that the "Arab press referred derisively to the Mandate government as a 'law factory'." During the first ten years of British rule, nearly as many laws were passed in Palestine as in the British parliament.³³

In 1925 alone the Annual Report of the GDH summarized the contents of that year's most important health ordinances. These ranged from the regulation of industrial conditions to the planning of towns and housing, from the compulsory registration of births and deaths to new regulations for the training of midwives, doctors, pharmacists, and dentists, from the practice of abortion and the medical conditions in which it was carried out, to the prohibition of cultivation, import, export or possession of hashish, opium or other "dangerous drugs."³⁴

³² M. Kolinsky, *Law, Order, and Riots in Mandatory Palestine, 1928-35*, Macmillan in association with King's College London, Basingstoke, 1993, p. 2.

³³ N. Shepherd, *Ploughing Sand...*, p. 74.

³⁴ PRO, CO 733/130/5, 1927, Health Department, *Annual Report 1925*.

This vast legislative work imposed a legal framework which did not respect the cultural and social differences between Arabs and Jews and was, therefore, unlikely to lead to equal social and political opportunities. The presence of a western administration which imposed its rules and legislated according to its own parameters, excluded those who did not suit the western standards it had set. This latter element in particular constituted a hindrance for the organization of medical services which could reflect the local culture and society's structure. During 1925 for example, a large number of applications had been received from the private doctors and midwives of some Arab areas applying to open small local clinics or nursing homes. Despite their importance for the development of a local dimension of health care, all the applications were rejected. They were in fact understood as representing "a retrograde step in the general improvement of the standard of hospital work which has taken place in Palestine."³⁵

The ordinances which focused on the adoption of strictly medical, hygienic or sanitary measures certainly played a crucial role in shaping the structure of the system. The connection between the organization of medical services, the administrative framework and the materialization of the Zionist national aspirations was however revealed by those ordinances which, already in the 1920s, had set the requirements for the allocation of resources. These pieces of legislation also contributed to promote the local dimension of medical work and to regulate the profession of medicine.

Both local autonomy and the allocation of resources were regulated in Palestine by four main ordinances: the 'Local Council Ordinance' (1921)³⁶, the 'Religious Communities Order in Council' (1922),³⁷ the 'Religious Communities Organisation Ordinance and Regulations' (1926)³⁸ and the 'Jewish Community Regulations' (1930).³⁹ The first ordinance sanctioned the right of each local community to levy and collect taxes for the organization of

³⁵ *Ibid.*

³⁶ PRO, CO 733/131/5.

³⁷ PRO, CO 733/136/4 and PRO, CO 733/136/5.

³⁸ PRO, CO 733/136/5.

³⁹ PRO, CO 733/241/14.

social services.⁴⁰ The following two ordinances derived a number of provisions from the *millet* system⁴¹ to extend the same right to each religious community that applied for such permission. Together with taxation came the right to political representation. The fourth ordinance gave statutory recognition to the Jewish administrative organs.

It was only the Jewish community which chose to avail itself of the right to organize a system of taxation for its members, in this way distancing itself from the Arab community. As a result of these ordinances, autonomous taxation for the organization of social services guaranteed the entry of funds for their maintenance. It also realized the local dimension of administration and it assured political representation. Where an administrative framework which went beyond the municipality existed, as in the Jewish case, the identification between religious and national community was immediate. This mechanism established a procedure whereby confessional recognition was given important political effect.

The British legislative work also had important consequences on the regulation of the medical profession. At the beginning of the 1930s pharmacy, medicine, dentistry and midwifery were all professions whose curriculum, access and exercise became regulated by specific ordinances. These changed not only the way in which some of these professions had been practiced for centuries, but also their social significance. The ordinance on midwifery, for example, established that midwives had to be able to speak both Arabic and Hebrew in order to receive a certificate to exercise their profession.⁴² That on pharmacists led to the progressive disappearance of the *suklaktarim*, those merchants who sold spices for various medical treatments and who played the

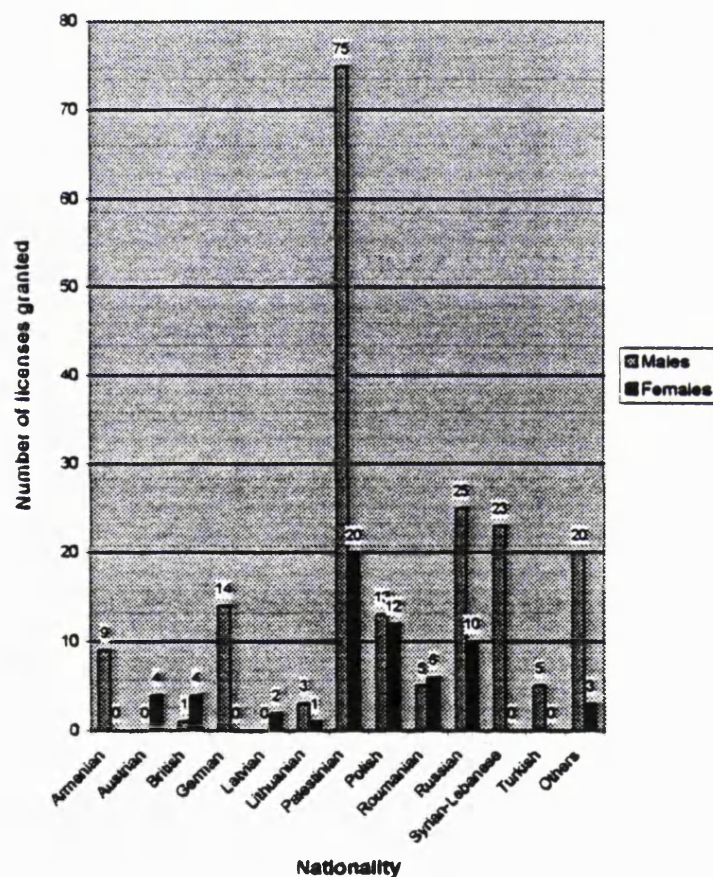
⁴⁰ The autonomous organization of social services was seen as one of the main instruments for the encouragement of self-government, one of the principles founding the mandatory system as expressed in art. 22 of the Covenant of the League of Nations. Health and education were considered crucial to create those much needed social and political improvements for "peoples not yet able to stand by themselves under the strenuous conditions of the modern world." The principles of the Covenant of the League of Nations can be found quoted in Cmd. 5479..., p. 29.

⁴¹ The *Millet* system was a combination of statutes and sets of laws which regulated the administrative, juridical and social relationship between the different non-Muslim religious communities and the central administration in the Ottoman Empire.

⁴² ISA, M 4/42 M 224.

role of the pharmacists in a pre-modern society.⁴³ A similar fate was that of those assistants to doctors who called themselves dentists and who had always been considered as such by the local population.⁴⁴ In this sense, the presence of a western government which emphasized the need to regulate most aspects of welfare and medical provision by legislation contributed to marginalize those local inhabitants who had represented, by means of their professions, a whole class of social intermediaries. Despite their progressive marginalization, midwifery and pharmacy were in 1935 two professions still in the hands of the Arab population, as the following charts demonstrate graphically.

2. Number of licenses by the Palestine Administration to male and female pharmacists prior to 1935.⁴⁵

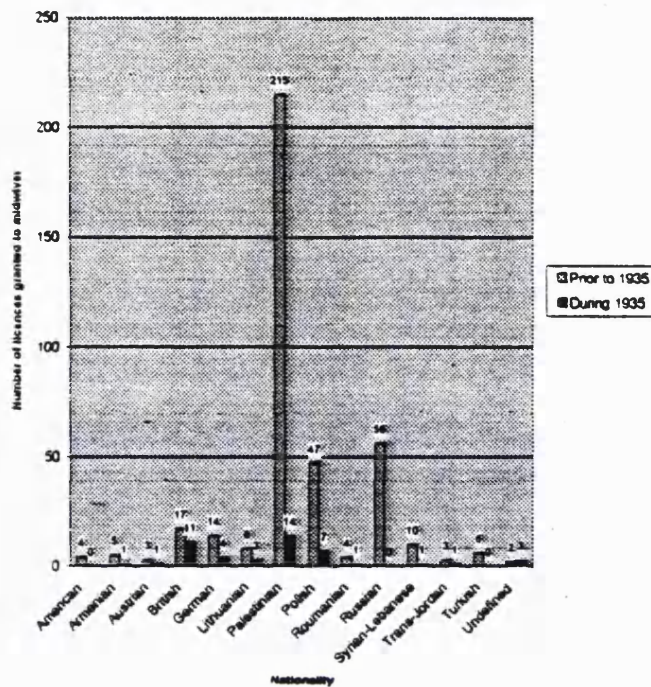


⁴³ The Public Health (Pharmacists) Ordinance (1921) and the Public Health (Pharmacists) amendment Ordinance, (1927) can be found in PRO, CO 733/144/12.

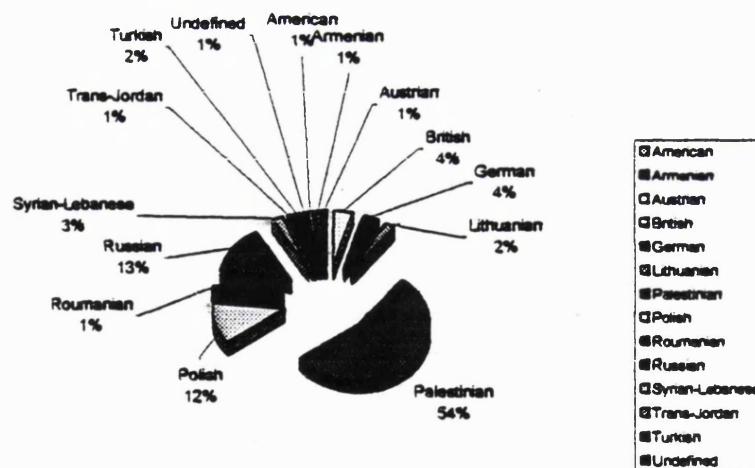
⁴⁴ Interview of the Author with Dr. Ibrahim Daqqaq, East Jerusalem, 12th April 1998

⁴⁵ Elaboration of data from GDH, *Annual Report for the year 1935*, Government Printing Press, Jerusalem, 1935.

3. Number of licenses granted to midwives
classified by nationality prior and during 1935.⁴⁶



4. Percentage of licenses granted by the Palestine Administration
to midwives prior to 1935 classified by nationality.⁴⁷



⁴⁶ Ibid.

⁴⁷ Ibid.

As the political situation considerably worsened during the 1930s, the British legislative work in public health also became one of the mirrors in which important aspects of the Arab-Zionist confrontation were reflected. The debate on the desirability of a law on compulsory health insurance for workers - one of the most important and long-waged battles of the *Histadrut* - was one example of the British ambivalent and shifting attitude towards the two communities. Supporting a health insurance scheme through an agency which protected the interests of the Jewish workers on this occasion was perceived as denying the same opportunity to Arab labourers. They did not in fact have a similar institution upon which to rely.⁴⁸ Such a proposal was therefore declined in 1929.⁴⁹ The British administration refused again the following year on financial grounds, although admitting the practical desirability of such a measure.⁵⁰ Another case was the amendment in 1935 of the Medical Practitioners Ordinance (1928) in a restrictive sense,⁵¹ when, following the so-called German *alyia* (1933),⁵² the number of Jewish physicians in Palestine had increased to the extent of representing a threat to the employment possibilities of the Arab ones.⁵³ The following chart illustrates graphically the situation before the coming in force of the above mentioned ordinance on physicians.

⁴⁸ S. Shvarts, "Health reform in Israel...", p. 77.

⁴⁹ PRO, CO 733/165/2.

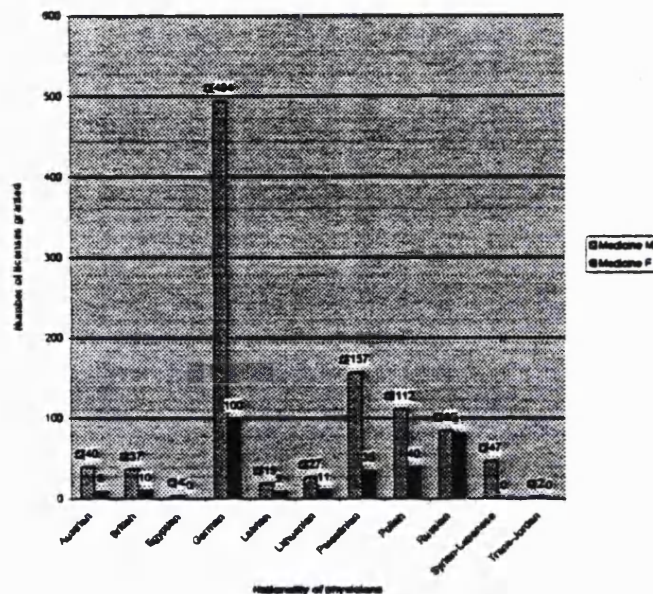
⁵⁰ PRO, CO 733/209/9 *Memorandum on health conditions in Palestine with proposals for essential reforms*, 1931.

⁵¹ PRO, CO 733/281/15, 26th January 1935. See also PRO, CO 733/301/4, 1936, "The position is that the Medical Practitioners (Amendment) Ordinance, 1935, provides *inter alia*, that the High Commissioner may on or before the 31st December in each year, by notice in the gazette, prescribe the maximum number of licenses to practice medicine which may be granted during the following year to persons who became Palestinian citizens or received permission to remain permanently in Palestine at any date subsequent to the 1st of December 1935. (...) The measure is designed to secure the medical profession in Palestine from further overcrowding and from the economic hardships and professional abuses to which such overcrowding must almost inevitably give rise." With the 1938 Amendment to the Medical Practitioners Ordinance (1935), the government further increased the restrictions upon candidates to enter the medical profession in Palestine. See PRO, CO 733/380/10, 1938. Also PRO, CO 733/375/3, 1938.

⁵² In 1933 the proportion of German Jewish immigrants to the total of Jewish immigration was 25 per cent, a rate which declined to 23 per cent in 1934 and to 13 per cent in 1935. The percentage rose again to 31 per cent in 1936. Jewish Joint Distribution Committee Archives, New York (henceforth JDC), 33/44 # 752. The General Council of the Jewish Community in Palestine. *Bulletin of the Department for Social Services*, n. 12 (July-September 1936), p. V, table 7. See also R. Gay, "Danke Schön, Herr Doktor. German Jews and Palestine", *The American Scholar*, Autumn 1989, pp. 567-577.

⁵³ Taking Jews alone in 1933 there was one Jewish doctor for every 245 Jews, at a time when there was only one Arab physician for every 3,779 clients. Colonial Office, Colonial n. 134, *Palestine Royal Commission, Minutes of Evidence Heard at Public Sessions*, London, 1937, p.

5. Number of licenses granted by the Palestine Administration to male and female doctors in 1935, by nationality⁵⁴



By the beginning of the 1930s, the British approach to medical provision and public health in Palestine was thus characterized by delegation – dictated primarily by economic necessity – limited but significant decentralization, and a plethora of legislation. By the mid-1930s, these three factors had already determined the structure of the system. They had also consolidated a process of division between the country's two main population groups from a practical, administrative, legal and cultural perspective. The system that emerged out of this framework also provided the Zionist group with the administrative and legal foundations to develop independently. It was in part thanks to this situation that the Zionist medical agencies could consolidate that process of networking which contributed to the strengthening of a civil society which was not free of nationalist aspirations.

326, evidence of Jamaal Bey El Hussein. During 1934 the number of persons licensed to practice medicine increased by almost 50 per cent. PRO, CO 733/281/15 and HDS, b. 32, f. 14, *Physicians in Palestine*, 1934. See also PRO, FO 371/16928, 1933.

⁵⁴ Elaboration of data from GDH, *Annual Report for the year 1935*...

2. The Zionist administrative structure of health provision.

Since the very beginning of its presence in Palestine, the British government had made clear that all the measures necessary for the establishment of the Jewish National Home had to be realized by the Jews themselves. "His Majesty's Government" in fact did not "regard their obligations under the Mandate as implying any financial obligation towards facilitating the establishment of the Jewish National Home."⁵⁵ The government intended to limit its role to removing the legislative impediments present in the Ottoman legislation and to providing the country with a legislative and administrative system appropriate to western standards. It intended to facilitate Jewish immigration according to the country's absorptive capacity; it would also encourage trade and industry through the introduction of particular customs and fiscal measures. The acquisition of land, the foundation of schools and universities and the establishment of a system of medical provision were however left for the Jewish institutions to organize. The Zionist administrative structure had originally been envisaged to respond to this approach.

The Zionist administrative system was the product of complex, historical growth. As a result, it was not as straight-forward as the British one. Several agencies and institutions often duplicated the functions one of the other. While the Jewish Agency represented Zionist interests with the British government,⁵⁶ a number of other Zionist institutions coordinated the Zionist social work and regulated its financial management. As the system grew more complex and structured, these coordinating agencies gradually detached themselves from British control, with the exception of those dealing with finance. These remained under British supervision until the end of the 1930s.

The Zionist administrative system took final shape at the end of the 1920s when the Jewish Agency (acting for the Jews of the world) was enlarged

⁵⁵ PRO, CO 733/130/5, 1927.

⁵⁶ Under art. 4 of the mandatory charter, the Jewish Agency had been recognized as "a public body for the purpose of advising and co-operating with the Administration of Palestine in such economic, social and other matters as may affect the establishment of the Jewish national home and the interests of the Jewish population in Palestine, and subject always to the control of the Administration, to assist and take part in the development of the country." Cmd. 5479..., p. 35.

to admit the representation of non-Zionist Jewish bodies in its ranks.⁵⁷ In March 1930 a number of items was transferred from the program of the Executive of the Jewish Agency to that of the Executive of the *Knesset Israel*, the assembly of the local communities (*kehillot*), acting for the Jews of Palestine.⁵⁸ This transfer was intended to separate economic undertakings and the "so called non-productive" ones.⁵⁹ After this date, the Agency continued to devote its attention to questions of immigration, colonization, labour, land and politics, industrial and commercial enterprises, credit institutions etc. The *Knesset Israel* took over from the Agency the provision of health and education and their administration with the aim of establishing a complete social service.⁶⁰

The institution connecting the periphery to the centre was therefore the *Knesset Israel*. This assembly in turn elected the *Vaad Leumi* (National Council). While the *Knesset Israel* represented Jewish interests locally, the *Vaad Leumi* had representative functions on a national scale. In 1930 the *Vaad Leumi* was sub-divided into committees, the *Vaad Ha-Briut* being the one for health.⁶¹ (See Appendix, Scheme n. 1)

⁵⁷ In retrospect, it can be argued that the enlargement of the Jewish Agency in 1929 constituted one of the greatest political advantages for the *Yishuv vis-à-vis* the Arab community. Considering the importance of that process whereby the images which the British government had of the two national groups contributed substantially to the direction of their policies in Palestine, the enlargement of the Jewish Agency represented that moment when "British politicians and civil servants" began to classify "the Jewish Agency as an institute promoting interest group rather than as the embodiment of a militant and fervid national movement." G. Sheffer, "The images of Arabs and Jews as a factor in British policy towards Palestine", *Studies in Zionism*, 1 (1), Spring 1980, pp. 105-128, p. 111.

⁵⁸ CZA, F 49/2868, H. Szold, *The future of women's work in Palestine*, May 1930 and PRO, CO 733/223/4, 1932.

⁵⁹ CZA, F 49/2868. It is worth in this context to note Henrietta Szold's strong opposition to the use of this term to designate "such tingling human activities as are conveyed by the headings health, education and the social service. (...) In connection with the Jewish National Home it is provocative of resentment."

⁶⁰ Ibid.

⁶¹ HDS, b. 56, f. 2, Editorial in *Davar*, 13th June 1936. "According to the plan accepted in Palestine, the Va'ad Habriuth was to consist of 7 members - two from the Jewish Agency, two from Hadassah and three from the Va'ad Leumi." A different version of the composition of the *Vaad ha-Briut* is given in RH, MSS Mss Brit. Emp. S 284, Chancellor, b. 11, f. 7, "There shall be an Advisory Board to be called the Vaad Habriuth associated with the Director. It shall be composed of seven members, of whom four shall be appointed by the Executive and two by the Vaad Leumi in consultation with each other, and the Director of the Kupat-Holim. (...) The Vaad Habriuth shall be consulted by the Director on all matters concerning negotiations with the Government and with outside institutions (medical, political and social) and concerning all action required by unforeseen circumstances such as epidemics, sanitary precautions etc. The Vaad Habriuth has only advisory and no executive powers."

Within this administrative framework, two medical associations – KH and the HMO – were in practice delegated the medical work which the GDH could neither organize nor maintain. Both KH and HMO were to grow and develop in the 1930s thanks to the British policy of decentralization and through an advancement of the idea of delegation.

Before turning to analyse how the British policies of decentralization and delegation were received and employed by the Zionist medical agencies for the advancement of their national aims, I will briefly introduce the main cultural traits of KH and of the HMO and their ideological and practical approaches to medical provision for the *yishuv*.

a) *Kupat Cholim and Hadassah Medical Organization*. These two agencies constituted the two main poles of medical provision in the history of the *yishuv* and, later, of the State of Israel. The beginning of the medical involvement of both can be traced back to the first decade of the 20th century. Their cultural backgrounds – as well as their development and organization in the following two decades – was however based on very different cultural models, work methodology and means of financing.

The origins of the idea and of the working method of KH⁶² derived from the 19th century German model of medical insurance for workers.⁶³ Those of HMO were rooted in the late 19th century American progressivism and in Jewish philanthropy.⁶⁴ The former organization was founded from the merger of three workers' sick funds: the Judea Workers' Health Fund (1913), the Galilee Workers' Health Fund (1915) and the Samaria Workers' Health Fund (1916). KH emerged therefore from a rural setting where it maintained the bulk of its activities in the following decades. HMO had been founded in 1918 following the experiences in Palestine of a group of American Jewish nurses in

⁶² For a history of KH see S. Schvarts, *The Workers' Health Fund ...*

⁶³ For a history of the German model of health provision, see D. Porter, *Health, Civilization and the State ...*, pp. 97-110.

⁶⁴ M. Waserman, "Henrietta Szold: American progressivism, Zionism and modern public health", in M. Waserman and S. Kottek, *Health and Disease...*, pp. 263-300.

1913⁶⁵ and of the American Zionist Medical Unit, (AZMU, 1918), a mission of physicians who arrived in the country immediately after the First World War.⁶⁶

These very different birthmarks influenced not only the ideological orientations and the ways in which the two organizations structured medical provision, but also affected the choice of the setting in which the HMO and KH conducted their work. While KH was ideologically and practically tied to the *Histadrut*, HMO worked as a foreign private agency operating for the health of the *yishuv*. The former concentrated on the needs of the rural workers, while the latter provided assistance to the urban population and to the poor, and specialized in the assistance to women and children. KH's work was mainly organized around the network of Jewish rural settlements, while HMO focused on the urban reality. The first operated until the mid-1930s through small clinics and dispensaries; the other had already begun by the mid-1920s to elaborate plans for larger projects - the foundation of hospitals in the larger centres (Tel Aviv, Jerusalem and Haifa) or the establishment of a comprehensive medical structure to be developed into the national medical centre for the *yishuv* (the Rothschild Hospital in Jerusalem). While both had a national aim in view, KH's dependence on the *Histadrut*'s ideological and political choices made its progress dependent on the latter's internal political struggles.⁶⁷

The inevitable rivalry which continued to oppose these two medical organizations in the first half of the 1930s, their endless competition for membership and for the limited resources available, shaped and favoured the development of services to the population. Consequently, it improved the

⁶⁵ The history of the famous first three nurses who arrived in Palestine from New York in 1913 has been constructed as one of the founding myths of the history of Hadassah and of medical provision for the *Yishuv*. The nurses were Rose Kaplan and Rachel Landy. The two were joined by Dr. Helena Kagan, a University of Geneva graduate. As a woman, she was not allowed to practice medicine under the Turkish rule. The three concentrated on mother and child care work.

⁶⁶ The involvement of the AZMU with the health of the *Yishuv* is analysed in M. Waserman, "Henrietta Szold...", pp. 278-280 and S. Schwarts, *The Workers' Health Fund...*, pp. 75-76. See also S. Sufian and S. Schwarts, "'Mission of Mercy' and the ship that came too late: American Jewish Medical relief to Palestine during World War I", in J. Targarona Borrás and A. Sáenz-Badillos, (eds.), *Jewish Studies at the Turn of the Twentieth Century*, Proceedings of the 6th EAJS Congress, Toledo, July 1998, Vol. II: Judaism from Renaissance to Modern Times, Brill, Leiden, Boston, Köln, 1999, pp. 380-389.

⁶⁷ Z. Sternhell, *The Founding Myths of Israel...* and S. Schwarts, *The Workers' Health Fund...*, pp. 249-290.

country's medical standards. It also contributed to the growth of their administrative autonomy and to their political and national awareness. In different ways, both the KH and the HMO could develop their work thanks to the favourable context offered to them by the British administrative policy between the end of the 1920s and the beginning of the 1930s. The following section will sketch Zionist administrative activity both in relation to the British government and to these two medical agencies.

b) Decentralization. The decentralization of medical services - as it had been imposed by the British government - favoured the autonomy of Zionist administration in a number of ways: it facilitated the development and the consolidation of a municipal and local dimension; it gave the possibility to the medical agencies to create the administrative structures which connected the local reality to the national framework; it encouraged their search for funding and its management. The sum of these elements led to the creation of an institutional network which, by the mid-1930s, constituted the administrative backbone of Zionist civil society. The communities represented its administrative centre. In September 1931 Henrietta Szold described some of the difficulties which the system still encountered:

The Knesset Israel is supposed to be constituted of *kehillot* (...) of which there could be about 120 in Palestine. The Vaad Leumi is only the Executive Committee. It is suspended in mid air so long as the *kehillot* are not organized in such manner as to levy taxes upon their constituencies and collect them. (...) The Vaad Leumi has no existence without organized *kehillot*.⁶⁸

The *kehillot* represented therefore not only the administrative and practical centre of this system, but also its economic heart. The *Vaad Leumi* had no revenues apart from those of the *kehillot*. Under the aforementioned administrative ordinances, they could in fact charge and collect taxes. Where these ordinances could be enforced - like in Tel Aviv (with Jaffa) and Petach Tikva for example - the communities were able to organize and maintain a municipal system of medical provision through specific financial agreements with either HMO, KH, or with both.

⁶⁸ M. Lowenthal, *Henrietta Szold. Life and Letters*, The Viking Press, New York, 1942, p. 227.

In the context of the competition between the two medical agencies, the *Vaad Ha-Briut* – the Department of Health of the *Vaad Leumi* –worked as a mediator and as a coordinating body for the health work of both. It was also recognized by both the medical agencies and by the *kehillot* as the only representative institution allowed to negotiate with the government in regard to the government's participation to health services. The *Vaad Ha-Briut* controlled the ways in which the government's grant to both KH and HMO was spent. For this purpose, it had representatives sitting on the management committees of the major hospitals, like those of Haifa and Tiberias.⁶⁹

While the British had granted substantial autonomy to the Zionist structures, questions of finance remained under strict British control. A scheme was negotiated for this purpose between the Jewish Agency and the government in 1930. This scheme operated at both a municipal and a national level. In the former case it gave the government control over the taxation rates of the *kehillot* through the local councils; it also established that larger local projects presented by *kehillot* would need the special approval of the District Commissioner. At a national level, the larger Zionist projects presented by the *Vaad Leumi* remained subject to the government's prior approval.

In this way two parallel systems of local and national administration grew side by side in the first half of the 1930s. The Zionist system remained dependant upon the British one because of the mandatory institutional framework; it also succeeded to develop its own autonomy by linking the local, the religious and the national dimensions of social work. This phenomenon was further reinforced by the ways in which the British policy of delegating to private institutions the provision of medical services was translated into practice by the Zionist medical institutions – and by the HMO in particular.

c) *Delegation*. The British policy of delegation left the Zionist medical agencies with no choice other than to provide for themselves. This approach ultimately favoured the embedding of Zionist work in society – as we shall see in chapter two. While the British government had made recourse to delegation

⁶⁹ HDS, b. 56, f. 4, Letter from H. Yassky to Mrs. Robert Szold, Jerusalem 5th April 1936.

because of shortage of means, the HMO expanded this British key administrative principle in a national direction. Having been delegated to provide medical services as a private agency, HMO decided in 1931 to transfer them to those municipalities which would be steadily connected to the Zionist administrative network. Their financial management should have also been sound enough to be able to continue the HMO's work autonomously.

With regard to the development of a programme of medical provision, already in 1927 the 15th Zionist Congress had suggested "the gradual transfer of complete units of activity to the local bodies of the Yishuv (municipalities, local communities etc.)."⁷⁰ In its suffocating dependence upon the *Histadrut* and upon its ideologically-oriented agenda, KH did not have the financial means, the administrative autonomy or the political will to inaugurate a policy of transfer of its medical structures and services to the municipalities. The HMO launched its scheme of transfer in 1931. Such a scheme envisaged the (Jewish) municipalities' gradual assumption of responsibility for the main hospitals which HMO had built and supported until then.

The HMO policy of transfer - or 'devolution' as it was called in 1931 - was conceived as an important instrument for achieving a fourfold result. Firstly, it aimed at strengthening the local administration. Secondly, this scheme was meant as a way to consolidate the *yishuv's* sense of responsibility and sense of national mission. In the third place, devolution would have favoured the eradication of the tradition of European philanthropy and charity (*haluka*). Hadassah had in fact refused it since the very beginning of its medical work in Palestine, considering it as humiliating.⁷¹ As founder of Hadassah and Director of the Department of Social Services of the *Vaad Leumi*, in 1936 Henrietta Szold wrote to the Jewish Joint Distribution

⁷⁰ HDS, b. 30, f. 1 *Material on reorganization of health work*. Congress Basle (1927) Resolutions.

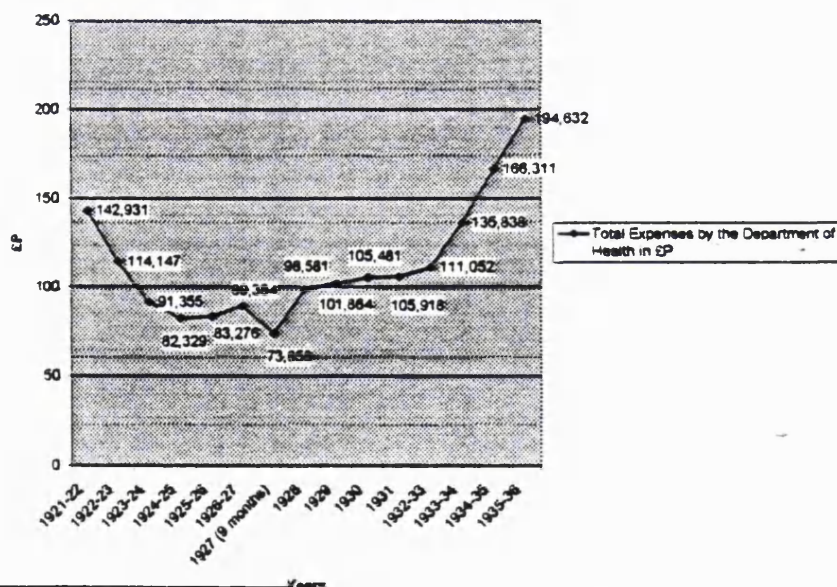
⁷¹ Basic medical provision and religious education had been maintained in Palestine for centuries through the donations of the European Jewish communities to resident Jews. Such practice had on the one hand generated dependency in the Palestinian *Yishuv*. On the other it had exacerbated the existing European patronizing attitude towards the Jews of the Old *Yishuv*. This mechanism was firmly rejected by Zionism for two reasons. Dependency upon European Jewish money would have hindered the process of nation-building, institution- and state-building. Secondly, Jewish philanthropy embodied that one aspect of Jewish bourgeois culture against which Zionism had represented a generational and intellectual rebellion. See D. J. Penslar, *Shylock's Children. Economics and Jewish Identity in Modern Europe*, Berkley, California University Press, 2001.

Committee (JDC), one of Hadassah's sponsors since its early beginnings. In her letter she emphasized the strong conceptual achievement which Hadassah had helped to bring in Palestine, the refusal of charity:

On the whole, our communal workers of the New Yishuv hold the opinion that it is the duty of the Jews in Palestine to care for their poor and helpless as is done in every healthy Jewish centre whose economic status has not been shattered. Moreover we regard every settler after a year's residence in Palestine, as a Palestinian, with the rights and privileges of a Palestinian.⁷²

Finally, the delegation of medical services to the Jewish municipalities had been conceived as an effective instrument to relieve the HMO from the financial burden of providing for most of the country's working medical structures. Hadassah had in fact already spent LP 1,340,000 on health and medical activities between 1918 and 1930. This sum was considered too burdensome by the US-based Hadassah headquarters,⁷³ especially if compared to the GDH's expenditure between 1921-22 and 1930. This only reached LP 893,822.⁷⁴ As the chart below shows, after this date the GDH's expenditure in health began to rise slowly.

6. Total Expenses by the Department of Health in EP (1921-1936)⁷⁵



⁷² JDC, AR 33/44 # 746, Palestine, general, letter from Henrietta Szold to the Chairman and Executive Committee of the JDC, 26th November 1936.

⁷³ HDS, b. 79, f. 8, Letter from H. Yassky to Col. Kish, 26th December 1930.

⁷⁴ Cmd. 5479..., p. 313.

⁷⁵ Elaboration of data from Colonial n. 133..., p. 137.

The complete devolution of the main HMO medical centres to the Jewish municipalities had been envisaged to take place within five years from its inception. Such transfer had been conceived as a gradual process, rather than as a direct or immediate hand-over. The administrative and political aspects of the transfer policy were in fact connected to an inescapable financial dimension which really dictated its pace throughout the 1930s. Speaking at a meeting of women in 1930 Henrietta Szold outlined the main traits of the mechanism of devolution.

For instance, recently Hadassah has taken the first step towards executing its long-considered plan of transferring its hospitals in Tel Aviv and Haifa to the Jewish communities in those two cities. From the beginning of the next fiscal year they are expected to increase their participation in the financial support of the institutions up to a fixed percentage and to assume responsibility for their management to a degree corresponding with their money contributions. In the course of five years the process of transfer should be completed and the Hadassah Medical Organization withdraw entirely from their administration. The Government of Palestine has been invited to take part in the negotiations with a view to its accepting just a share in the maintenance of these hospitals.⁷⁶

However, under the pressure of the Treasury, the government had at this stage confirmed the principle that private institutions had to pay their way.

Throughout this period the relationship between the HMO, the GDH and the Zionist administrative institutions - marked by continuous arguments over resources allocation⁷⁷ - was primarily concerned with the degree of financial participation of the different parts. If the HMO was to decrease its participation in the management of its medical centres, it was putting pressure on the government to supply temporarily the funds needed until the *Knesset*

⁷⁶ CZA, F 49/2868, Henrietta Szold, *The future of women's work in Palestine*, Jerusalem, May 1930.

⁷⁷ The Jewish Palestinian press did not miss the opportunity to report on such arguments. See HDS, b. 49, f. 8, [n.a.], "Domination of Government over Tel Aviv hospital", *Davar*, 30th November 1932. "It appears that Mr. Heron, who is responsible for the public health work and therefore for these very queer terms is a very good merchant: for the small sum of LP 2,500 he has decided to acquire for this Department an institution which was established and strengthened and fostered and reared for many years by others, an institution whose maintenance cost other bodies the sum of LP 16,000 a year. And this would be a very good transaction indeed, one which Mr. Heron could boast of if... if there were any hopes of his being able to make the purchase. For the institutions of Tel Aviv are not for sale."

Israel would find the means to enter the scheme. Instead, the government agreed instead only to take responsibility through participating in the hospitals' administrative committees.

Funding from abroad was in this context a necessity which went beyond Hadassah's ideological stand against Jewish foreign charity.⁷⁸ The collection of funds from Hadassah's US chapters and from the *Keren Ha-Yesod* – the World Zionist Organization's financial organization – could in fact be presented under a new light and justified for national purposes. Their mobilization ultimately saved the autonomy of both the medical services and that of the municipalities.

Convinced of the necessity of rendering autonomous and self-supporting each municipality at an individual level, and the *Knesset Israel* as a collective, Henrietta Szold proposed that the same sum collected in the first year by the *Keren Ha-Yesod* should be collected in the following years by the *Knesseth Israel*. Writing to the national president of Hadassah, she explained:

All those who are interested in the Knesseth Israel plan are convinced that unless it expressed itself through the financial support of communal interests, it will remain a hollow shell. (...) The point I wish to stress is that, assuming the responsibility for financial management in the above sense, the Knesseth Israel is afforded the indispensable basis for normal growth.⁷⁹

The budget collected outside would be diminished in the measure to which the taxing powers of the *Knesset Israel* enabled it to enlarge its contributions over and above the receipts from the *yishuv*. Such an arrangement would have continued until the *Knesset Israel* had covered the whole cost.⁸⁰

However, in 1931 the *kehillot* were not yet organized to levy and collect taxes; elections⁸¹ for the Haifa community had still to take place in

⁷⁸ HDS, b. 56, f. 3, Letter from H. Szold to the members of the Agency Executive, 15th February 1930, "I cannot agree with Mr. Sacher that there is no cause for dismay in the prospect of an appeal for funds direct from the Knesseth Israel to the Diaspora. I deprecate such an arrangement because it is bound to interfere with the success on the Keren Ha-Yesod collections and because it would derogate from the dignity we all want the Knesseth Israel to possess."

⁷⁹ HDS, b. 56, f. 4 Letter from Henrietta Szold to Mrs. Edward Jacobs, Jerusalem 28th April 1931.

⁸⁰ HDS, b. 56, f. 3, Letter from Henrietta Szold to the members of the Agency Executive, 15th February 1930.

⁸¹ Municipal councils were elected according to the proportional representation of the different communities. In the case of mixed populations, provision was made for separate community

September 1931 and those for Jerusalem were scheduled for "somewhat later, the exact date not being fixed."⁸² Despite this slow beginning, this process of devolution consolidated the various communities' political awareness of being independent centres of Zionist political power, particularly in Tel Aviv, Haifa and Tiberias.

The first three HMO hospitals to be municipalized in 1930 were those of Tel Aviv, Haifa and Tiberias. The proportion to which the government, the *Knesset Israel*, the *kehillot* individually and the Zionist fund-raising foreign institutions contributed to these three processes varied greatly. A sharing of costs and responsibilities between Jewish institutions, the government and the municipality had for example led to the municipalization of the Tel Aviv hospital in March 1930.⁸³ The municipalization of the HMO hospital in Haifa could be realized only after the HMO threatened to close the Haifa hospital if the municipality would not assume its share of responsibility.⁸⁴ The donation of LP 3,500 by the 16th Zionist Congress saved in this case the interim phase of the transfer.⁸⁵ The municipalization of the Tiberias Schweitzer hospital was the result of prolonged negotiations which saw the HMO continuing its financial support to this small centre until 1935, with the symbolic financial participation of the other parties.⁸⁶

The towns of Tiberias, Haifa and Tel Aviv were different in size, in the composition of their population, in their commercial and strategic roles.⁸⁷ However, in all of them the municipalization of public health and of medical

registers. The government then allotted the number of members to be elected in proportion to the number of persons on different registers. In PRO, CO 733/131/5 *Annual Report 1926, Submission to PMC*, and PRO, CO 733/134/12.

⁸² HDS, b. 56, f. 4, Letter from H. Szold to Mrs. Edward Jacobs, 28th August 1931.

⁸³ PRO, CO 733/223/4, 1932.

⁸⁴ HDS, b. 30, f. 9, *Vaad Habriuth on Haifa hospital building*, 6th March 1930. "Should the Haifa Community Council not furnish its share of the building fund by the date designated by Hadassah Medical Organization, the latter will close the hospital. On the other hand, should Haifa community find it possible to contribute more than LP 5,000 toward the building fund, the Hadassah Medical Organization ought to suggest to the Joint Hospital Committee in America that it increase its grant in a suitable degree, so to make possible the carrying out of the full program to the largest extent possible."

⁸⁵ *Ibid.*, Letter from Deputy Director Haifa to HMO, 13th March 1930.

⁸⁶ HDS, b. 30, f. 13, *Memorandum of conversation between H.M.O. Administration (Dr. Yassky and Dr. Bromberg) with the Mayor of Tiberias*, 20th October, 1930 and *Ibid.*, Letter from Tiberias Hospital Committee to HMO, 8th August 1930.

⁸⁷ On Tel Aviv see J. Schlör, *Tel Aviv. From Dream to City...*

services represented the first step and a major means for the progressive autonomy of their municipalities. Despite the different ways in which the process of municipalization was achieved, the history of hospital management in these three towns also indicated the greater sophistication, political determination and financial availability of the Zionist medical institutions *vis-à-vis* the GDH.

A comparison between the two not only reveals the different political aims behind their work. It also illustrates and denounces how hospital construction and management remained a bare administrative duty for the British government. For the Zionist group the same duty encompassed - in the words of sociologist B. S. Turner - "many of the most fundamental processes of industrial society, namely urbanization, secularization, the dominance of professional power, and the development of the service factor."⁸⁸

With the implementation of its devolution policy, Hadassah embodied and exemplified the idea that administrative practice represents the long-term objective of a nation, more than any form of political power. Within fourteen years of its presence in the country (1916-1930), the HMO had almost succeeded in turning the Jewish municipalities into autonomous managers of their curative health institutions, to a great extent financially independent from British sources. Within twenty years (1936), preventive health care as well had become part of that programme of devolution which saw the Jewish administrative bodies become the new repositories of decentralized political power. This would have never been possible had the British government not encouraged local administration, viewing the autonomy of the municipalities as an important tool and as the first step for the promotion of self-government in Palestine.

The events which in the mid-1930s altered the international and the domestic scenario, precipitated the Palestinian political situation but did not bring substantial changes to the British administrative framework, at least as regards medical work. They modified instead the way in which services were

⁸⁸ B. S. Turner, *Medical Power...*, p. 157.

provided by those private medical agencies which had been delegated this work. If the British administration of health remained in fact substantially unchanged, the Zionist path towards autonomy became even more patently a process at the service of the national cause. This process culminated with the take over by the private (Zionist) medical agencies of the public (British) service in both public health and medical provision. This new situation carried important consequences for the consolidation of Zionist civil society in its path towards statehood from an administrative point of view.

3. *The beginning of the British (administrative) surrender after 1935.*

1935 has been aptly defined as "the last year of peace in Palestine."⁸⁹ The Italian invasion of Ethiopia in October of the same year and the outbreak of the Great Arab Revolt of April 1936 irrecoverably shook the British confidence in the strategy they had pursued since the beginning of the 1920s both inside Palestine and in the Mediterranean.⁹⁰ The Italian conquest had given rise to doubts "as to whether Britain retained either the capacity, or even the determination, to defend her predominant position in the region."⁹¹ The start of the longest and most important Arab revolt in Palestine until the First *Intifada* (1987),⁹² threw the country into a state of unremitting unrest for the following three years.

In order to confront this new situation, the British government increased its investments in security and further reduced the already scarce funds it had set aside for the development of medical services and education. Reliance upon private institutions became in this context even more extensive, while involvement in public health decreased in scope and size. In 1935 the British government completed a disinfecting station in Haifa, selected a site for the construction of a hospital in Ramle, and planned the construction of the

⁸⁹ M. Kolinsky, *Law, Order...*, p. xiv.

⁹⁰ D. Omissi, "The Mediterranean and the Middle East in British Global Strategy, 1935-39", in M. J. Cohen and M. Kolinsky (eds.), *Britain and the Middle East...*, pp. 3-20.

⁹¹ M. J. Cohen, "British Strategy in the Middle East in the Wake of the Abyssinian Crisis, 1936-39", in M. J. Cohen and M. Kolinsky (eds.), *Britain and the Middle East...*, pp. 21-40, p. 24; see also R. Quartararo, "L'altra faccia...", pp. 759-820.

⁹² K. W. Stein, "The Intifada and the 1936-39 Uprising: A comparison", *Journal of Palestine Studies*, 19 (4), Summer 1990, pp. 64-85.

long-awaited mental hospital in Jerusalem (which never came into being).⁹³ In 1936 it improved a scheme already devised in 1933 to supply Jerusalem with clean water.⁹⁴ There are many other examples of such decline in the British involvement in public health.⁹⁵ They all, however, demonstrate how British work became complementary - and not instigatory - of health work. This continued to be carried out by private medical agencies.

These new conditions opened the way for Zionist administrative institutions to assume responsibility also for measures of public health, thereby expanding their administrative autonomy from the municipal to the national dimension. By the end of the decade, the management of medical provision and public health became one of the fields which led Zionist agencies to become national institutions, both in the perception of the population and in the consideration of the government. This element was also remarked upon by the Peel Commission (1937). I will now turn to analyse the final steps of this administrative emancipation to verify how the Zionist health structure became national and public at the same time, albeit exclusively on religious and political grounds.

a) The Zionist administrative network from municipality to nation.

Until 1934 the *Knesset Israel* as a unitary body was not yet financially able to cover the expenses of its own medical budget.⁹⁶ Still in 1936 the municipality of Jerusalem could not afford any contribution either for schools, medical or social services. Jaffa-Tel Aviv still needed Hadassah's subsidies, while Haifa was then the only municipality which could afford the burden of maintaining a large hospital.⁹⁷ The *kehillot* had therefore to participate individually - rather than collectively - in the maintenance of the medical institutions which the

⁹³ MEC, Forster-Turner.

⁹⁴ PRO, CO 733/240/9, *Report to the PMC*, 23rd session, 1933, p. 115.

⁹⁵ PRO CO 733/392/16, 1939. *Annual Report Department of Health, 1937*. Public works in 1937 focused on the containment of malaria. They comprized the drainage of the river Falik, a special scheme for the Lake Tiberias, minor anti-malaria work to protect the military camp near Natanya and the recurrent clearance of rivers and streams.

⁹⁶ HDS, b. 56, f. 4, *Memorandum on Hadassah-Vaad Leumi Relations*, 19th April 1934.

⁹⁷ *Ibid.*, Meeting of the Vaad Leumi Executive and the HMO Administration, 10th August 1936.

HMO continued to transfer to them.

This difficult context forced the HMO to confront the *yishuv's* growing adverse criticism of its management of health. After two decades of financial battles with the government, of political controversies with other Zionist bodies and of administrative compromises, the HMO believed it was now time to leave unsupervised the complex system it had contributed so extensively to create, without however withdrawing from medical work altogether.

In 1936 the HMO adopted the role of a private agency working for the welfare of the *yishuv*. Beginning from October it started the transfer of all preventive and public health activities to the one Zionist institution elected nationally by the communities.⁹⁸ Starting from this date,

the Vaad Leumi shall assume complete responsibility for the maintenance budget of these activities; the school hygiene service, the Anti-trachoma service and the health welfare centers (including pre-natal care, infant welfare and the care of the pre-school child) throughout the country.⁹⁹

In the same way as municipalities had represented the key institutions to promote the autonomous management of medical work on a local base at the beginning of the decade, the *Vaad Leumi* was now recognized as that representative body which could take over the management of public health in a national perspective. The technical and financial aspects of this second devolution were to follow the method already experimented with during the devolution of medical services to the municipalities. However, the difficulties encountered back then suggested that HMO should set a slower pace for the transfer and should demand smaller contributions. This policy was adopted for example with the 'Central Department for Preventive Medicine of the Knesseth Israel', one of the main institutions of the HMO's network of public health.¹⁰⁰

⁹⁸ HDS, b. 56, f. 5. The transfer policy was approved at the 22nd Annual Convention of Hadassah held in Philadelphia between the 18th and the 21st October 1936.

⁹⁹ Ibid., Draft agreement between the administration of the HMO and the one part of the Executive of the Vaad Leumi of the Knesseth Israel, July 1935.

¹⁰⁰ Ibid., 21st July 1935, "Hadassah's share in the budget of the Central Department for Preventive Medicine would be fixed only up to the end of '37-'38 fiscal year. As against this, Hadassah's participation for '36-'37 would be decreased only by 10% compared to the '34-'35 participation. (...) In 1937-38 Hadassah's participation would be reduced of another 12% with the same conditions."

In 1936 Dr. Jack I. Kligler – chairman of the *Vaad ha-Briut* - explained the ideal foundations of HMO's new course:

After all it is not only the function of Hadassah to establish activities. It is our duty to train the youth to carry on these activities and to assist it to carry the responsibility by degrees. As a Zionist body, you owe this to Palestine.¹⁰¹

By re-defining in such a way its own function in Palestine, Hadassah also contributed to the emergence of KH from the financial and practical subjection in which it had remained until then. It also favoured its expansion. By the mid-1930s these two medical agencies had also begun to overcome their mutual rivalry, with important results for both the advancement of health care in the country and for its acquiring an even more defined national dimension. By 1934-35 KH had started to catch up with the HMO's width of services and territorial coverage. In 1935 the first practical steps were taken by both agencies to conduct joint work in public health in the Sharon and Judea areas.

Incorporating the rural dimension – represented by the work of KH - into the administrative framework which represented the first skeleton of Jewish autonomy in Palestine had numerous and important consequences. First of all the Zionist administrative system could now follow the British subdivision in districts, extending its control from the municipalities to much larger areas. Secondly, if the history and destiny of KH was tied to that of the *Histadrut*, the HMO's withdrawal allowed the Workers' Union to enter the field of medical provision with the same functions of national coordination it had already displayed in other areas: labour, banking (*Bank Ha-Poalim*), the building sector (*Solel Bone*), the food industry (*Tnuva*) etc. Lastly, the devolution of preventive services to the *Vaad Leumi* allowed HMO to remain in Palestine as a medical agency with less administrative and political responsibilities but with more funds available for "other aspects of medical work in Palestine." The new priorities therefore became strengthening medical institutions as national reference points for the *yishuv* (starting from the Hadassah-University Hospital in Jerusalem). The HMO could now dispose of more funds to develop national health and social programmes targeted at

¹⁰¹ HDS, b. 56, f. 6, Letter from Dr. I. Kligler to Mrs [Rose] Edward Jacobs, Hadassah NY, 15th April 1936.

specific categories - women, children, Mizrahi Jews, young offenders, refugee children¹⁰² - or aimed to eradicate specific diseases - trachoma, venereal diseases among the others.¹⁰³

From 1930 onwards, Hadassah had been in search of the "ideal public health administration."¹⁰⁴ The transfer of preventive medical activities embodied the last stage of Hadassah's quest. It was now the *yishuv* as a whole, both as a network of institutions and as a community of individuals, which had the full financial and political responsibility of its preventive and curative medical activities.

When the Peel Commission arrived in Palestine to investigate the reasons for the outbreak of the 1936 riots, it identified in the existence of these two parallel systems of administration grown out of the organization of social services, one of the main causes for the separation between the Arab and the Jewish religious and national communities. After months of hearings and interviews, it reached the conclusion that a Jewish-Arab coexistence was impossible. Territorial partition was suggested as the only solution. Jerusalem would remain an international city under British control.¹⁰⁵

b) *The Peel Commission on administration and health.* The Peel Commission Report stands out as one of the most complete contemporary studies written on Mandatory Palestine.¹⁰⁶ Notwithstanding the commission's

¹⁰² One of the most important activities developed by the HMO after 1933 was the program 'Youth Aliya' to help the escape of Jewish children from Germany to Palestine. Some of its aspects have been analysed by A. J. Edelheit. *The Yishuv in the Shadow of the Holocaust. Zionist Politics and Rescue Aliya, 1933-1939*, Westview Press, Boulder, 1996. In his work Donald Miller dealt extensively with this subject. In particular he quotes as a source of great interest an unpublished manuscript (Z. Harman, *Youth Aliyah*, vol. I, 1945). This manuscript reproduces all the letters of Henrietta Szold on the subject for the period 1934-1944. D. Miller, *A History of Hadassah 1912-1935*, Unpublished Ph.D. thesis, New York University, New York, 1968, pp 314-322.

¹⁰³ HDS, b. 56, f. 5, 21st July 1935

¹⁰⁴ HDS, f. 56, b. 2, 1936.

¹⁰⁵ I. Black, "A judgement of Solomon that could not save Palestine", *The Guardian*, 7 July 1987.

¹⁰⁶ Other analyses were written while the Mandate was still in force. See J. Stoyanovsky, *Mandate for Palestine* Longmans & Co., London, 1928. This remains one of the most painstaking juridical examinations and comprehensive analyses of the Mandate text. See also

evident self-serving aim - at a time when both the CO¹⁰⁷ and the British government in Jerusalem were ready to resign the Mandate - this document was applauded as "a great literary work of art"¹⁰⁸ when it was published in July 1937. For the first time, political analysis was here flanked with an investigation of the country's administrative system and integrated into an analysis of social policies.

The study of the Palestinian educational system weighed considerably on the decision to indicate partition as the only possible solution for the coexistence of Arabs and Jews.¹⁰⁹ The hearings of medical officers, of representatives of the Zionist organizations and of Arab physicians - together with an analysis of statistical data and surveys - played however an equally important role in orienting the commission's judgement.

As in education, so in medical provision, an analysis of both figures and of cultural attitudes indicated the existence of a large gap in the availability of services to the two population-groups. The standards of provision were different and the administrative framework through which they were dispensed was also unequal. The parallel between health and education was however not limited to these elements. It was also apparent in the political processes they had been able to trigger: the link of the local dimension to the national framework and the definition of the religious communities as national entities. Both health and education had been at the centre of the process of institution-building for the only population group whose social agencies were rooted to the territory's new administrative framework. For the Zionist group in fact health and education could be developed locally within each municipality; the

H. J. Simson, *British Rule and Rebellion*, Blackwood and Sons, Edinburgh and London, 1937. For the vast number of memoirs and recollections written by some British administrators, see my comments in the introduction, part four.

¹⁰⁷ After 1936 the FO became increasingly involved in the administration of Palestine. As a result, the CO changed its approach. While the latter had, until then, encouraged the formation of local moderate national movements, the FO - fearing their aggressivity - preferred to encourage a pan-Arab movement. G. Sheffer, "The image of Arab and Jews ...", pp. 127-128.

¹⁰⁸ A. S. Klieman (ed.), *The Rise of Israel, The Royal Commission Report, 1937*, Garland Publishing, New York and London, 1987, [n.p. in the Introduction]

¹⁰⁹ Cmd. 5479..., pp. 340-344. "We were informed that, common though interracial friendships are in school days, they often fail to survive the passage into adult life. The segregation of the races and the pressure of home influence both operate powerfully on the side of nationalism. (...) Meanwhile the educational outlook, determined as it is by Art. 15 is disquieting. The existing Arab and Jewish school systems are definitely widening and will continue to widen the gulf between the races."

two sub-committees of the *Vaad Leumi* – the *Vaad Ha-Briut* for health and the *Vaad ha-Hinuch* for education – had functions of national coordination. For the Arab group there was no similar administrative framework to provide for the medical or educational needs of the population in such a decentralized and autonomous way.

The role played by this administrative framework in splitting the country's population along national and religious lines was acknowledged by the commission.¹¹⁰ The commission, however, also took into consideration the practice which had developed out of this system. Concluding their section on medical provision, the commissioners commented:

The division between Jews and Arabs is markedly shown in hospital services. The non-Jewish hospitals and clinics maintained by religious and missionary bodies are open to all communities. Before the War the bulk of those treated at them were Arabs and since the War this has continued to be the case. Jews are reluctant to go to hospitals where there are Arab patients and conversely few Arabs now, save in exceptional circumstances, go to Jewish institutions.¹¹¹

The space given to the analysis of public health and medical provision is not particularly extensive in the commission's report, especially if compared to other issues, like education, administration, local government or the history of Palestine. The minutes of evidence, however, reveal the number of political and national implications which the organization of medical provision was acknowledged to carry.

Henrietta Szold, Dr. Kligler and Dr. Avraham Katzenelson - in charge of health matters in the Executive of the *Vaad Leumi* - provided the three main testimonies called to explain the Zionist perspective on such developments. In their interviews they detailed their numerous grievances, explaining how low government spending in social services – and in health in particular - could contribute to widen the gap between the Arab and the Jewish communities.

Low government spending represented the weakest element of the whole British system; since 1933 the government had further reduced its financial contribution to the Zionist medical institutions. Such policy was

¹¹⁰ Cmd 5479..., pp. 357-362.

¹¹¹ Ibid., pp. 313-314.

perceived as unjust and unjustified in the context of the *Vaad Leumi's* assumption of responsibility for the HMO's system of public health on a national scale in 1936. It appeared even more unfair in view of the enormous pressure which the riots had put on the Zionist medical system. Moreover, as political conditions deteriorated, the Zionist organizations - and HMO in particular - had increased their financial engagement in medical and social work.¹¹² Whilst acknowledging such efforts, the Peel Commission used the pages of the report to justify the government's policy, even when, because of the riots, the British government had reduced its own budget for work in the social sphere.¹¹³ Interviewed by the commissioners, Henrietta Szold - then Director of the Social Services Department of the *Vaad Leumi* - summarized the opposed approaches which these financial lines entailed:

If one asks the question, which is preferable, security or these services, my answer in part is that whilst security, of course, is a primary requisite, it also contributes to security to have those services of an educational, social and medical character spread over larger portions of the community with a lower cultural level.¹¹⁴

With her words Henrietta Szold pointed at one of the greatest misunderstandings of the British policy in Palestine: mistaking security for military control. The Zionist social services - organized on the principle of integration between the administrative, political and social spheres - were in this way presented as the workable alternative to the British system. The *Vaad Leumi's* representatives presented the Zionist social work as that element

¹¹² CZA, F 49/2872 *Hadassah Reports for the year's work* [1936]. Hadassah's report for 1936 showed a phenomenal increase in strength and achievements. In the same year "American Jewish women showed their moral and practical support by enrolling 12,000 new members and raising large funds for their Palestine projects." \$ 34,000 were allocated to Hadassah's non medical activities. \$ 750,000 were sent to Palestine by Hadassah NY "for the year 1936-37 to meet its specific medical obligations." This sum was divided as follows: \$ 215,000 were allocated for the regular medical work which included: hospitalisation, school hygiene, infant welfare etc., \$ 315,000 were spent for the building of the Rothschild-Hadassah-University hospital and for the School of Nursing on Mount Scopus. \$ 136,854 were spent in connection to the relief activities of Youth Alyia. \$ 15,000 contributed to the construction of buildings at Kfar Noar Dati and Kfar Hassidim. \$34,000 was reserved for Hadassah's non-medical activities administered by the Palestine Council of Hadassah. The remaining \$ 10,000 were spent by Hadassah for playgrounds and recreational activities as the administrator of the Bertha Guggenheimer Playground Fund.

¹¹³ PRO, CO 733/301/2, 1936; PRO, CO 733/392/16, 1939, Letter from Harold MacMichael to Malcolm Mac Donald, 14th April 1940; see also HDS, b. 56, f. 6, Letter from Rose L. Halperin to Mrs. Robert Szold, 18th August 1938.

¹¹⁴ Colonial n. 134..., p. 210, 28th December 1936.

which had allowed the transformation of the Zionist movement into a nationally organized community.

The Peel Commission demonstrated for the first time that the promotion of self-government and the creation of a decentralized system of administration could not produce conditions of equality in mandatory Palestine. Only one of the two population groups had in fact the financial and cultural means to connect administration to the territory locally. It was again only the Zionist group which was able to establish a link between population, its social organization and its ideology on a national scale. In this context, the organization of health and education – the two factors which were expected to lead to the two communities' self government – were identified as responsible for having triggered that administrative mechanism which had led to their progressive separation.

The successive step of the Zionist medical agencies – their turning from private into public bodies – represented just the natural consequence of this situation.

c) *From private to public.* From 1937 onwards the Zionist private health structure was turned into the country's public system of medical provision, while the British one began to work in its shadow. This change represented the crowning effort of the Zionist medical work in Palestine and the achievement of its complete financial, administrative and political autonomy.

Such a result was the outcome of a decade-long process which had begun with the indications of the already mentioned 15th Zionist Congress in 1927. The ways in which this transformation was to take place had been extensively discussed inside the *Vaad Ha-Briut* already in 1933.¹¹⁵ The HMO's two phases of devolution could retrospectively be seen as stages of this process. The gradual and consistent reduction of the British financial participation in the Zionist system of medical provision and public health throughout the decade - culminating with the cuts of 1936 - only accelerated

¹¹⁵ HDS, b. 56, f. 5, *Vaad Habriuth*, Minutes of meeting held on 12th December 1934.

the pace of this process. As the relationship between the British and the Zionist institutions became more antagonistic during the riots and during the interim phase of the HMO's second devolution, a series of negotiations between the GDH, the HMO and the *Vaad Leumi* sanctioned the end of British financial control over Zionist institutions. By 1937 the conversion from private to public was concluded with the almost complete disengagement of the Zionist health system from British control.

This highly relevant development was sparked off by an apparently minor controversy on the standards of medical provision which had poisoned the relationship between the two sides throughout the whole decade. The British government could not tolerate the Zionist standards, "higher than in any European country," their ratio of doctors to patients,¹¹⁶ their excessive number of beds in Jewish hospitals and, most of all, the financial contributions which they continued to ask to maintain such system. Both the Treasury and the CO considered them too high and too expensive to maintain. Already in 1932 the CO had explained:

One cannot but feel considerable sympathy for the Jewish organisations which have done such excellent health work in Palestine and now find themselves financially strained. (...) I think, however, that we are fully justified in our present policy of economy. In the first place, there seems little doubt that the Jews, in the first enthusiasm of the National Movement, started their health organisation, as well as other institutions, on too lavish a scale, hence, both capital and maintenance costs have been unduly high, and it is inevitable that some lowering in the standard must now take place.¹¹⁷

In the first half of the 1930s the Treasury began to exert an increasing influence on the British administration in Palestine. In 1932 the Treasury had decided to strongly resist any proposal for new capital work. Its general attitude was that "the capital equipment of Palestine must be kept as far as possible within the power of the country to pay for it."¹¹⁸ As a result of its directives, from 1933 the GDH's financial participation in the Zionist medical

¹¹⁶ HDS, b. 33, f. 3, Report 185 from *Davar*, 10th May 1934. "While in Switzerland there was one physician to every 3,000 of the population, in France to every 1,700, in England to every 1,300 and in Austria (owing to the large number of physicians) to every 700, the ratio of the Jewish community of Palestine was 1 to 226 souls."

¹¹⁷ PRO, CO 733/223/4, 1932, minutes.

¹¹⁸ *Ibid.*

work became more fragmented. The government believed in fact it should discourage the Zionist institutions from maintaining their system on the standards and scale that "the Jewish community in Palestine itself can never hope to maintain."¹¹⁹ From this date onwards, the GDH offered financial help only to the Zionist hospitals or medical centres which extended those services the government had committed itself to provide, but had never succeeded in so doing. In 1933 the Emek Hospital (KH) received LP 3,000, the tuberculosis hospital in Safad (HMO) received LP 1,700 for maintenance purposes, the school for ophthalmic services of the Jewish Agency was assigned LP 1,500 and LP 500 were given for the maintenance of the Jewish Agency's infant welfare services.¹²⁰ The British financial participation for the following years became subject to the lowering of the Zionist standards.

If an appearance of equality had to be maintained in the subventions made to the Jews and to the Arabs, the cost of maintaining a public health service for the Arab population with the same standards offered by the Zionist medical agencies would have been absolutely prohibitive, reaching LP 1 ½ million.¹²¹

Heron ultimately considered the Zionist medical agencies to be responsible for the British failure to provide equally for different population groups. The very existence of the Zionist medical agencies, their modern equipment, the qualification of their staff and their new hospitals were all elements that made the difference between the British and the Zionist systems tangible in the geography of the land and in the perception of the population.

In 1932 the question of the standards of medical provision had been at the centre of an exchange between Heron and Chaim Yassky - the Director of the HMO in Palestine. One of their conversations was reported and summarized at the Hadassah headquarters in New York.

Dr. Yassky: We have been discussing the question of standards for a long time, but after all, it is important to realize that the population consists in two parts that will go on living for many years in accordance with two distinct standards. Does not think that lowering the standard would be a blessing to the land. On the

¹¹⁹ Ibid., *Notes on proposals to subsidize Jewish medical services*, by Director of Health.

¹²⁰ PRO, CO 733/242/13, 1933.

¹²¹ PRO, CO 733/205/10, 1931.

contrary, the high standard has proven the best stimulus for the development of the country during the past few years.

Col. Heron: Does not agree with that view. As for the classes of population, not two classes only can be counted here, but twenty or more, with different standards. If not for politicians, it would have been possible long ago to merge them into one unit, and such fusion should have its beginning in hospitals. Special hospitals should not be maintained for Jews and other for Arabs etc. But common hospitals for all classes.¹²²

The Zionist high standards had been tolerated until then for two reasons: they had effectively contributed to maintain the country's medical system at almost zero cost for the British administration. In this sense, they had offered a service the government could not provide. They had also been tolerated on the tacit assumption that Zionist health services would be financed from Jewish funds.¹²³

With the implementation of the HMO's transfer policy, it had however become clear that the Zionist administrative structure was encountering a number of structural and practical difficulties in providing for its own medical budget. Against the Zionist refusal to lower the standards of medical provision as requested by both the Treasury and the CO in order for them to continue their financial contributions,¹²⁴ the GDH pressured the government to leave the Zionist medical institutions to look for alternative sources of funding.

This sharp decrease of British financial participation had a two-fold effect. While some of the services had to be discontinued, most of the Zionist medical structures became dependent upon the Zionist administrative system also from a financial point of view. This factor was understood to provide "ample justification for distinguishing Jewish Health Services from other private institutions."¹²⁵ Lack of funds was a generalized problem for all the communities in Palestine (each for the standards it had decided to offer). The capacity to find new resources and to administer the available ones constituted an element through which the Colonial Office made explicit judgements on the

¹²² HDS, b. 31, f. 14, *Memorandum on Dr. Yassky's conversation with Col. Heron*, 26th October 1932.

¹²³ PRO, CO 733/223/4, 1932, minutes.

¹²⁴ Ibid.

¹²⁵ PRO, CO 733/241/14, 1933.

degree of political maturity of the different communities.¹²⁶

The community which suffered most from this state of affairs was that at the receiving end of the British system of medical provision, i.e., the Arab population. The government intervened at this point voting a palliative budget of LP 12,000 to be spent on health services for the Arab community.¹²⁷ By addressing the Arab needs through such an extraordinary measure, the British government excluded the possibility of promoting a structural reform of the administrative conditions which had caused the Arab population to remain in its conditions of dependency. In this way it continued to maintain a financial and administrative control over it. This approach had another important effect: it hindered the Arab population in its progress towards an administrative and cultural framework within which to develop an autonomous system of medical and social care. It therefore really reduced its possibility to access the benefits of a citizenship which was becoming defined through the social, administrative and political standards set by the Zionist institutions.

The "special position of the Jewish community in Palestine" was always invoked by the British government to justify the "large measure of communal autonomy" which the *yishuv* received and upon which it could build its administrative structure.¹²⁸ Even if the British administration had left to the Jewish institutions the task of organizing their own social services, it had provided them with the legal and administrative framework for transforming their status of private organizations into that of public institutions. When the process of handing over the Jewish medical services to the *Vaad Leumi* had been completed, and when the *Vaad Leumi* had undertaken also the complete

¹²⁶ PRO, CO 733/350/24, 1937. The incapacity of the Arab community in Gaza to manage their local hospital in an autonomous way as late as 1937 aroused a storm of protests from the CO and from the Treasury. This case also stood in stark contrast to that of Tel Aviv. In the same year, the municipality of Tel Aviv had begun autonomous negotiations with the Prudential Insurance Company for a loan of one million pounds. Such a loan was meant to provide the means to extend the capacity of the existing hospital (from 234 to 300 beds), and to build a new one for 400 more patients. As the municipality could not give sufficient guarantees, the negotiations were interrupted before the two parties could reach an agreement. PRO, CO 733/384/4, 1938.

¹²⁷ PRO, CO 733/242/13, 1933.

¹²⁸ PRO, CO 733/241/14, 1933.

financial responsibility for them, it could no longer “be said that these services are maintained by a ‘private’ body” as “the National Council and the local councils of the Jewish community are fully ‘public’ bodies, e.g., municipalities, village councils etc.”¹²⁹

With KH’s emergence as the new Zionist health provider in the mid-1930s, the change of status from private to public became apparent not only in governmental circles, but also within the *yishuv*. Given the *Histadrut*’s growing public responsibilities at a political and practical level, KH could hardly claim that its medical insurance was private. Expanding its medical engagement from the rural environment to urban settlements (as with the construction of the Beilinson Hospital in Petach Tikva in 1936), KH also became from the mid-1930s onwards the most successful health provider within the *yishuv*. By the end of the decade, its reliance and dependence upon the *Histadrut* really meant the backing of the whole Labour movement, turning KH into the true and only national Zionist medical agency.

The administrative framework imposed by the British government in Palestine had favoured the autonomy of the Jewish municipalities, their financial independence and their political awareness of being crucial links of a national administrative network. Medical provision played an important role in this process. It in fact functioned as a connecting element between different aspects of the Zionist work of national construction – the economic, legislative, political, practical and administrative. At a time when medical provision represented one of the most basic and immediate needs of the population, the British policies of delegation, decentralization and legislation represented one of the major assets for a Zionist movement in search for the means to transform their administrative and representative institutions into autonomous instruments for state-building.

¹²⁹ Ibid., emphasis in original.

II

Society

Administration and society maintained in Mandatory Palestine a mutual relationship. The more conspicuous investments the Zionist medical agencies were able to make and to manage, the more administrative concessions the British government allowed to the Jewish Agency, the *Knesset Israel* and the *Vaad Leumi*. The larger administrative autonomy they were granted, the more extensively KH and HMO could operate in society. As a result of this circle, their network of affiliated institutions and their activities became more articulated, more various and diversified.

This mechanism contributed extensively to transform the *yishuv* into a networked civil society. Its founding features remained generally unchanged during this decade. At an administrative level Zionist society co-ordinated itself through its nationally representative institutions. At an ideological level, it was united by its members' highly developed sense of national belonging, a cohesion which generally proved stronger than the existing divisions. Zionist society was also characterized by a sense of constructive pragmatism. The emergence of a civil society out of a network of associations and institutions was also the result of a process of boundary delimitation. All those who were external to its cultural homogeneity - because of geographical provenance, different political orientations or national affiliation - remained excluded from a system whose membership became during the 1930s increasingly defined according to religious, political or national loyalty. The combination of all these elements allowed Zionist civil society to negotiate its path towards statehood. Civil society is therefore not only an analytical category we use today to explain the complexity of Zionist associationism; it is also the process by which a powerful political instrument was forged which then shaped and contained the country's administrative, social and geographical space.

Health played a founding role in this process. Immigration, land ownership, the regulation of labour, the construction of an educational system were all elements which allowed the Zionist group gradually to establish its dominance in Palestinian society. Public health and medical provision constituted two constant threads which intertwined with most of the Zionist activities.

Land ownership depended upon the possibility of implementing the public health requirements dictated by the British legislation.¹ New settlements were constructed only after the British government's surveyors and medical officers had sanctioned the suitability of the location for health.² The anti-malaria ordinances of the British government³ together with the programmes of the Zionist medical agencies – and of KH in particular⁴ – contributed to the pioneers' survival in the *kibbutzim*. A large number of children could continue to attend the schools of the Zionist educational network thanks to the HMO's anti-trachoma campaigns.⁵ In schools the HMO also conducted special courses of hygiene. Jewish immigration was in part also dependent upon health. Immigrants were screened for diseases upon their arrival⁶ and the medical inspectors of the government often had a say on who to accept or reject – as in the case of mental illness.⁷ The centrality of health in the Zionist project was

¹ ISA, RG 10 11/70/35 M 321, G. Heron, *Control of Malaria in Palestine*.

² PRO, CO 733/130/5, 1927. "Colonies should be laid out in advance of occupation by immigration with water and sanitary installation by the body or organisation that is promoting the colonisation group and the construction and the formation of the buildings of the colony be not allowed until this has been done. The Government has such powers under existing Ottoman Law and Town Planning Ordinance."

³ The 'Public Health Anti-Malarial Ordinance 1922' was the first of a number of ordinances which instructed on the ways and methods to eradicate malaria. See also League of Nations, Health Organisation, Malaria Commission, *Reports on the Tour of Investigation in Palestine in 1925*, Geneva, 1925.

⁴ S. M. Sufian, *Healing the Land...*

⁵ HDS, b. 33, f. 6, Letter from Miss Goldman to HMO, 5th May 1934. Between 1918 and 1933 the HMO had succeeded in reducing the incidence of trachoma in Jewish schools from 34 to 6,3 per cent. See HDS, b. 33, f. 10, *Ophthalmological work of Hadassah Medical Organization in Palestine*, memorandum submitted by Dr. Yassky to Vaad Leumi, 18th December 1934.

⁶ PRO, CO 733/130/5, 1927. Upon arrival immigrants were disinfected and vaccinated or, if necessary, kept in quarantine stations maintained by the government. Quarantine lazarettes and Port Disinfecting Stations existed in Jaffa and Haifa. See also PRO, CO 733/144/18, 1927.

⁷ Under the amendments approved by Lord Passfield in 1930 to the Immigration Ordinance (1925) repatriation or deportation was contemplated "in cases where other measures are impracticable and where no doubts exist as to the lunatics of alien nationality." In PRO, CO 733/184/9, 1930. This measure had however already been implemented before. In the summer 1928 it was applied to two Polish nationals Hanna Plotnitzka and Abraham Malinarezavsky. In ISA M 1576 54/18. Another case was that of Mrs Rashel (sic) Sugar, an immigrant from

also the result of the objective conditions of the country, ravaged by endemic disease and by recurrent epidemics,⁸ plagued by infant mortality⁹ and severely hindered by the lack of proper sanitary structures.

The role of health in the formation of civil society was not limited to its already analysed administrative and institutional dimension, or to the above-mentioned practical aspects. Its importance emerged in the unification of the Zionist process of social construction and in the enhancement of its national dimension. The consolidation of this process took the whole decade. During this period Palestine witnessed the sharpening of the hostility between Arabs and Jews. In this context, the 1936-39 riots can be understood not only as a reaction against Jewish land ownership or immigration.¹⁰ They can also be seen as a social, political and national rebellion against a Zionist society which was becoming more complex and diversified, as well as increasingly co-ordinated and state-oriented.

As the main providers of medical services to the *yishuv*, KH and HMO were thus two important actors within civil society. Chapter two investigates their role – and that of the several other associations affiliated to either one or to the other. Such an analysis could have more than one starting point. I have here adopted a perspective which explores the intertwining between the territorial, the social and the national dimensions of medical work. In order to

Hungary arrived on a tourist visa and was deported at the beginning of 1939. Her full story can be found in ISA M 1577 54/45.

⁸ Epidemics were reported as follows; measles in 1925, enteric fever and typhoid fever in 1926, smallpox in 1928 and in 1933, tuberculosis in 1930 and 1932; plague in 1937 and 1941. In PRO, CO 733/130/5, 1927; PRO, CO 733/144/18, 1927; PRO, CO 733/351/1, 1937. See also ISA, M 1533 15/85.

⁹ During the Mandate there was a substantial decline of infant mortality rates for both Arabs and Jews. Already in 1926 “the infantile mortality, under one year,” had fallen “from 186 to 163 per 1000 births” for the Arab population. The decline in infant mortality rates among the Jewish population was from 108 to 100 per thousand. In PRO, CO 733/144/18, 1927.

¹⁰ Jewish land ownership increased during the inter-war years. During the 1930s, the Yishuv acquired some 300,000 dunams which have to be added to the approximately 530,000 they had bought in the previous decade. One dunam corresponds to one quarter of an acre. As for Jewish immigration, in 1929-31 Jewish immigration in Palestine stood at 4,000-5,000 people annually; in 1932 there were 9,500; in 1933, 30,000; in 1934, 42,000; and in 1935, 62,000. (After this date Jewish immigration began to decline: 30,000 in 1936 and 10,000 in 1937, 15,000 in 1938 and 31,000 in 1939). B. Morris, *Righteous Victims. A History of the Zionist-Arab Conflict 1881-1999*, Alfred A. Knopf, New York, 1999 pp. 122-123. See also M. Yazbah, “From poverty to revolt: economic factors in the outbreak of the 1936 rebellion in Palestine”, *Middle Eastern Studies*, 36 (3), July 2000, pp. 93-113.

initiate and complete its path towards state-building, civil society had in fact to be rooted territorially, widespread in society and integrated on a national scale.

Part one of the present chapter analyses the territorial implications of the Zionist system of medical provision. The work of HMO and KH was tightly connected to the territory, each one through its clinics and hospitals. The HMO dominated in minor and major urban centres. KH was most active in rural settlements. Most towns with a Jewish majority and Zionist rural settlements witnessed, during the 1930s, a growing presence of medical institutions. New medical centres were established where there had been none before, local health centres were developed into larger institutions, small surgeries were turned into specialized clinics and imposing hospitals were built.¹¹ As a result of this transformation, Zionist medical provision became more coherently organized, complex and specialized. In order to respond to the needs of an increasingly diversified *yishuv*, new sick funds and medical agencies emerged from both HMO and KH. They successfully integrated areas of the country - and sections of the (Jewish) population - not otherwise included in the Zionist medical network. This development further enhanced the functions of national co-ordination of the *Vaad Ha-Briut*. As the coverage of medical provision became more extended and organized, Arab areas were *de facto* excluded from the Zionist network, i.e., from the only structured system of medical provision effectively working in the country.

This process of setting roots in the territory corresponded in the 1930s to an increased diversification of medical work in society. In part two, I focus on the growth - both in number and kind - of (mainly) local (and some foreign) organizations which joined the Zionist medical and welfare network. This expansion led to the integration of social issues into medical discourse. New and specific categories of patients – women, Mizrahi families, the poor etc. – were progressively included in the provision offered by the Zionist medical agencies, especially after the HMO's second devolution. The integration of

¹¹ On the role of the modern hospital as a complex structure of social power and medical knowledge, on its functions in the development of the medical profession as elitarian and as the locus of political, ideological and cultural conflict, see B. S. Turner, *Medical Power...*, p. 157-171. See also the groundbreaking study of M. Foucault, *Naissance de la clinique. Une archéologie du regard médical*, Presses Universitaires de France, Paris, 1963.

medical and social aspects allowed the Zionist network to reach the population of the *yishuv* in a systematic and capillary way.

The influence of medical provision was not however limited to the ways in which it contributed to shape its territorial or social organization. In an immigrant society medical work also favoured the cultural and professional integration of a large number of newcomers, whether as physicians or as patients. In this respect, health played in the 1930s that function of integration and development which had been that of education in the previous decade,¹² and which belonged to the army from the 1940s onwards.¹³

Part three looks at how the territorial and the social aspects of public health and medical work were combined to favour the emergence of a Zionist civil society which would be territorially based, socially integrated and nationally representative. This new development was symbolized by the foundation and growth of two hospitals: the Hadassah-University Hospital in Jerusalem and the Beilinson Hospital (KH) in Petach Tikva. Although the construction of these two medical structures did not extinguish the competition between HMO and KH, their co-operation and interaction on the field improved. This was also one of the results of the mounting importance of the *Histadrut* in the country's life. After 1935 hospitals became not only centres of medical provision. They had become the focal points of a larger network which included laboratories, schools of nurses, research institutes and centres of higher learning. All of them were constructed as central institutions of the *yishuv*. Through the integration of its territorial, social and national aspects, medical work was able to contribute substantially to the political advancement of the *yishuv* from society to civil society, and from administration to state.

1. *Networking in territorial terms.*

The connection between medical provision and Zionist settlement is evident from its territorial trajectories on the land and in the cities of

¹² S. Sitton, "Zionist Education in an encounter between the British colonial and the Hebrew cultures", *Journal of Educational Administration and History*, 29 (2), 1997, pp. 108-120.

¹³ U. Ben-Eliezer, *The Making...*

Palestine.¹⁴ The Zionist medical system had a three-fold aim: the complete coverage of the areas of Jewish settlement: no colony on the land could be complete unless it could guarantee the health and the lives of its settlers. In the second place medical coverage had to be organized and optimized so as not to duplicate medical services. In the third place, each new medical institution was to function as a frontier outpost. At the border between healthy and unhealthy areas, the Zionist medical centres were also understood as signposts of civilization. They played therefore a clear role of boundary delimitation, from both a geographical and ethnic point of view.

The Northern area constituted the heart of the Zionist project. Galilee – despite its malarious swamps – still represented one of the mythological sites of pioneering.¹⁵ Tel Aviv was then the capital city of the Zionist movement. As a result, the HMO and KH dominated the Northern District, the Emek Valley, the cities of the coastal area and their surroundings, and, to a lesser extent, Jerusalem.¹⁶ With the exception of Hebron, no Jewish hospital or clinic were established in the Southern District.¹⁷ This difference in the pattern of settlement caused a diversity in the development and availability of social and medical services, adding another division to an already fragmented country, that between North and South.

The Southern District was severely under-provided. It relied upon an SMO's station in Jaffa and upon the five centres operated by government medical officers in the district's main towns (Ramallah, Bethlehem, Hebron, Beersheba and Gaza). Smaller towns and villages were provided only with a few casualty and epidemic posts, governmental medical inspection rooms or small outpatients clinics.¹⁸ Some villages were visited by one of the

¹⁴ A. Dieckhoff, "Les trajectoires territoriales du Sionisme", *Vingtième Siècle*, 7 (21), 1989, pp. 29-44.

¹⁵ S. M. Sufian, *Healing the Land...*

¹⁶ Y. Katz, "The marginal role of Jerusalem in Zionist settlement activity prior to the founding of the State of Israel", *Middle Eastern Studies*, 34 (3), July 1998, pp. 121-145.

¹⁷ Figures in the 1931 census were reported as follows: 267,587 Moslems, 78,723 Jews, 15,155 Christians and 332 classified as Other lived in the Southern District. The Jerusalem District was inhabited by 173,019 Moslems, 54,959 Jews, 38,488 Christians and 96 Other. The Northern District was the most populated with 319,106 Moslems, 40,928 Jews, 37,755 Christians and 9,673 classified as Other. In Cmd. 5479..., p. 404.

¹⁸ The map at the beginning of this work shows in detail the availability of medical services in the country.

government's travelling clinics.¹⁹ They were inspected by the SMOs or reached by particularly devoted missionaries.²⁰ This difference in the availability of medical services became even more apparent with the unfolding of that administrative process analysed in chapter one. While during the 1930s the Jewish municipalities assumed progressive responsibility for their own medical services, the transfer of local medical services to the Arab municipalities – many of which were in the South – failed to achieve any substantial result, with very few exceptions.²¹

Thanks to the administrative freedom the Zionist institutions had reached by 1930, both HMO and KH could embark in the first half of the decade on a programme of construction and development. This allowed the Zionist medical agencies to assert their practical presence inside the life of the *yishuv*. It also led them to establish their predominance in medical provision over the government and the missions, at least in areas where all three operated.

I will now turn to analyse three of the main factors which shaped the territorial networking of Zionist medical services. In section one I concentrate on medical coverage and boundary delimitation. The creation of a hierarchy between medical agencies is the subject of the section two. The third explores the expansion of medical services over the territory and in society.

¹⁹ PRO, CO 733/144/18, 1927; PRO CO 733/223/4, 1932. Both documents refer to the existence of such clinics when they had to be shut down for economic reasons.

²⁰ Knight Order of St John in Jerusalem Archives, London (henceforth KOSJ), Report of the Committee for 1930, London [1931], p. 6. The most interesting reports on the visits of the Order of St. John's to the Arab villages refer to the Southern District. The "villages of the Southern plain" were in fact considered as "veritable hotbeds of (...) pestiferous disease." See RH, MSS Brit. Emp. S. 284, b. 15, f 1, J. C. Stratherarn, Warden, St. John Ophthalmic Hospital, (Honorary Consulting Ophthalmic Surgeon, Government of Palestine) *Memorandum on the problem of blindness in Palestine*, 30th November 1932. Missions also visited Arab villages in view of their "urgent need for local work through dispensaries and infant welfare clinics." The medical involvement was conceived as a first step for the creation of "centres of Christian work." Here the medical missionary activities could be flanked by schools, churches and by Christian workers. Each of these sectors would have helped the work of the other, "and so create a vital centre for new life, educational, religious and social." MEC, J&EM b. 58, f. 2, *Medical work* [1935]. The following places were identified as potential locations where to establish these "centres of Christian work": Lydda, Hebron, Beit Jala, Jifna, Bir Zeit, Beit Sahur, Taybeh, Ailaboun, Aboud, Nusef Jabil, Bassas, Yafa (Galilee), Nazareth, Shafa Amr, Kafr Yaseef, Zebabdeh, Rafidieh, Burka, Jenin and its neighbourhood.

²¹ In 1924 the administration of the government hospitals in Gaza, Nablus, Jaffa, Tulkarem and Beersheba had been transferred to the municipalities. That of Tulkarem was closed already in April 1925 "as the Municipality was unable to contribute to its support." PRO, CO 733/130/5, 1927. Those of Gaza and Nablus were returned under the GDH's administration in 1937. In PRO, CO 733/350/24, 1937.

a) *Medical coverage.* Medical coverage was related to both territory and population. The inadequacy of the Zionist network in respect to both emerged with the 1929 riots. Not only did this event find the *yishuv* politically unprepared. From the point of view of medical and hospital provision, the 1929 riots also revealed the extent to which its existing structures were insufficient in number and standards, as well as under-equipped for emergencies. The *Palestine Bulletin* reported:

Hospitals in Jerusalem had a very busy week. The hospitals of Hadassah, of the Government, Bikur Holim, Shaare Zedek and several others had to treat hundreds of wounded. Hadassah should be specially praised for having energetically organised first aid through the whole country in an excellent manner. (...) The local Jewish communities have organised committees to provide social aid.²²

The 1929 riots had initially hit Jerusalem and Hebron. From here they expanded to the rest of the country and then to the North. Five days after the massacre of Hebron another bloodshed took place in Safed. There was only one HMO hospital functioning here. It was a sanatorium for tuberculosis and it was staffed with three physicians alone. In this situation several Jews had turned to the missions' hospitals, as in the cases of Tiberias and Jerusalem. In Tiberias some patients had been "sent (...) to the [Scottish] mission hospital."²³ In Jerusalem the "English Mission Hospital" was "occupied entirely by Jewish patients (to the number of about 1,300)."²⁴ The emergency had also revealed the inadequacy of the Haifa hospital. Originally built in 1922, it needed structural renovation and expansion. Here in fact, already between 1928 and 1929, more than "1,000 Jewish patients went to the mission hospitals (German and Italian) and to the government hospital because Hadassah had no room for them."²⁵

These episodes were acknowledged by both HMO and KH as an unacceptable evidence of inadequacy for a system which aimed at being

²² [n.a.], *The Palestine Bulletin*, Monday 2nd September 1929.

²³ HDS, b. 27, f. 4, Letter from Dr. Bluestone to Drs. Gurewitz and Goldberg 30th May 1930.

²⁴ HDS, b. 30, f. 5, 1930.

²⁵ HDS, b. 30, f. 9, Letter from B. Nissebaum to HMO, 13th February 1930.

conducive to state-building. It was short of beds, room and staff.²⁶ There were three immediate implications of this state of affairs: the Zionist medical agencies did not have total control over the territory. Secondly, they had proved unable to provide in an adequate manner for the Jewish population. As a result of these factors, they had, in the third place, left space for missions to operate.

As an answer to this situation the HMO launched in 1930 a large programme which aimed at the construction of new medical centres and at the re-organization and expansion of the existing ones. From here had also begun the HMO's process of devolution. This scheme also included counselling, advice and financial help to KH for it to follow suit.

In this context, the opening of a hospital in Tiberias was considered in January 1930 "of urgent importance."²⁷ As Henrietta Szold pointed out to the Jewish Agency, upon it would "depend the hospitalization of the community of Tiberias and of 20 settlements in its district."²⁸ Opened in May 1930, it contained a medical, paediatric and obstetrical ward.²⁹

The HMO's undertaking in Tiberias was then reproduced on a larger scale in Haifa. The expansion of the Haifa hospital as well had been conceived as a measure to improve the connection between the town and its surroundings. Because of the new settlements established in the area, the total population depending upon Haifa for medical services had by 1930 reached the number of 20,000.³⁰ Haifa was a crucial case not only because of the town's importance,

²⁶ Ibid., Letter from B. Nissebaum to HMO, 13th February 1930. Until 1933 shortage of medical staff in hospitals remained constant and often physicians worked in more than one hospital at the same time. Here are three examples: Dr. B. Nissebaum - the Haifa Deputy Director of HMO and Head of the Medical Department of the Haifa Hospital - was also appointed as medical and business director of the Tiberias HMO branch. He also visited the hospital in Tiberias once a week where he acted as consultant in all medical questions. Dr. N. Kagan - HMO gynecologist at Haifa - acted as a consultant for female diseases and maternity cases at Tiberias, with duties to visit the city whenever required. Dr. Ostrowsky - HMO paediatricist at Haifa - visited Tiberias regularly once a week as consultant.

²⁷ HDS, b. 33 f. 7 Memorandum from H. Yassky to J. J. Golub, *Peter Schweitzer hospital, Tiberias*, 14th August 1934.

²⁸ CZA F 48/43, Letter from H. Szold to the members of the Jewish Agency for Palestine, 2nd January 1930.

²⁹ The troubled history of this hospital, its recurrent closures because of economic mismanagement or lack of funds can be found in HDS, b. 33 f. 7 Memorandum from H. Yassky to J. J. Golub, *Peter Schweitzer hospital, Tiberias*, 14th August 1934.

³⁰ HDS, b. 30, f. 9, Letter from B. Nissebaum to HMO, 13th March 1930. The new settlements were Benyamina, Karkur, Pardes Hanna, Jedda Minor, Nahalal, Afula, Balfouria,

of its size and because of the population which depended upon it. In view of its urban development – the construction of the harbour dated to 1931³¹ – it represented an important test for establishing a connection between medical provision, a changing territory and an evolving society. On its administrative office fell the responsibility of co-ordinating all the activities of the HMO in the North. The Haifa hospital kept contact with the colonies; it co-ordinated hygiene work in schools; it managed outside obstetrical service; it also provided for infant welfare stations. Last but not least, it maintained a continuous exchange of information with medical committees run independently by various associations – like the Anti-Tuberculosis League (ATL), to cite just one example. As such, the expansion (and the later municipalization) of the HMO hospital in Haifa represented at the same time a medical, social and political operation. As HMO Deputy Director in Haifa indicated:

It must be realized that Haifa is becoming an industrial port city, and that it is bound to develop along such lines. The presence of factories is necessarily bound up with accidents. The lack of surgical wards at the Safad and Tiberias hospitals make it all more necessary to have a surgical ward at the Haifa hospital.³²

With the expansion of the HMO Rothschild Hospital from a local institution to “the central hospital for the whole Yishuv,” Jerusalem too was included in this project of expansion and re-organization.³³ A number of other Jewish hospitals had existed in Jerusalem since the 19th century. Among them were *Shaarei Tzedek* and *Bikkur Cholim*.³⁴ However, the Rothschild Hospital was developed in the first half of the 1930s to underline the difference between the new Zionist institutions and those which had originally been founded on philanthropy. The former were meant to be part of a larger network, while the

Tel Adashim, Kfar Jehoshua, the so-called Hasidic colonies, the Children's Village, Jadzur and not better specified others.

³¹ The different phases of the construction of the Haifa harbour, its connection to the construction of the projected Haifa-Baghdad railway and of the pipeline to run parallel to it can be found in PRO, CO 732/39/7, PRO, CO 732/45/10, PRO, CO 732/46/2, PRO, CO 732/46/3, PRO, CO 732/47/1, PRO, CO 732/48/6, PRO, CO 732/46/7, PRO, CO 732/62/16, PRO, CO 732/66/12, PRO, CO 732/70/2, PRO, CO 732/71/4, PRO, CO 732/74/5.

³² HDS, b. 30, f. 9, Letter from Deputy Director Haifa to HMO, 13th February 1930.

³³ *Ibid.*, Report *Maternity Ward Rothschild hospital*, Letter from Jerusalem Deputy Director to Hadassah Medical Organization, 19th February 1930.

³⁴ On hospital construction in 19th century Jerusalem and their political function, see N. Schwake, “Hospitals and European colonial policy... pp. 231-262.”

latter stood alone. The Rothschild hospital in Jerusalem had also organized the first school for the training of nurses (1921) of the Zionist system.³⁵ This institution offered an important possibility to create a self-perpetuating class of professionals able to establish and maintain an on-going dialogue with society. Until 1934, the Rothschild hospital moreover coordinated the work of the Hebrew University's (HU) departments of medical sciences and hygiene. A new major hospital was then developed in Jerusalem next to the medical faculty of the HU – as we shall see at the end of this chapter.³⁶

To this phase of hospital construction and expansion of the HMO corresponded a parallel growth of activity of KH. Both the Zionist medical agencies had understood the importance of providing adequate medical coverage on the territory and for the Jewish population. Both had begun to perceive the dangers represented by the missions working in Nazareth, Tiberias or Jerusalem. KH was moreover encouraged to undertake a programme of expansion by two other factors: it considered it necessary to relieve the pressure on its only existing medical facility - the hospital at *kibbutz* Ein Harod founded in 1923.³⁷ Secondly, it wanted to set itself free from depending upon the HMO.³⁸

In April 1930 KH opened its first independent hospital in Afula, one of the doors to the North of the country and to the Emek Valley (also known as Emek hospital). This institution was intended to address the specific needs of a Jewish population engaged in the colonization of rural (and malarious) areas. "The pioneers of the Jewish community of the Emek" could in fact no longer tolerate the idea of having to depend upon "the favours of the missions at Nazareth."³⁹ Forty-five per cent of the patients hospitalized in the summer of

³⁵ See L. Zwanger, *Preparation of Graduate Nurses in Israel, 1918-1965*, Unpublished Ph.D. thesis, Columbia University, Teachers' College, 1968, p. 100. "From 1921 to 1935, the Hadassah School of Nursing graduated 204 registered nurses. Of the graduates 65% were employed by the Hadassah Medical Organization; 5% by other health agencies; 1.5 % pursued further studies; 16.5% did not work; 6% left the country, and 4% died."

³⁶ HDS, b. 56, f. 2. *Memorandum concerning negotiations with Hadassah on the reorganization of the health work in Palestine*. [n.d., 1930? 1931?].

³⁷ HDS, b. 56, f. 3 Letter from Dr. Nissembaum to the HMO administration, Haifa, 17th June 1930.

³⁸ S. Schvarts, *The Workers' Health Fund...*, p. 207

³⁹ HDS, b. 31, f. 2, 'Conclusions of Dr. A. Katzenelson and B. Hershowitz (members of the Committee of the Central Emek Hospital), 10th April 1934.

1931 came in fact from Galilee and Samaria.⁴⁰ Despite its troubled financial situation, by the end of the year the Emek hospital was already capable of dealing with a great number of infectious cases. They came to represent forty per cent of the total cases admitted to the hospital.⁴¹ As the department of internal medicine of the Haifa hospital closed in 1931, the Emek hospital became the centre of medical provision for the North. Its centrality was also enhanced by the construction of a road from the Afula railway station to the hospital, completed at the end of 1931. From 1932 the Emek hospital became a pole of medical training and instruction. It offered monthly seminars for doctors, research in preventive medicine and supervision of regional health services. The staff headquarters – so that personnel could be ready twenty-four hours a day – were inaugurated in 1934.⁴²

Zionist civil society developed different features, depending upon whether its territorial networking had been favoured by the work of the HMO or of KH. Where the HMO dominated, medical facilities were at the centre of a system which integrated schools for training, educational institutions and the municipalities. A whole series of committees to co-ordinate the social aspects of medical work was also part of the HMO's system. In those areas where KH was the main provider of medical services, its institutions represented the points connecting different settlements.⁴³ The first had adopted an approach which aimed at integrating the different aspects of medical work into society. The second developed starting from the geography of the settlements. This difference was rooted in the history and in the ideology of the two organizations. It also reproduced the disparity between the urban and the rural (Jewish) realities in which the two operated. Although HMO and KH had followed different strategies in their work, they achieved a common result

⁴⁰ S. Schvarts, *The Workers' Health Fund...*, p. 217

⁴¹ PRO, CO 733/223/4 *Memorandum on the contribution of the Government towards the Health services of the Jewish community in Palestine*, Jerusalem 7th August 1931.

⁴² S. Schvarts, *The Workers' Health Fund...*, p. 223.

⁴³ When Eliezer Perlson was nominated director of KH in 1924, he divided KH into five districts (Jerusalem, Jaffa, Tiberias, Safed and Haifa). Each district maintained a regional office, a permanent secretariat and one director *in loco*. Such decentralized approach was considered crucial for a complete coverage of the Jewish settlements of the North. The HMO maintained a much more centralized approach. See S. Schvarts, *The Workers' Sick Fund...*, p. 101.

which was evident in the geography of the territory. Haifa, Tiberias, Safed and Afula came to represent the corners of a quadrangle which marked the boundaries within which the Zionist project of settlement and colonization could develop and advance.

With the construction and development of the Emek hospital, KH had demonstrated the possibility of an alternative to the HMO's model of fostering the Zionist aspiration to an autonomous civil society co-ordinated in its different parts. Despite this important success, KH was still far from being freed from its dependency upon the HMO. Until the latter withdrew from direct involvement in the health of the *yishuv* in 1936, KH remained in fact subject to the HMO's financial, organizational and practical control. I will now turn to analyse some aspects of this hierarchical relationship *vis-à-vis* both territory and society.

b) *The hierarchy of medical provision.* In a country like Palestine medical provision proved essential for the physical survival of the *yishuv*. Because of its centrality, it contributed to bring together rural and urban realities. It could play this unifying role also because until 1936 it continued to remain under the control of one medical organization, the HMO. Its leadership allowed the development of medical provision within the boundaries of one general project.

The leadership of the HMO was sanctioned first of all by the way medical provision was organized territorially. The HMO maintained in fact a number of medical structures and institutions greater than any other association.⁴⁴ These were also more widespread in the country than those of KH or of the missions. Its leadership was also the result of its financial resources. The HMO entertained a privileged relationship with the British authorities, a status KH never obtained, despite its repeated attempts.⁴⁵ The existence of a clear hierarchy between the two was again reflected in the

⁴⁴ HDS b. 56, f.2. *Memorandum concerning negotiations with Hadassah on the reorganization of the health work in Palestine.* [N.d., 1930? 31?]

⁴⁵ PRO CO 733/223/4, 1932.

composition of the *Vaad Ha-Briut*.⁴⁶ During the 1920s the HMO had supplied staff, equipment and medications to KH.⁴⁷ Until 1928 moreover, members of KH had received free medical treatment to the amount of LP 12,000 a year from the HMO “as inhabitants of the country, with the rights and duties as the rest of the Yishuv.”⁴⁸ Members of the HMO instead paid dues to KH to secure for themselves medical services outside Hadassah hospitals.⁴⁹ In this situation KH seemed to the HMO

to be the only sick fund in the world which collects dues from its members, without holding itself responsible for the payment of fees to the hospital of another organization for treatment of members.”⁵⁰

Only in 1930 was a specific agreement reached so that the patients of the one could be treated in the structures of the other.⁵¹

The construction of the Emek hospital had been planned as a way to extend the territorial coverage of KH. It had also been conceived to free KH from its dependency upon the HMO. It accomplished the opposite result instead. Membership dues (covering fifty-seven per cent of the KH's budget)⁵² had been sufficient to guarantee a minimal autonomy to the Labour Sick Fund before the building of the Emek hospital.⁵³ When a new financial crisis caused the KH to temporarily shut this institution - from July 1931 to October 1932 - the HMO accepted responsibility for that part of KH's budget provided until then by the Jewish Agency.⁵⁴ In this way KH was brought under the complete budgetary control of the HMO.⁵⁵ Because of the territorial development of the Zionist medical network, such control became territorial as well as economic.

⁴⁶ RH, MSS Mss Brit. Emp. S 284, Chancellor, b. 11, f. 7. *Resolutions of the XVI Zionist Congress*, Zurich, July 28-August 11, 1929.

⁴⁷ For more details on the negotiations between HMO and KH over these single issues, see S. Schvarts, *The Workers' Health Fund...*, pp. 188-191.

⁴⁸ HDS, b. 29, f. 9 Letter from Kupat Holim to HMO 1st March 1928.

⁴⁹ HDS, b. 30, f. 13, 9th October 1930

⁵⁰ HDS, b. 29, f. 9., Letter from Dr. Bluestone to Kupat-Holim, 24th February 1928.

⁵¹ HDS, b. 30, f. 12 *Resolution of Vaad habriut on budget of Kupat-Holim from 5691*, 30th June 1930.

⁵² S. Schvarts, *The Workers' Health Fund...* p. 100.

⁵³ HDS, b. 71, f. 1, *Constitution of Kupat-Holim*, 1928. “Membership dues are from 100 to 150 mils Palestinian per month in accordance with the regulations adopted from time to time by the headquarters and the governing Committee of Kupat-Holim with the sanction of the Executive Committee of the Histadrut.”

⁵⁴ HDS, b. 56, f. 4, Letter from Dr. I. Kligler to Mrs. Samuel Halperin 13th April 1931.

⁵⁵ HDS, b. 30, f. 12, *Resolution of Vaad Habriuth on Budget of Kupat-Holim from 5691*, 30th June 1930

As the system of medical provision took a more definite shape in its structures and institutions, the diversity of cultural models introduced into the country by the HMO and KH began to take on the features of an ideological confrontation over which would ultimately dominate the (medical) culture of the *yishuv* - whether the socialist-national ethos of the *Histadrut*, or American progressivism. This confrontation reached its peak while Dr. Ephraim Bluemstein was president of the HMO (1926-1928). Even though the relationship between the HMO and KH improved after the appointment of his successor - Dr. Chaim Yassky (1928-1948) - the mutual perception of the two medical agencies prolonged into the 1930s the bitterness of that confrontation.

In the new decade KH continued to see the HMO as a philanthropic agency (with all the negative implications this term carried from a Zionist point of view), as alien from the culture of the *yishuv*. On the contrary, KH perceived its own work as that of a voluntary organization built on principles of equality and of mutual help (*ezra hadadit*). Moreover, KH feared that the HMO's greater economic possibilities would allow the latter organization to control completely the country's system of medical provision.⁵⁶ On the other hand, the HMO saw KH's ideological link to the *Histadrut* as limiting the potential of KH - and therefore as a severe hindrance for the development of medical services for the *yishuv*. When the HMO withdrew from direct involvement in medical provision, KH found itself at the same time freed from its dependency and in need to find alternative sources of funding. Also because of this reason was membership in the *Histadrut* made compulsory to obtain KH's medical services in 1937 (joint dues - *mas achid*).⁵⁷ The adoption of this procedure

⁵⁶ S. Schvarts, *The Workers' Health Fund...*

⁵⁷ On the steps which led to the introduction of the *mas achid* see S. Schvarts, *The Workers' Health Fund...*, pp. 249-300. Throughout the 1930s the relationship between KH and the *Histadrut* was marked by a protracted struggle over the question whether members of KH had to have compulsory *Histadrut* membership in order to receive the benefits of the Labour Sick Fund. Deferred through the years, it was only in 1935 that this debate started to reach its final stages. It was in fact in 1935 that David Ben Gurion, who had been the General Secretary of the *Histadrut* until then, and who had opposed the collection of the *mas achid*, was elected at the presidency of the Zionist Executive and to that of the Jewish Agency. David Remez therefore replaced Ben Gurion as General Secretary and the collection of the *mas achid* began in 1937.

allowed the link-up of the KH's growth to that of the *Histadrut*, a system which remained substantially unchanged until 1993.⁵⁸

However, by 1936 KH was no longer the only 'other' Zionist medical agency operating on the territory. Medical coverage was by then in the hands of more than just two organizations. I will now turn to examine briefly some of the reasons for the establishment of other sick funds in the 1930s and to their role within an expanding *yishuv*.

c) The expansion of medical coverage between territory and society.

Between 1931 and 1940 three more sick funds were established in Palestine. Kupat Cholim Amamit (KHA) was founded in 1931. Kupat Cholim Leumit (KHL) was established in 1933. Kupat Cholim Maccabi (KHM) came into being in 1940. The first originated from and within the HMO. The second was founded by the Revisionist movement as a reaction against the growing influence of the *Histadrut*.⁵⁹ The third embodied the reaction of the physicians arrived with the German *alyia* to the ban imposed by both the HMO and KH on private medical practice.

The role of these three relatively minor sick funds could seem marginal within the general picture of medical provision. However, their coming into being during this decade represents an important indication of the territorial and social diversification of the *yishuv*. The cultural and practical models offered by the HMO and KH were in fact no longer adequate for a society which had multiplied in numbers, which had spread over the territory and which had become more articulated in the social and geographical provenance of its members, as well as in their political affiliation.

⁵⁸ Between 1930 and 1931 the membership in the *Histadrut* reached the number of 30,000 individuals. In 1933 it rose to 35,389. In 1939, the *Histadrut* could already count on more than 100,000 members. These figures were further destined to increase. In 1940 the *Histadrut* counted 112,000 adherents, a number which reached 176,000 in 1947. At the end of 1949 the members were 251,000 which meant 40.7 per cent of the country's adult population. In 1950 they became 330,000, i.e. 46 per cent. In Z. Sternhell, *The Founding Myths...*, p. 179. As for membership in KH see HDS, b. 71, f. 2, I. Kanevsky, *The activities of the Sick Fund in 1937*, 1937. KH had 2,000 members in 1920. Membership had risen to 12,350 in 1925 to increase to 18,045 in 1930. In 1935 KH had 49,471 members. Within two years it reached 71,630 individuals.

⁵⁹ On the Revisionist movement see Y. Shavit, *Jabotinsky and the Revisionist Movement 1925-1948*, Frank Cass, London, 1988.

This substantial increase in the number of medical agencies did not necessarily also entail the construction of new hospitals. These sick funds began in fact as relatively small medical agencies. They lacked the economic possibilities of the HMO and of KH and their systems were less articulated. They had a membership base which depended upon specific political affiliation or broad geographical provenance. As a result, they never succeeded in challenging the position of the HMO. The role of KH was instead brought into question in several ways.

Kupat Cholim Amamit. The construction of the Emek Hospital had only partially relieved the medical facilities of the HMO from overcrowding. Those settlers not affiliated to the *Histadrut* (workers in the *moshavim* for example, or the Yemenite workers) were in fact generally restricted from attending that institution. As a result, they turned to the HMO hospitals in Jerusalem, Tiberias and Safed. To relieve the increasing pressure on its system, HMO launched in 1931 the establishment of a new sick fund: the KHA. Its membership counted 6,000 individuals in the first year. Affiliation rose to 10,000 in 1932. The following year KHA had already reached the number of 14,000 members.⁶⁰ Within two years from its foundation, this medical agency could already provide for emergency cases and proceed to mass inoculations, as in the case of the 1933 epidemics of influenza and smallpox. As a creature of the HMO, KHA did not establish its own hospitals. A whole series of agreements were signed between the two medical agencies so that members of KHA would be secured cures, x-ray facilities, specialist visits and private maternity wards in the HMO centres.⁶¹

For the purpose of networking different parts of the territory, KHA played an important function. It in fact operated as a connecting agent between the Jewish rural settlements and the urban centres, in particular Jerusalem with its central hospital. Based in a rural environment and, at the same time, rooted in the HMO's tradition of urban provision, the new sick fund contributed to bridge the gap between these two sections of the Jewish society. It also

⁶⁰ HDS, b. 32, f. 14., *Kuppat-Holim Amamit-Report for 1933*.

⁶¹ HDS, b. 33, f. 6, *Kuppat Holim Amamit – Agreement with HMO, 27th March 1934*.

strengthened their bond in a bi-directional way. KHA offered the possibility to those patients living “tens and hundreds kilometres’ distance from Jerusalem” to be admitted “to the hospital by the same method as local resident.”⁶² The establishment of a sick fund with these characteristics also allowed a greater co-ordination of medical work. It in fact imposed a continuous exchange of medical and social information between the physicians in charge of the rural sector and the specialists in charge of the central hospital.

The activities of KHA threatened at times the monopoly of KH in the rural sphere. The foundation of the other two sick-funds represented however an even more serious danger for KH. Those who opted for KHL after 1933 or for KHM after 1940 took away members from KH because of political or ideological reasons.

Kupat Cholim Leumit. In the framework of an increasingly powerful and controlling *Histadrut*, KH represented one of its large scale sub-organizations. Like them, KH contributed to establish the political dominance of the Labour group over the others. As such, it followed those disciplining policies which were also part of the *Histadrut*’s strategies of cultural conformism and political control, as analysed by Zeev Sternhell.⁶³ The *Histadrut* had subordinated medical provision to ideological and political loyalty. Through the establishment of the *mas achid* in 1937, it could easily exclude large categories of Jews from the benefits offered by KH. The executive committee of the *Histadrut* for example controlled admission to KH by reserving the option of expulsion.⁶⁴ It normally rejected the applications of those who employed Arab workers. Those who belonged to the Revisionist movement were also automatically turned down. In this sense, looking for an alternative to the KH in the mid-1930s equalled looking for an alternative to the political dominance of the *Histadrut*.

The first workers to opt out of KH at the beginning of the decade were those affiliated to the Revisionist movement. The organization and

⁶² HDS, b. 53, f. 1, Dr. R. Katzenelson, *The rural Yishuv and the Hadassah-University hospital*, May 1934.

⁶³ Z. Sternhell, *The Founding Myths...*, p. 183.

⁶⁴ S. Shvarts, “Kupat Holim and Jewish Health Services ...”, p. 349.

management of an independent Revisionist sick fund was in fact envisaged as an important source of votes against Labour.⁶⁵ The movement aimed in particular at including Oriental groups - Yemenites and the Jews from Kurdistan. For this purpose, Revisionists had applied to the HMO's Department of Statistics and Social Insurance in 1932 for assistance in the organization of a separate sick fund.⁶⁶ As the HMO did not want to be identified with any political group, they were initially diverted to KH "since they are actually of the social status of workers provided for by Kupat-Holim."⁶⁷ The political climate which followed the assassination of Chaim Arlosoroff in 1933 contributed to giving an important move forward to a social and political movement in search of the means to consolidate its position inside the *yishuv*. Accused of being both instigators and executors of the second political assassination in the history of Zionism,⁶⁸ the Revisionists resigned *en masse* from KH. Authorized by the British government in 1934,⁶⁹ the Revisionist sick fund took the name of Kupat Cholim Leumit.

Kupat Cholim Maccabi. The establishment of KHM was one of the results of the German *alyia*. Upon their arrival, most German physicians had found employment with KH. However, their role inside this medical agency became increasingly complicated during the 1930s. On the one hand they recognised in KH some traits of the 19th century German model of sick fund. On the other hand they also encountered great difficulties in trying to reproduce in Palestine the same working conditions which they had known at

⁶⁵ On the strategies of the Revisionist movement, see L. Weissbrod., "Economic factors and political strategies: the defeat of the Revisionists in Mandatory Palestine", *Middle Eastern Studies*, 19 (3) July 1983, pp. 326-343.

⁶⁶ HDS, b. 80, f. 4, Minutes of conference held on 1st January 1932.

⁶⁷ Ibid.

⁶⁸ For an analysis of the first political assassination of the history of Zionism, see M. Berkowitz, "Doubled Trouble. A call to investigate the Life and After-lives of De Vriendt and De Hann", in *Arnold Zweig-Sein Werk in Kontext der deutschsprachigen Exilliteratur*, Jahrbuch für Internationale Germanistik, Reihe A, Band 49, Verlag Peter Lang, Bern, Berlin, Frankfurt am Main, New York, Paris, Wien, 1999, pp. 111-124. For an analytical overview of political assassinations in the history of Zionism and Israel, see J. Barromi, "L'assassinio di Rabin", *Nuova Storia Contemporanea*, Quaderni Numero speciale, supplemento al n. 3/98, anno II, maggio 1998, pp. 137-152.

⁶⁹ PRO, CO 733/234/6.

home.⁷⁰ Most of them expected to practice privately and, at the same time, to be employed by one of the medical agencies.⁷¹ This issue continued throughout the decade to stand at the core of the working relationship between German physicians and both the *Histadrut* and the HMO. The *Histadrut* had in fact banned private practice in the KH's structures and so had the HMO. This situation sparked off the foundation of a new sick fund. Shifra Shvarts - the historian of Kupat Cholim - analyzed the situation of the German physicians:

65% of the immigrant doctors from Germany started private clinics with capital they brought with them. Those doctors had either found no employment with Kupat Holim and Hadassah or else refused to comply with the regulations of either of the two organisations.⁷²

Most of these new private clinics merged into Kupat Cholim Maccabi in 1940. The KHM was mainly urban based. It maintained a minimal administrative apparatus and it did not establish or build large hospitals or clinics. It never grew to reach the size or the importance of the HMO or of KH; it also came into being relatively late in the process of civil society formation of the *yishuv*. One of its main features remained the freedom of choice it left to both patients and doctors. In an ideological context where everything was subordinated to the establishment of the Jewish National Home, physicians working for KH or for HMO had been subjected to a vertical management of health. They had been instruments in the hands of the two major medical agencies and had obtained very little space to negotiate the terms of their careers. By putting at the forefront their freedom of choice, KHM offered a model of networking which stressed individual enterprise and choice in the creation of bonds between different parts and various sectors of the *yishuv*.⁷³ In

⁷⁰ S. Shvarts, "Kupat Holim and Jewish Health Services...", pp. 349-350. "In Germany (...) doctors were used to an open, market driven medical system. Patients were allowed free choice of doctors, examination centres, laboratories and pharmacies. German doctors worked in private clinics, research centres and hospitals and, at the same time, they practised for medical insurance companies which contracted their services. The German system was, in effect, a combination of private practice and public service, which kept medical care in the market economy while it provided universal medical coverage for all employees.

⁷¹ J. M. Efron, *Medicine and the German Jews. A History*, Yale University Press, New Haven and London, 2001.

⁷² S. Shvarts, "Kupat Holim and Jewish Health Services...", p. 351.

⁷³ S. Shvarts, "Kupat Holim and Jewish Health Services...", pp. 351-352. Kupat Holim Maccabi was not the only new medical insurance fund established in these years. "Following the footsteps of Maccabi, the Hebrew Medical Federation set up its own sick fund known as

this way it really stressed the difference between its own system and that of KH or of the HMO. The former was decentralized but hierarchical and ideologically subjected to the *Histadrut*; the latter remained highly centralized and bureaucratic.

The territorial networking of medical services proved an essential factor for the transformation of the *yishuv* into a civil society in a number of ways. It provided the Jewish rural settlements with the possibility of surviving in an altogether hostile environment. It also supplied most towns with a Jewish presence with the means for maintaining and increasing such presence. It implied the control over the territory *vis-à-vis* both disease *per se*⁷⁴ and the non-Jewish medical agencies. In this sense medical work helped the expansion and consolidation of those Jewish areas within which the *yishuv* could grow. It therefore excluded all those who did not belong to the *yishuv*, beginning from the Arab population. Medical institutions were in fact structures which made the Jewish presence on the land more visible. In this respect, this process of setting roots in the territory marked the territorial and the social boundaries of Zionist civil society. Most of all, Zionist medical work brought this political and national instrument closer to the daily needs of its population.

Medical services were not only in the hands of the HMO, of KH or of the above-mentioned other sick funds. A vast number of committees and associations also took part in this collective effort. They organized medical work starting from society and its needs. Their work contributed to the inclusion of welfare provision into the medical framework. This new element - which could also be seen as the progressive medicalization of a developing

the *Ozar Harofeim* or "Doctors Treasure" in 1942. In 1950 it became the Assaf Sick Fund. Another medical insurance company was called Shiloah. As a result, numerous small private hospitals were founded, mainly in the Tel Aviv area, none of which had over twenty beds." About the developments which took place in the 1940s with regard to the issue of salaried doctors and private practice see also S. Shwartz, L. A. de Leeuw, S. Granit, "The salaried model in Israel...", p. 256.

⁷⁴ S. M. Sufian, *Healing the Land...* p. 75.

society⁷⁵ – favoured the interaction of a much larger number of social and medical actors in society. Medical services on the ground could be connected to a growing academic and research sector. In this way medical work could reach and involve growing numbers of immigrants, settlers and professionals within a progressively larger network. I will now turn to examine some aspects of this process of networking in society.

2. Networking in society.

As we have seen, by the mid-1930s the HMO and KH had contributed to shape the Zionist administrative system as autonomous. Medical work on the territory had contributed to the establishment of geographical boundaries within which the Zionist national aspiration could materialize; in society it established social and cultural boundaries. Medical institutions became physical reference points for new immigrants. In society they represented important moments of their integration.⁷⁶ Medical work on the territory had reached and integrated groups originally marginalized because of areas of residence and social class – as in the case of Mizrahi Jews. In society, it came to dictate the norms of their inclusion into the *yishuv* – from a cultural and social point of view. This process of boundary delimitation was necessary for a civil society which needed a territorial and cultural homogeneity to nourish its own project of state-building. Both on the territory and in society, medical work was therefore functional to the construction of a coherent system meant to be conducive to institution- and state-building.

This process of civil society formation was developed in two converging ways. It was on the one hand organized by the two major medical agencies from above. On the other, it was also the result of a growing social mobilization from below. It is possible to talk of ‘dense’ networking for the first case, in contrast to the ‘loose’ aspect of the second.⁷⁷

⁷⁵ W. F. Bynum, “Medicina e Società”, in M. D. Grmek (ed.), *Storia del Pensiero Medico Occidentale*, Vol. 3, Dall’Età Romantica alla Medicina Moderna, Editori Laterza, Roma-Bari, 1998, pp. 451-492.

⁷⁶ See A. Doron and R. M. Kremer, *The Welfare State in Israel*, Westview Press, Boulder, San Francisco, Oxford, 1991.

⁷⁷ F. Piselli, *Retti...*

In the following two sections, I explore these two complementary dimensions of the relationship between medical and welfare provision, and society. First, I concentrate on the means adopted by the HMO to expand its coverage in society and among the population. From 1934 the HMO and the *Vaad Leumi* displayed all their experience to consolidate a socio-medical network which operated at two levels. At a community level, it began from local welfare stations to involve growing sections of the population. It reached out to schools. It also turned the profession of nursing into one of the centres of its system. At a more institutional level, this network constituted the basis for the creation of the Faculty of Medicine of the Hebrew University. It incorporated its research laboratories, the already existing HMO hospitals, the ones under construction, the schools of nurses and the epidemiological units spread in the country. At this level, networking in society was intended as a means to combine the medical, the professional, the social and the academic discourses into one framework. The contribution of the HMO to the networking of the *yishuv* was in this respect imposed from above.

There was however another dimension of networking in society. This began from below, at a fundamental, basic and more original level. Of particular importance was the role played by a consistent number of generally small, local and autonomous committees, associations, centres of medical and scientific information, all founded in Palestine in the 1930s. These associations addressed the medical and welfare needs of the *yishuv* beginning from its smaller constituents - the local communities, families and individuals - or from its weaker members - the poor, the insane, the orphans, etc. Despite their localized character, these committees often went beyond offering medical services only. Many of them dealt with the social needs of the local communities. They often promoted autonomous initiatives. They came to represent in fact the centres - albeit small - in which to receive information on prevention, for example. They were, territorially speaking, sparsely located, but they grew exponentially during the 1930s. In this way they represented one of the most spontaneous and lively aspects of the Zionist civil society. This grassroots mobilization remained generally autonomous. Some of these

committees and associations became affiliated to KHL. Others received partial economic subventions and contributions from the HMO, the Jewish Agency and/or the *Vaad Leumi*. As a general phenomenon, such proliferation grew substantially uncontrolled, at least *vis-à-vis* the British authorities. The latter were often unaware of the existence of some of the committees until they suddenly appeared in the context of cadastral mapping, of housing disputes or in other similar contexts.⁷⁸ It is possible to talk of them as 'loose' networking in contrast to the 'dense' aspect of the HMO and KHL.

a) Organization from above. The involvement of the HMO in society ranged from its centres for mother and child to its institutions to rehabilitate juvenile delinquents. The HMO dealt with refugees with the same dedication it displayed in the education of children. Its method of work changed the significance of the nursing profession in Palestine. It also maintained a youth movement in Palestine, the Young Judea. There could be many other examples of the HMO's role in driving the different parts of the *yishuv* together into a social and national network. I will here concentrate just on a few issues which are related to the relationship between the medical work, its social implications and the formation of civil society. My analysis will therefore be limited to the HMO's welfare centres, to its work in schools and to its growing partnership with the Hebrew University (HU).

These examples – three among many possible – show how the HMO developed networking in society as a two-fold process. On the one hand, the existence of a medical network had been conceived as a way to accomplish a complete medical coverage of the population, to reach into each family and school. On the other hand, it had also been envisaged as a starting point to branch out in other directions. By establishing links between various sectors of society and different institutions - like the HU for example - the HMO opened up a whole new series of possible social economic, professional and political interactions. Physicians interacted with the population; the medical students could build a working relationship with the university; nurses acted as a liaison between the families and the medical agencies; patients had the feeling of

⁷⁸ ISA, M 1513 5/103.

being part of an integrated social structure. In turn these relationships further reinforced the connection between medical institutions and society.

The HMO had originally been founded by a number of women as an organization to promote the welfare of other women. The extensive role it then came to play in medical development led to its transformation into a large-scale medical agency. During the 1930s however, it still preserved its original birthmark. Amidst administrative, territorial and social work, it also continued to pay special attention to women in particular, albeit with some contradictions.⁷⁹

The central institutions of the HMO's medical network in society remained its centres for mother and child.⁸⁰ They embodied a vision of medical provision which maintained a social and an educational core. In these centres women from all Jewish backgrounds received education in hygiene. They also attended preparatory courses in child delivery and childcare.⁸¹ In 1929, for example, more than 13,000 mothers had been assisted in the HMO centres. In the same year the nurses of the HMO had imparted 45,000 home visits.⁸² Stations for antenatal and children assistance were also constructed next to the centres for mother and child. These institutions were in fact also meant as centres where to engage one of the HMO's most consistently waged battles, i.e. the reduction of infant mortality. The welfare of the mothers and that of the children were in fact understood as inevitably intertwined.⁸³ Figures for the Jewish population indicate a decline of infant mortality in the first year from

⁷⁹ M. McCune, "Social workers in the Muskelejudentum: "Hadassah Ladies," "Manly Men" and the significance of Gender in the American Zionist Movement, 1912-1928", *American Jewish History*, June 1988, pp. 135-156, p. 135.

⁸⁰ The first centres for mother and child were established in the mid-1920. In 1927 the HMO had opened 13 centres where 13,527 children were cared for. There were also centres maintained by the Women International Zionist Organization (WIZO). Of the 5,000 babies born of Jewish parents in 1928, 3,800 had been registered in the twenty-one health welfare centres of the HMO and nearly 950 in the three similar centres conducted by the WIZO. These figures meant that 94 per cent of the Jewish babies were given medical supervision and care in Jewish structures. CZA, F49/2665, The Palestine Executive of the WIZO to the Conference of the WIZO, Jerusalem, June 1931.

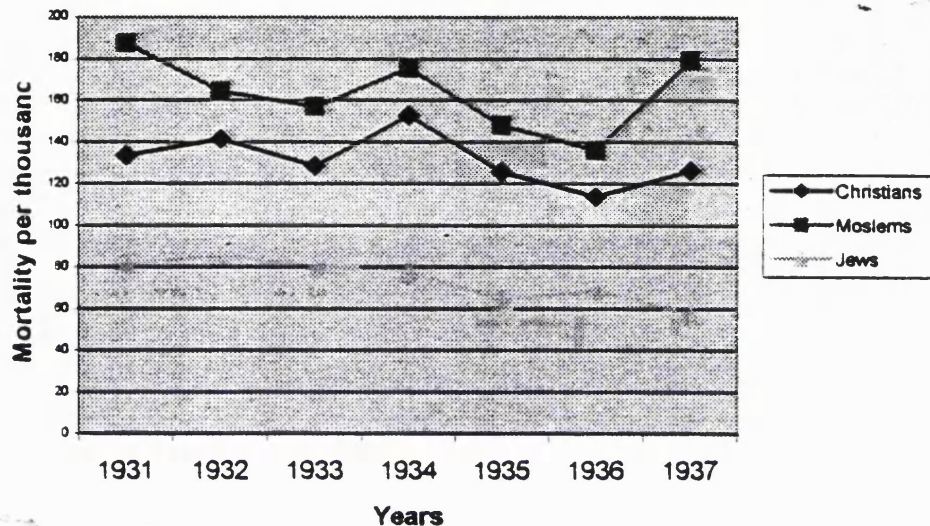
⁸¹ HDS, b. 3, f. 6.

⁸² [n.a.], *Jewish infant rate reduced. Ghastly infant mortality figures among Arabs*, "The Palestine Bulletin", 24th June 1930.

⁸³ J. Korczak, *La Palestine. Notes de voyage et correspondance 1927-1939*, Les Éditions Noir Sur Blanc, Montricher, 2002.

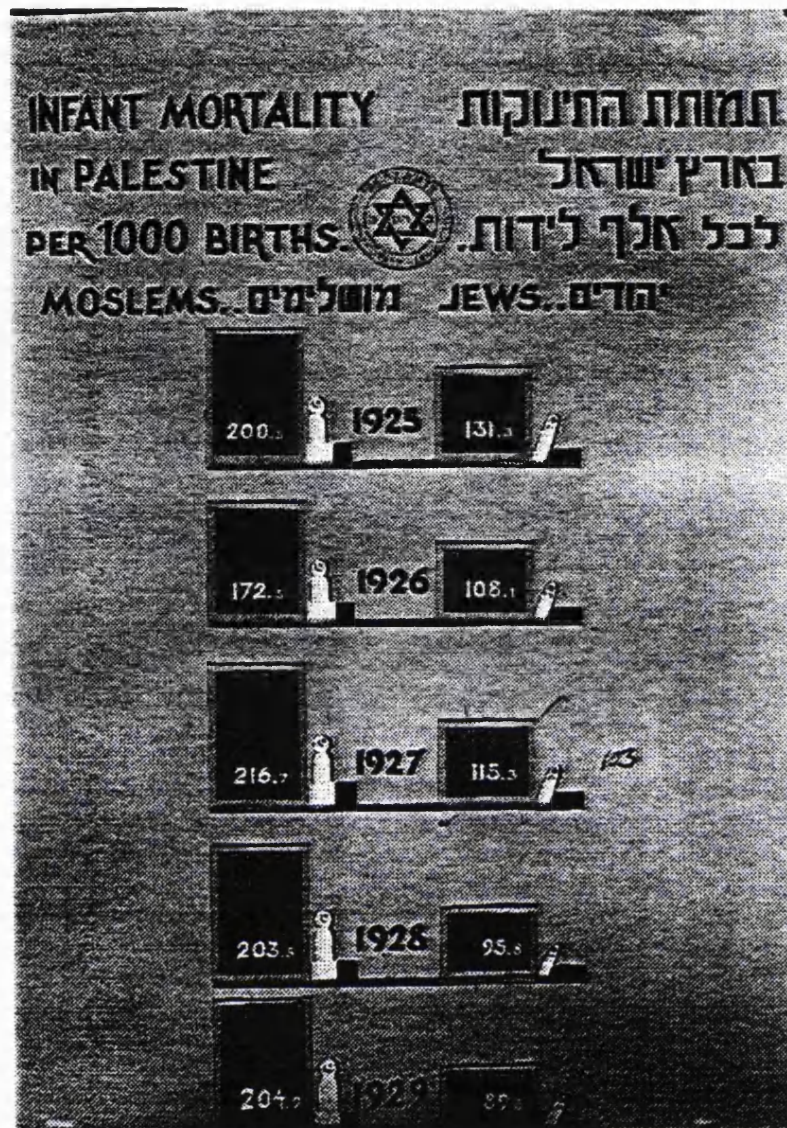
131,3 per 1,000 births in 1925 to 90 per 1,000 in 1929.⁸⁴ The establishment of the Hadassah Health Welfare Department at the beginning of the decade contributed to further reduce Jewish infant mortality “to 80 per thousand” in 1931, as the data below indicate graphically.

7. Jewish infant mortality per thousand births (1925-1931)⁸⁵



⁸⁴ [n.a.], *Jewish infant rate reduced. Ghastly infant mortality figures among Arabs*, “The Palestine Bulletin”, 24th June 1930. The Arab infant mortality rose in the same period from 200,5 to almost 204, being 44 per cent higher among them than among Jews.

⁸⁵ Elaboration of data from HDS, b.72, f. 1, B. Gruenfelder, *Report on infant mortality in Palestine*, 30th June 1936.

Illustration n. 2: Infant Mortality in Palestine per 1000 births.⁸⁶

A considerable decrease in the deaths of maternity patients was also reported in the same year.⁸⁷ In 1935 85 per cent of the Jewish mothers living in Palestine had come under the wing of the HMO.⁸⁸

⁸⁶ Private collection. This postcard published by the HMO is most possibly part of a series to advertise the results of the HMO's campaigns against infant mortality. See also HDS, b.72, f. 1, B. Gruenfelder, *Report on infant mortality in Palestine*, 30th June 1936. Here Dr. Gruenfelder stated: "From long observations in our children's sections of the hospital we know that children who died from grave nutritional troubles belonged to parents of whom 12 % immigrated from Europe or American and 88% from Africa and other Eastern countries."

⁸⁷ HDS, b. 57, f. 5, 1931.

⁸⁸ HDS, b. 5, f. 40, *Hadassah today*, 2nd January 1935.

As we shall see in chapter three, such a high rate of attendance was one of the practical outcomes of the medical and educational propaganda conducted by the HMO welfare stations. These targeted not only the women of mainstream (Ashkenazi) society. The HMO made a substantial effort to include those (Mizrahi) women and families often considered outsiders because of their miserable living standards and minimal education.⁸⁹ Eight hundred families had been registered in 1934 with the Jerusalem Health Welfare Station. At the end of 1935, the twenty-two HMO welfare stations located in various parts of the country could count a total number of 25,000 affiliated.⁹⁰ These centres undertook the crucial function of bringing the idea of medical treatment closer to those who had proven reluctant to attend clinics and hospitals. In Jerusalem for example

the mothers in the Warsaw Houses (...) (Eastern European element) have begun to take an interest in the health welfare work. Though no actual improvement in the living conditions has been effected, owing to the technical difficulties within this quarter, there is a willingness to do better.”⁹¹

By far the two largest and most important of these medical and welfare centres remained the Straus Health Centre in Jerusalem and the one in Tel Aviv, both maintained and managed by the HMO.⁹² They conducted extensive health education propaganda through lectures, exhibits, classes, printed matter

⁸⁹ M. Simoni, *Orientalism and gender in Mandatory Palestine: the case of Mizrahi women*, forthcoming in I. Kalmar - D. Penslar (eds.), *Jews and Orientalism*, University of New England Press, Hanover, NH, 2004.

⁹⁰ HDS, b. 5, f. 40, *Hadassah today*, 2nd January 1935.

⁹¹ HDS, b. 33, f. 10, HMO Department of records to Jerusalem Health Center, 2nd December 1934.

⁹² Nathan Straus was originally a philanthropist, who had opened in 1893 the first infant milk depot in New York City. When he arrived in Jerusalem in 1913, he tried to reproduce those conditions with the opening of a soup kitchen. His kind of philanthropy had a very different background from 19th century European one. It had in fact incorporated the main American social principles developed at the turn of the century: the introduction of modern public health nursing and the use of education as an instrument to advance preventive medicine. The significant innovations of this period included the introduction of specialized nurses to visit sick babies in the district of New York (1902); compulsory medical inspections were organized for all the public schools of Massachusetts (1906); the first municipal Division of Child Hygiene was established in New York City in 1908; the American Association for the Study and Prevention of Infant Mortality was founded in 1909. Between 1906 and 1912 a movement to establish a national department of public health began to gain ground. In 1912 a federal U.S. children bureau was created. See the remarks of M. Wasserman, “Henrietta Szold...”, pp. 271-272.

and preventive activities.⁹³ The activities of the Jerusalem centre⁹⁴ included a health education department, a corrective gymnasium for children, the Clara Wachtel Dental clinic, a nutrition department an adult health examination clinic (for mental, physical and sex hygiene), a public reading room, a station of the School Hygiene Department, a pre-natal and infant welfare station, a day nursery (*Histadruth Nashim Zionot*), and a pasteurization Plant (*Tnuva*). In the Tel Aviv centre the activities included a health education department, stations for sex hygiene and sport, corrective gymnastics for children, a day nursery, a children's dental clinic, a food-testing laboratory, courses in first aid, mothercraft etc.⁹⁵ One of their main activities was to co-ordinate programmes for hygiene in schools, especially against the spread of trachoma.⁹⁶

The inclusive approach of the HMO emerged most of all from its welfare programmes in schools. The school luncheons programme represented a crucial cultural and practical undertaking to impart a teaching which could unify and uniform the culture of all children. They were in fact expected to "do marketing, learn food values, the preparation of meals, balancing menus, setting and serving at the table, table manners, and above all, sanitation in the kitchen."⁹⁷ By 1937 the programme served eighty-four schools of the Zionist educational network. Another example of the HMO's ability to involve different sectors of society was the Playground Program, originally financed by Bertha Guggenheimer and started in Jerusalem in 1925. By 1937 one thousand children were registred at the six existing Guggenheimer playgrounds (two in Jerusalem, one in Tel Aviv, one in Haifa, one in Safed and one in Tiberias). The educational and recreational model was so successful as to be reproduced independently of the HMO in several other towns. In 1931 the town of Raanana established its own recreational plan for children. In 1933 the towns of Herzlia and Hedera followed suit. By 1936 the playground programme had

⁹³ HDS, b. 32, f. 14, *Digest of the Palestinian Correspondence*, 1934.

⁹⁴ HDS, b. 47, f. 1. Here can be found the reports of 'The Nathan and Lina Straus Health Centre' from 1930 to 1937.

⁹⁵ CZA, A 187, *Cooperation between Jews and Arabs in Health Work*, 1929.

⁹⁶ HDS, b. 33, f. 14, *Preventive medical work in Tel Aviv*. Letter from HMO to Mr. Dizengoff, 12th March (April?) 1935.

⁹⁷ HDS, b. 33, f. 1, *Report of the Palestine Penny Luncheons Fund Committee to the 13th Annual Convention of Hadassah*, June 23-25, 1927, p. 4.

become the subject of two study courses, at the HU and at the Hebrew Teachers' College.⁹⁸

The partnership between the HMO and the HU for the education and specialization of physicians constituted another central aspect of this process. The education and specialization of nurses and physicians were integrated into a wider 'Medical Center Project'. This combined education, training in medical practice and control on the country's medical activities. Within this scheme, the activities of Nurses Training School became part of the post-graduate medical school. The establishment of the Hadassah-University hospital - to become part of the medical faculty of the HU - reunited most of these activities within one framework from 1935-36. So complete a medical centre provided hospital care for patients and an outpatient department for ambulatory ones. It allowed nurses undergoing training to reside within the school. It covered the needs of postgraduate medical education. This scheme foresaw an expansion with the institution of three departments in the HU medical faculty: pharmacology, physiology and anatomy.⁹⁹ Speaking at the opening of the 1933-34 academic year, Judah L. Magnes, - the Chancellor of the University - outlined the plan for the construction of such a medical centre:

What is the medical centre? It consists, in the first place, of scientific laboratories at the University; in the second place, of a University hospital. It being expected that the Rothschild-Hadassah hospital in Jerusalem, if possible in new quarters, will serve this purpose. The University laboratory men and those clinicians of Hadassah who are recognised by the Board of Governors as a University calibre will form together the faculty of the Medical Centre, or, as we have also called it, the Graduate School of Medicine and Hygiene. It is to be for the present only for post-graduate doctors.¹⁰⁰

As a result of this process of expansion and of autonomous management of health by the municipalities, these also began to be actively involved in welfare work. In 1934, the municipality of Tel Aviv established 'The Jubilee Fund for Children'. It consisted in an institution for delinquent

⁹⁸ D. Miller, *A History of Hadassah*..., pp. 307-314.

⁹⁹ HDS, b. 34, f. 6 Memorandum by Dr. Yassky on the 'Medical Center', 26th August 1935.

¹⁰⁰ ISA, M 125 E/83/31, J. L. Magnes, *Address at the opening of the Academic Year 1933/34*, Hebrew University, 5th November 1933.

children,¹⁰¹ one for abandoned children and a day school for backward children. An advisory department helped parents. Evening classes also existed within this scheme for those youngsters who, for some reason, could not be placed in the Zionist schools. The Fund was then enlarged in 1936 with the establishment of special vocational schools. Here boys could be taught carpentry, leatherwork, shoe repairing, book binding and other professions.¹⁰²

The approach of the HMO to networking in society had combined social, medical, educational and national factors. The HMO had been able to attract a larger number of segments of society in its sphere than KH. This fact can be explained in several ways. The HMO was not subject to the ideological control of the *Histadrut*, or to its political agenda.¹⁰³ It could count on a larger financial availability than KH. It was more open to integrate the social and the medical discourses. This element proved invaluable to reach those parts of the society and of the population which did not belong to that Ashkenazi elite epitomized by the *Histadrut*.¹⁰⁴ The HMO was therefore able also to respond to the different needs of a Jewish population which was becoming increasingly differentiated as to hygiene, medical and social habits and, most of all, original geographical provenance. Lastly, if eight out of ten Jews were in 1931 already living in the cities,¹⁰⁵ the HMO's focus on the Palestinian urban context made its engagement in society closer to the reality of Jewish settlement in Palestine.¹⁰⁶

¹⁰¹ On delinquent children see M. Simoni, *A Dangerous legacy. Welfare in British Palestine*, "Jewish History", 13, (2), 1999, pp. 81-109.

¹⁰² HDS, b. 49, f. 8, letter from Mrs. [Rose] Samuel W. Halperin to Mrs Robert Szold, Chairman, Palestine Committee Hadassah NY, 10th March 1936.

¹⁰³ Although it remained under the influence of American Zionism in its different orientations. See G. Allon, "The Mission motif in American Zionism", *American Jewish History*, 75 (4), June 1986, pp. 363-385.

¹⁰⁴ On the "virtues of Ashkenazi pioneering" see the remarks in G. Shafir and Y. Peled, *Being Israelis...*, pp. 37-46.

¹⁰⁵ Z. Sternhell, *The Founding Myths...*, p. 25. Sternhell points out how Jewish Palestine under the British Mandate was one of the most urbanized countries in the world.

¹⁰⁶ G. Biger, *An Empire in the Holy Land...*, p. 230; "During the first decade of the British administration, the urban Jewish sector underwent a sweeping transformation. The Jewish population in towns doubled its size, reaching 128,467 in the 1931 census. This trend was clearly towards the three principal urban centres with more than 51,000 Jews in Jerusalem, more than 45,000 in Tel Aviv and 16,000 in Haifa."

KH responded as well to the medical needs of this society in transformation. Its impact on the formation of a civil society remained however more dependent upon the *Histadrut's* ideological and political framework. In this sense it was less able to develop along with society. Even though its membership had already reached 49,400 at the end of 1935 (53 per cent of whom coming from urban Palestine), its network included mainly rural centres. It counted 1 central hospital in the Emek Valley, 140 rural (and some urban) branches, convalescent homes at Motza and on Mount Carmel, the rheumatic (Schweitzer) hospital in Tiberias,¹⁰⁷ 8 dispensaries and first-aid stations in the villages, 12 dental clinics, 32 infant centres, a central medical store and 2 pharmacies in the towns.¹⁰⁸ While remaining more active in rural Palestine, KH too had developed a network which aimed at integrating social issues into medical provision. In 1934, *Davar* emphasised its many activities for the welfare of workers.

Kuppat-Holim is not limited to the care of the sick. It also does Hygiene work and preventive work. It provides maternity services (1400 were served last year); it cares for the health of the children and infants; provides for convalescents facilities for 1500 workers every year; conducts extensive health educational activities; gives sanitary supervision in the labor settlements.¹⁰⁹

By providing increasing medical coverage to society, the HMO and KH embedded medical work into it, though acting in different ways. As both medical agencies were closely connected to the Zionist representative institutions or – in the case of KH – dependent upon the *Histadrut* – such setting roots in society could only be organized from above.

Also relevant to a capillary medical and social coverage was the work of a large number of private committees and associations. These addressed from below some of the most urgent questions of medical provision. Sometimes they dealt with those marginal cases which could not be handled by

¹⁰⁷ HDS, b. 32, f. 14, *Schweitzer Hospital opened by Kupat Cholim*, 1st February 1934.

¹⁰⁸ PRO, CO 733/303/5, Jewish Agency, *Memorandum to PMC*, 1935.

¹⁰⁹ HDS, b. 32, f. 14, [n.a.], "Jewish Labor's Demands upon the Palestine Government. Compulsory Health Insurance, Annual Grant to the Emek Hospital, Exemption of taxes for Kupat-Holim", *Davar*, 6th February 1934.

either the GDH or by the Zionist sick funds. The most typical example of this phenomenon were the numerous committees created to cure and accommodate mental patients. In this respect they undertook several functions: they first of all filled a gap in the medical provision for the *yishuv*. They also revealed the extent to which medical and sanitary issues had been incorporated in the national discourse. The mission of not leaving any settlement of Jews unprovided had been one of the guidelines of the HMO and of KH since the inception of their work in Palestine. The same concept had now been translated into social terms. No group of ill Jews should be left without some kind of medical assistance available.

b) Mobilization from below. Where the HMO, KH or the other sick funds could not reach, a number of committees grew up with the aim of translating into practice the Zionist commitment to welfare. In 1929 there were no less than seventy-two such committees in Tel Aviv alone. Some of them received support from Diaspora funds.¹¹⁰ Others came under the influence of either the HMO or KH (through the *Histadrut*). Most remained self-managed and self-funded.

It is almost impossible to render a complete account of a phenomenon which remained sparse and differentiated. Most of these committees had sprung out of society as an immediate and temporary response to the inevitable shortcomings of a medical and welfare system in the making. Some had a short life. Others are still working in Israel today. *Tipat Halav*¹¹¹ was for example founded in 1920 for the distribution of free milk to the poor infants.¹¹² It represents today an important centre for immigrant welfare.

Some of these committees were concerned with the fate of small numbers of patients, like the association for the treatment of the few existing Jewish lepers.¹¹³ Other associations addressed medical problems on a national

¹¹⁰ CZA, A 187, *Cooperation between Jews and Arabs in Health Work*, 1929.

¹¹¹ <http://www.tipa.co.il>

¹¹² In December 1920 Mrs. Harold Solomon from London equipped a milk kitchen for the poor of Jerusalem. By July 1921 a second kitchen was established next to the Rothschild hospital. During the first two years both kitchens were managed by HMO nurses. The *Histadrut Nashim Ivrit* also cooperated to this scheme. In D. Miller, *A History of Hadassah...*, pp. 289-290.

¹¹³ ISA, M 1534 15/132. This association was absorbed into the network of the HMO after 1931.

scale, like the already mentioned ATL; at the end of 1934 there were 911 patients registered at its centres. It maintained clinics in Tel Aviv, Jerusalem and Haifa in co-operation with the HMO. In 1935 the ATL built a convalescent home in Mekhor Haim (Jerusalem).¹¹⁴

A few associations defended the social and welfare rights of women, like the 'Palestine Jewish Women Equal Rights Association' founded in 1919 (PJWA). The *Histadrut Nashim Zionot* (HNZ) combined the protection of women's rights with social values. The activities of the Women International Zionist Organization (WIZO) for women can also be included in this framework.

Other committees sponsored a number of German Jews to attend courses in vocational schools or in institutes of higher learning. The Central British Fund for German Jewry (CBF) raised funds for the employment of a number of them at the Haifa Technion as doctors, engineers, and technicians.¹¹⁵ Others foreign-based organizations also converged to establish a German Emergency Fund.¹¹⁶

One of the fields where both the Zionist and the British system had been most lacking was in the provision for mental diseases. The two major hospitals existing in the country (the governmental mental hospital at Bethlehem and the Jewish Ezrat Nashim) remained in fact constantly short of funds, space and personnel.¹¹⁷ In this context, a number of private associations provided a service which was much needed in a country reported to have an extraordinary high number of then-called lunatics.¹¹⁸

¹¹⁴ ISA, M 1512 5/72.

¹¹⁵ CZA, L 13/120, Letter from the Principal of the Central British Fund for German Jewry to the Joint Secretaries, London 2nd August 1934.

¹¹⁶ ISA, M 125 E/83/31, J. L. Magnes, *Address at the opening of the Academic Year 1933/34*, Hebrew University, 5th November 1933. The CBF contributed in 1933 with £ 5,000. The JDC donated £ 2,500. The American Friends of the Hebrew University gave £ 860, Mrs Felix Warburg from New York City participated with £ 2,000, the American Jewish Physicians Committee (AJP) put in the fund £ 800, Senator Van Den Bergh from The Hague took part with £ 400 and Mrs. Helena Davis from London with £ 200.

¹¹⁷ PRO CO 733/223/4, ISA M 1576 54/4, ISA M 1576 54/18, ISA M 1577 54/30, ISA M 1566 43/110, ISA M 1561, 33/57, CZA S 48/43, PRO CO 733/144/18, PRO CO 733/155/13, PRO CO 733/225/4, PRO CO 733/226/4, RH-MSS-Brit. Emp. 400, b. 129, f. 43, Colonial n. 134..., ISA M 1576 54/18, ISA M 1577 45/30, ISA M 1576 54/6, ISA M 1576 54/27.

¹¹⁸ The figures for Palestine were reported to be similar to those of England for the same period, i.e. one patient in 300. ISA, M 1576 54/4 [n.d.] No figures are available for the Arab

The following are just a few examples among the many possible. A 'Committee for the help to the Insane' had been founded in Tel Aviv in 1931.¹¹⁹ It aimed not only at providing medical work. It also intended to become a possible academic centre for the study of mental illness. Statistical surveys, scientific research, publication of scientific literature on the subject and institutionalized workshops connecting the other associations dealing with the insane were also part of their organized effort.¹²⁰ The first building purchased by the association was in Ramat Gan (Tel Aviv); in the summer of 1934 the association moved to Bnei Beraq (Tel Aviv).¹²¹ Patients were admitted on payment of fees by relatives or by Jewish charitable societies. There existed several other Jewish private homes for mental patients. One was run in Bat-Yam by Mr. Shemuel Gefen, accommodating in 1939 twelve persons. Another one was the Bitan Nursing Home in the Jerusalem on the Petah-Tiqva Road, assisting in the same year 40 patients. Another institution of this kind, the Har Hazofim House on Mount Scopus, was discovered accidentally in Jerusalem:

from the terrible screaming that comes from this place, notably at night, we are forced to the conclusion that it is an insane asylum for women.¹²²

The Palestine Government had acknowledged its failure in this sector in 1939. It decided to turn a blind eye on private nursing homes more out of necessity than out of approval.¹²³ That inadequacy of the provision in the

population for a complex set of cultural reasons. See ISA M 1576 54/18. See also M. Simoni, "At the roots of division..."

¹¹⁹ ISA M 1577 54/30. From 1934 the same organization is also referred to as the 'Committee for the help to the Insane' to which the Government denied official recognition for the first time in 1936 on grounds of the society's unsatisfactory housing methods.

¹²⁰ Ibid.

¹²¹ Ibid., It hosted fourteen female patients, an office and a kitchen in a seven room building. Eighteen male patients were accommodated in a five room building. Other nineteen female patients were placed in a five room building for a total of 51 patients. Upon inspection the GDH emissaries reported: "In the three buildings only one is provided with flush latrines and a bathroom. There is an insanitary privy pit latrine and shower for each of the remaining two buildings. The general cleanliness of the kitchen is unsatisfactory."

¹²² ISA, M 1513 5/103, 20th February 1942.

¹²³ ISA, M 1576 54/18. See also ISA, M 1577 54/30. The main parts of the report of Dr. Roch on the conditions in the Lunatic Asylum of Bnei Berak were taken by the Southern District SMO in his letter to the District Commissioner on 21st July 1938. They read as follows: "The conditions outlined by Dr. Roch are very grave indeed and call for early remedy but what form that remedy is to take will need to be a matter for discussion: a) There is no room in the Mental Hospital, Bethlehem, for so large a number of patients. Indeed even single urgent cases from

Government hospital gradually brought to the legitimization of Jewish illegal institutions. This represented an important social and political recognition of the self-sufficiency of the Zionist system *vis-à-vis* both the other governmental system and the non-Jewish population. Those who belonged by religious or cultural affiliation to the Zionist network could see the effects of some forms of hospitalization and cures. The others, including the Arab population, were left out. By 1940 only 5 Jewish patients were accommodated at the Government Hospital in Bethlehem against the 68 cases of 1931. The total number of Jewish patients assisted in Jewish private institutions had risen to 380 cases.¹²⁴

These remain just a few examples of a network which involved committees for the cure of sexually transmitted diseases (STD), autonomously managed orphanages, institutions which combined teaching and welfare etc. As indicated by the numbers quoted above, they continued to address the needs of a small part of the *yishuv*. Still, they contributed to make a difference with an Arab population which remained excluded from this network because of cultural, social and national reasons. While the Arab lepers were banned from moving from the Silwan Leper House, where they were secluded,¹²⁵ the Jewish lepers could move freely in the country after they had begun treatment. As a result they could earn a living.¹²⁶ No facilities for the treatment of STDs existed in the country. Upon the publication of a report on their incidence in 1933, it was however discovered that STDs were among Jews less widespread than among other groups as a result of propaganda and teaching in schools.¹²⁷

this district cannot be accommodated. (...) b) It appears that the present management of the Bnei Beraq Home cannot find money to maintain it. c) You will recall that as long ago as 1934 I inspected the place along with Mr. Perowne, the then Acting Assistant District Commissioner and we rendered a report. (...) Though the place was unsatisfactory from most points of view, I did not feel justified in advising its closure, as it was felt that it was serving a useful purpose, but no license was granted."

¹²⁴ ISA, M 1576 54/18, 24th April 1942. The figures are as follows: a) Ezrat Nashim 60, b) Bnei Beraq Asylum 120, c) The Givat Shaul, Jerusalem 100 d) Private institutions in Haifa, Bnei Beraq, Bat-Yam and Jerusalem 100. These figures contrast with the situation of patients in the Government mental hospital in 1942, as reported in ISA, M 324 M/9/42.

¹²⁵ ISA M 1511, 5/8/A

¹²⁶ ISA M 1534 15/132.

¹²⁷ MEC, J&EM b. 58, f. 2 [1933] On STD in historical perspective, see C. Quétel, *Le mal de Naples*, Editions Robert Laffont, Paris, 1986.

The combination of these two modes of networking – ‘dense’ and ‘loose’, from above and from below – led to a capillary medical and social coverage in society and among the population. This ultimately corresponded to the capillary coverage displayed territorially. The integration of the medical network in society also contributed to a rising in the standards of medical provision. As social questions were increasingly addressed by medical agencies, strictly medical issues were dealt with in a more specialized way. As happened in administration, in society too, rising standards led to a progressively more marked autonomy from the British government. All these elements gave Zionist civil society the necessary cohesion and strength to become a political instrument geared at institution- and state-building. Such a network, organized at different levels appears even more impressive if compared to the altogether miserable results obtained in the same field by the GDH, as reported in the words of its director, Col. G. Heron:

The result has been that essential and normal developments have been postponed from year to year, staff has been steadily reduced, there is not adequate provision for hospital treatment of infectious disease, the expansion of school medical service has been limited to Government and a very few private schools, the establishment of infant welfare work by Government funds is limited to a few of the most backward areas and in the main has been left to voluntary effort, district maternity services so essential in an ignorant and neglected population, are only beginning to be established in two areas, a travelling ophthalmic hospital was abolished, specialised ophthalmic services have been limited to those areas of the country in which the scourge of blindness is most appalling, the provision for institutional treatment for sufferers from mental disease is hopelessly inadequate through postponement of capital expenditure, the investigation into the incidence of tuberculosis has been hampered by the reduction of staff and the formulation of a programme for dealing with this disease inevitably delayed, the two Government hospitals are still housed in inadequate and impoverished buildings, a general scheme for the prevention and treatment of venereal diseases cannot be undertaken, the institutional care of lepers is left to charitable agencies, the Government hospital accommodation in Northern District and elsewhere is inadequate.¹²⁸

¹²⁸ PRO, CO 733/223/4.

The phase of hospital construction which began after 1935 for both the HMO and KH represented one of the concluding stages in this process of medical networking which had involved progressively larger areas on the territory and increasing numbers among the population.

3. Networking the nation.

The second half of the 1930s saw the construction of two major hospitals: the Hebrew University-Hadassah Hospital in Jerusalem and the Beilinson Hospital in Petach Tikva (KH). Both these institutions had been planned as major medical centres and as the two structures which could provide for the needs of the whole *yishuv*. In this respect they were not meant as connecting points of a regional context, or to respond to the needs of their surrounding reality. They had both been planned as national institutions, able to connect the periphery of the Zionist settlement to its respective centres, Jerusalem (with its university) and Tel Aviv (Petach Tikva). Although arrived last in the medical network of the two medical agencies, they soon asserted themselves as its centres. As such, they undertook not only medical functions, but also those which were expected from national institutions in an immigrant country. They coordinated medical activities country-wide. They contributed substantially to the absorption of new immigrant physicians – and of German Jews in particular. With their imposing size on the Palestinian landscape, they also represented the tangible sign of the Zionist organized presence in the country.

Part three of this chapter accounts for the final steps which the two Zionist medical agencies undertook to consolidate their territorial and social networks into a major national undertaking. The way in which these two hospitals dealt with the emergency of the 1936-39 riots also indicates how they had acquired the relevance of national institutions, in their being indispensable for the whole *yishuv*. It also demonstrates the substantial progress which the Zionist medical agencies had been able to make since the riots of 1929.

Section one examines the foundation of the HU-Hadassah hospital in Jerusalem and its importance in the absorption of German immigrants. Section

two analyzes the process which led to the construction of KH's Beilinson hospital in Petach Tikva.

a) *The HU-Hadassah hospital in Jerusalem and the German alyia.* The construction of a large-scale hospital in partnership between the HMO and the HU represented an expansion of the plan for the construction of a medical centre begun in 1933-34. Two ideas directed this expansion: first of all, the new hospital was to "serve not only Jerusalem, but all of Palestine."¹²⁹ In drafting the plans for its construction, Dr. R. Katzenelson - the director of KHA and manager of the Department of Statistics and Social Insurance of the HMO - calculated the number of beds which would be necessary not only for the expected needs of Jerusalem. He took into account the needs of the whole *yishuv*, "which today counts a quarter of a million souls, and which is increasing at an unpredictable rate."¹³⁰ The new hospital was therefore meant to take over those functions from the Rothschild hospital. This would have remained as the medical centre of Jerusalem.¹³¹

The existing hospitals in the city will satisfy the immediate community needs, referring special cases to the University hospital in the same way as the Haifa, Tel Aviv and Emek hospitals are now sending special cases to the Jerusalem hospital.¹³²

In the second place one of the functions of this major medical centre was to co-ordinate from one single place both public health and medical provision. In this respect, the HU represented the best which the country could offer in terms of medical and biological research. It also provided the possibility to get going an educational and professional system which could perpetuate the formation of physicians.¹³³ The university base of the new

¹²⁹ HDS, b. 33, f. 9 *Hadassah-University hospital-Application for government grant*, Letter from Chancellor of Hebrew University to Chief Secretary, 22nd November 1934.

¹³⁰ HDS, b. 53, f. 1, Dr. R. Katzenelson, *The rural Yishuv and the Hadassah-University hospital*, May 1934.

¹³¹ HDS, b. 198, Letter from Mrs Samuel Halperin to Dr. Jehuda Magnes, 22nd October 1931.

¹³² HDS, b. 52, f. 1, Minutes of the meeting of the Hospital Site Committee, 29th November 1932.

¹³³ The construction of such medical school as a national institution represented a limit for those Arabs who wanted to study medicine. In this field the Arab population was disadvantaged by the fact that they had no access to institutions of higher learning in the country. Those Arabs who wanted to study medicine usually went to the American University of Beirut or to the American University of Cairo (AUB and AUC). The CO provided a number of scholarships for Arabs to study medicine or to specialize at the universities of London,

hospital could moreover be used to “attract high ranking men in special fields of medicine.”

After 1933, it was however no longer necessary to attract them, as they had already been flocking to Palestine throughout the year. On the boat that brought her to Palestine in 1933, the journalist and historian Gabriele Tergit [Elise Hirschmann] met many of them. Fleeing herself, she left a rather poignant diary of her trip and settlement in Palestine.

On the boat travel Jews physicians. They have exercised their profession for thousand of years. Experienced or uninformed, specialized or unspecialized, their knowledge and science has become useless. Useless is their determination. The world does not know what to do with it. Here in Palestine only a few hundred will find employment.¹³⁴

In August 1933 the *Daily News Bulletin* titled:

Expelled Jewish professors and scholars in Germany to be provided with opportunities in Hebrew University in Jerusalem: steps to be taken to widen scope of University: programme of development agreed upon for extension of existing institutes and inauguration of new Departments.¹³⁵

The previous day the president of the HU, had referred to the “recent wholesale dismissal of Jewish professors and scholars in Germany” as an emergency of unprecedented gravity. Since the beginning of 1933 the administrative offices and the governing bodies of the HU had been in constant consultation as to the most appropriate steps for widening the scope of the university and for providing facilities for the expelled German professors and scholars. This scheme included the preparatory measures for the establishment of a Faculty of Medicine.¹³⁶

Oxford and Cambridge, provided they would come back afterwards to serve as officers in the Department of Health. See PRO CO 733/188/6, 1930, PRO CO 733/227/7, 1932, PRO CO 733/241/7, 1933, PRO CO 733/261/6, 1934, PRO CO 733/306/9, 1936, PRO CO 733/340/3, 1937. See J. T. Shuval, *Entering Medicine. The Dynamics of Transition. A Seven Year study of Medical Education*, Pergamon Press, Oxford, New York, 1980.

¹³⁴ G. Tergit [E. Hirschmann], *Sul diretto per Haifa. Impressioni di viaggio in Terra d'Israele 1933-1938*, ECIG, Genova, 1996, p. 20, edited by J. Brüning.

¹³⁵ PRO, CO 733/235/3, Extract from ‘Daily News Bulletin’, n. 190, 19th August 1933.

¹³⁶ ISA, M 125 E/83/31 J. L. Magnes, *Address at the opening of the Academic Year 1933/34*, Hebrew University, 5th November 1933. Medicine was not the only field where expansion had been devised to absorb such educated *alyia*. The HU established the Chaim Nachman Bialik Chair of Hebrew Language, of which the occupant became Professor Torczyner, formerly of the ‘Hochschule für die Wissenschaft des Judentums’ in Berlin. The Music department was

The development of such faculty was not directly consequential on the arrival of so many refugees from Germany. However, this immigration certainly accelerated its foundation. Most of the pre-conditions for its coming into being were in fact already present: the existing medical laboratories and the research staff could constitute its research branch. "Hundreds of Jewish students both from Palestine and abroad"¹³⁷ could join its medical school. Those German physicians "of outstanding merit recently evicted from their academic posts in Germany" would represent an important part of its medical and teaching personnel. Given these conditions, the HU-Hadassah hospital would become the centre where all these activities could converge and be coordinated.

The foundation of the HU-Hadassah hospital in Jerusalem could also proceed so speedily because of the HMO's withdrawal from direct involvement in medical activities in 1936. Once the municipalities had assumed responsibility for the management of medical structures and services *in loco*, and once the diverse medical committees set up by the HMO had begun to be independent in their welfare and social work, the HMO could devote its energies and its resources to the national coordination of medical activities.

b) *The Beilinson Hospital.* Together with the *Histadrut*, KH grew in importance and size from the mid-1930s onwards. The construction in 1936 of the Beilinson hospital, KH's major hospital after that in the Emek, represented the expansion – and at the same time - the completion, of its national network of medical provision. The GDH had expressed a favourable opinion on the establishment of such centre, proposing to contribute with a capital grant of LP 4,000 from the government. On the 16th January 1937 the Treasury finally approved a grant of LP 3,700.¹³⁸ This approval was based upon the consideration that "the greatest proportion of the members of the Society are resident in Jaffa District and it is in this area where hospital facilities if any

equally enlarged with the appointment of Mr. Emil Hauser of Budapest and Mr Karl Salomon of Berlin.

¹³⁷ PRO, CO 733/235/3.

¹³⁸ PRO CO 733/323/13, 1936.

should be provided by the Society.” The planned hospital would have moreover relieved the pressure on the Tel Aviv Municipal Hospital.¹³⁹

In the same way as the HU-Hadassah hospital in Jerusalem was coordinating a whole range of social and medical activities, already in 1937 the Beilinson could coordinate on a national scale the activities of most labour settlements. Through its Department of Hygiene, KH supervised hygiene and sanitation in 130 labour settlements and workers' camps. In practical terms this meant that it had direct control over the arrangements of hygienic installations, showers, lavatories, laundries, the construction of living quarters, kitchens and dining rooms. It could also give the necessary teaching to prevent the spread of malaria and other infectious diseases. The existence of such a major national medical centre meant moreover that “even the remotest points” could be readily provided “with adequate first-aid.” Wherever a new settlement was being founded, KH could now be present not only in times of need or emergency. Each new settlement would represent a detached branch of the Beilinson, where its physicians and staff would be resident and where medical equipment would also be available.¹⁴⁰ Within a decade, the Beilinson Hospital had achieved a level of medical provision which equalled that of the HU-Hadassah hospital in Jerusalem.¹⁴¹

The existence of these two hospitals proved essential during the 1936-39 riots. They coordinated medical provision at a time of emergency, when the survival of the *yishuv* was perceived as threatened by an increasingly hostile Arab population. During this decade, the latter had almost entirely been excluded from the network which was being built by the Zionist medical agencies.

‘Networking’ represents one the main concepts for understanding the process which led to the Zionist domination of the territory and of society in Palestine. As the process of networking was fundamentally based on the idea of forging a community on a shared set of values, it left out all those who did not partake to this work of social and political construction. The Arab

¹³⁹ ISA, M 1561 33/102 Letter from Col. W. Heron to Chief Secretary, 14th December 1934.

¹⁴⁰ HDS, b. 71, f. 2, I. Kanevsky, *The Activities of the Sick Fund, 1937*, 1937.

¹⁴¹ S. Shvarts, L. A. de Leeuw, S. Granit, “The salaried model in Israel...”, p. 258.

population remained therefore in the background of an effort of cultural homogenization and political construction which did not – and was not meant to – involve them. Medical agencies played a fundamental role in this process which laid the foundations for a system which developed in an exclusive sense with respect to language, religion and culture.

In setting up this system the HMO and KH had been divided by a number of cultural, social, economic and political differences. However, they shared the vision of a national future which allowed them to build an entire system of medical provision from scratch. It also allowed that system to stand the pressure of an increasingly difficult political situation marked by the growing Arab hostility, the ever more shifting British attitude, the higher number of immigrants entering the country and the political divisions of the *yishuv*. The work of both for administrative autonomy, territorial coverage and expansion in society was kept united by a sense of national mission which turned the Zionist network into a civil society, ideologically coherent and determined to reach the foundation of a state. It is to the ideological dimension of the Zionist system of medical provision which I now turn.

III

Ideology

Mandatory Palestine was a setting where ideology saturated politics, economy, society and the daily lives of the population. Ideology dominated political relations internally to the Zionist movement. Externally, it set the tone of the Zionist exchange with the British government in Jerusalem. Settlement on the land depended upon ideology.¹ Economic policies to increase production were the outcome of fierce debates inside the *yishuv*. Upon productivity depended in fact the capacity of the country to absorb new immigrants – the British key principle to establish the quotas of Jewish immigration after 1931.² Political loyalty and/or affiliation also determined which immigrants were allowed to reach Palestine in the 1930s. According to the balance of power between the Zionist parties, the Jewish Agency prearranged in fact the distribution of immigration certificates in Europe.³ The social organization of the *yishuv* was one of the effects of the domination of ideology over other dimensions of settlement. The *kibbutzim* represent a case in point. Their approach to manual work and their internal division of labour was quintessentially ideological. So was the attitude of the then called pioneers towards the family as a social and economic unit.⁴ The same can be said in reference to the collective education of children.⁵ Distinct schooling systems

¹ The overall diversity between Degania and Merhavia epitomize the different ideological approaches which existed within the *yishuv* in regard to settlement. On Degania see J. Baratz, *A Village by the Jordan. The Story of Degania*, Harvill Press, London, 1954. On Merhavia see F. Oppenheimer, *Merhavyah*, no publishing house indicated, New York, 1914.

² P. Giordano, *Il principio...*

³ Y. Katz, *Partner to partition. The Jewish Agency's Partition Plan in the Mandate Era*, Frank Cass, London, Portland OR, 1998

⁴ Y. Talmon, *Family and Community in the Kibbutz*, Harvard University Press, Cambridge MA, 1972.

⁵ B. Bettelheim, *The Children of the Dream*, Thames and Hudson, London, 1969.

came into being according to ideological and political belonging.⁶ Different European youth movements,⁷ which had so extensively shaped Jewish immigration,⁸ became in Palestine rival youth factions in the power struggles between the Zionist parties.⁹ Diversified approaches obviously developed also in relation to the Arab question.¹⁰ The political dimension dominated the *yishuv* and divided it into keenly opposed groups.

However, all of them shared a national perspective which was embedded in most of their practical accomplishments, regardless of the field. Schools, *kibbutz* movements, youth movements, political parties, representative institutions, the HMO, KH and the other sick funds were all part of a larger project: the construction of the Jewish National Home. This national drive constituted the cultural base for Zionist civil society to translate into practice its political process of state-building, or – to use the terminology of Dan Horowitz and Moshe Lissak – to develop as a state within a state.¹¹ The Peel Commission Report had already used a similar expression for the functions of national coordination of the Jewish Agency.¹² From the mid-1930s this process was normally referred to as *ha-medina ba-derech* (the state on its way).

Health was less susceptible to become an instrument of ideological division than other fields. It responded to the practical collective needs of an

⁶ PRO, CO 733/141/8, 1927.

⁷ G. L. Mosse, *Ebrei in Germania tra assimilazione ed antisemitismo*, Giuntina, Firenze, 1991; R. S. Wistrich, *The Jews of Vienna in the Age of Franz Joseph*, Oxford University Press, Oxford, 1989.

⁸ J. Frankel, *Prophecy and Politics. Socialism, Nationalism and Russian Jews, 1862-1917*, Cambridge University Press, Cambridge, 1981. See also R. G. Braungart, "Historical and generational patterns of youth movements: a global perspective", *Comparative Social Research*, 7 (3), 1984, pp. 3-62.

⁹ For a schematic description of the different political parties and related youth movements within the *yishuv*, see MEC, Tegart, b. 1, f. 3 [n.d., but after 1934]. The diagram which accompanies this description is reproduced in Appendix, Diagram n. 2.

¹⁰ From the Iron Wall theory formulated by Vladimir Jabotinsky in 1923 to the idea of a bi-national state upheld by the Brit Shalom, just to mention the two positions at the extremes of a spectrum of possibilities. See V. Jabotinsky, "An Iron Wall: We and the Arabs", *Ravjet*, 4th November 1923. On the internalization of the Iron Wall theory by Labour, see A. Shlaim, *The Iron Wall and the Arab World*, Penguin Books, London, 2000. On the Brit Shalom see CZA, A 187/17.

¹¹ D. Horowitz and M. Lissak, *Origins of the Israeli Polity. Palestine under the Mandate*, University of Chicago Press, Chicago London, 1978.

yishuv in which disease was spreading regardless of belief or belonging. Secondly, health fulfilled one of the primary cultural and ideological needs of the Zionist movement: the regeneration of the Jewish people in a national perspective.

In order for the Jews to be normalized after centuries of physical, psychological and spiritual oppression,¹³ immigration to Palestine was conceived as the primary necessary condition. However, the act of 'returning' was not sufficient. To free the Jews from the legacy of the diaspora, the new Jew had to be healthy. Zionism had paradoxically internalized the eugenic and racial discourse on the moral, mental and physical degeneration of the Jews in the diaspora. The representation of the Jews as weak and diseased was taken as the image of a larger moral and national degeneration of the whole Jewish people. A reform of the moral and physical characteristics of the Jews was impossible for anti-Semites. For Zionists, these traits of degeneration were dependent upon environment and history, and could therefore be changed.¹⁴ In this perspective, the regeneration of the Jew was meant to be an individual and collective effort to build a new and healthy people (*livnot 'am bari ve-hadash*).

Manual work was celebrated as one of the means for this redemption. Tilling soil in a hostile and disease-ridden country could not however take place without medical assistance. The integration between these two aspects of Zionist settlement was for example constructed in the language of the time. As land had to be conquered through manual work (*kibbush ha-karka*), so health had to be conquered through hygiene (*kibbush ha-hygiena*).

¹² Cmd. 5479..., p. 174. "This powerful and efficient organization amounts, in fact, to a Government existing side by side with the Mandatory Government."

¹³ The controversial relationship between anti-Semitism and physical features has been discussed by S. L. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness*, Cornell University Press, Ithaca London, 1985; Id., *The Jews' Body*, Routledge, London and New York, 1991; Id., *Franz Kafka. The Jewish Patient*, Routledge, London and New York, 1995. One of the defining characteristics of anti-Jewish prejudice in the diaspora – and in Germany in particular – was its medicalization. See J. M. Efron, *Medicine and the German Jews...*

¹⁴ The idea of the regeneration of the new Jewish individual is generally attributed to Max Nordau (1849-1923), neurologist and one of Theodor Herzl's closest advisors. See D. Pick, *Faces of Degeneration: A European Disorder, 1848-1918*, Cambridge University Press,

While each school, *kibbutz* movement, political party, youth movement, etc., believed it could deliver such new individual, KH and the HMO remained the actual guardians of the health of the *yishuv*. They also protected and developed its ideological foundations. Both medical agencies had been founded as national institutions. Both had engaged in their work with a sense of national mission. The HMO in particular had emphasized the importance of “central national” medical institutions “open to patients from all parts of Palestine” serving “the hundred of thousands of sick who require systematic and skilful treatment.”¹⁵ Both organizations responded to the practical and ideological needs of the national movement of which they were main constituents. Given the larger and more sophisticated set of connections of the HMO and its functions of national coordination until 1937, this medical agency led the way in constructing the ideology of health too.

Constructing the new Jew, forming a healthy nation and building the state were therefore three intertwined aspects of one single process. It was not only the immigrant Jew who had the individual right to health. More importantly, the would-be state was also considered to have a right to healthy citizens. A healthy nation would lead to an ordered state. It would create the conditions for the existence of a vigorous army. A nation founded on the values of health would respond well to the demographical demands of a newly established state. It would also favour its economic growth. Healthy citizens were likely to be prolific and industrious. As Dr. Bluestone - former Director of the HMO - wrote in 1930:

The right of every individual to health is the foundation of all our efforts in the field of preventive medicine. The right of the State to a healthy community is the foundation of public health idealism. A healthy community is in fact one of the greatest needs of the state. No country may be considered truly modern that has not taken advantage of the teaching of hygiene which the last few generations have so painstakingly developed.¹⁶

Cambridge, 1989. See also E. D'Antonio, “Aspetti della rigenerazione ebraica e del sionismo in Cesare Lombroso”, *Società e Storia*, 24 (92), aprile-giugno 2001, pp. 281-309.

¹⁵ HDS, b. 53, f. 1, Dr. R. Katzenelson, *The rural Yishuv and the Hadassah-University hospital*, May 1934.

¹⁶ E. M. Bluestone, *Health and Homeland*, “The Palestine Bulletin”, 27th April 1930.

This ideological discourse worked as a connecting thread between the different sectors of a progressively more diversified *yishuv*. It was internalized by most groups until it became a pattern of collective behaviour. It represented an element of uniformity and homogeneity in a civil society otherwise fragmented at a political level. It also offered the background to what was perceived by the Zionist group as a dynamic process of change of the Jewish character and as an important signifier of a new national identity. As a result, it also constituted a strong element of boundary demarcation.

In chapter three I intend to look at medical provision as an ideological instrument to consolidate the cultural uniformity of the Zionist civil society and as a way to establish forms of cultural and social control over it.

The chapter is divided in two parts. In part one, I focus on prevention. This represented one of the main principles which the HMO struggled to introduce into Palestine. Prevention represented a medical attitude in the strictly medical field. In society, it was also constructed as an overall pattern of social demeanour. At an educational level, it became an instrument to branch-out in society. Children in schools were taught how to prevent disease; courses of hygiene were organized for families; lectures on the relationship between health and nation were often organized; exhibits too became a means to spread this message. The network established over the territory and among the population became in this context a powerful instrument to disseminate a culture of health. As Sufian has demonstrated, this operation was part of a larger nationalist undertaking to create a Hebrew culture in Palestine.¹⁷ Prevention was also conceived as the main instrument to make cities safer places to live and to turn the whole country into a healthier national environment.

As a national agency making use of health and medicine to regenerate Jews, the HMO could not but get involved with Mizrahi Jews. They had remained external to the boundaries of the Zionist civil society on account of their lifestyle and social attitudes. Part two of this chapter focuses on the

¹⁷ S. Sufian, *Healing the Land...*, p. 236.

medical and social measures undertaken by the HMO - and by its satellite welfare organizations - for the inclusion of *Mizrahim* in the Zionist civil society. Their (partial) re-entry into the body politic of the new Jewish nation carried a number of ambivalent connotations.¹⁸ Part of the discourse on the introduction of civilization into Palestine, the relationship between Zionist institutions and *Mizrahim* reproduced some of the most ambiguous cultural traits of Zionism. Medical and social work among them was conceived as a cultural and ideological battle in several ways. First of all, it was seen as a way to bring civilization to the old-type Jews against which Zionism intended to react. In the second place, the measures to educate *Mizrahim* to hygiene and health represented a way to make Zionist civil society even more uniform from a cultural point of view. In the third place, medical and social work among *Mizrahim* represented the ultimate frontier in the battle against missions. Unable to afford the insurance schemes of the Zionist medical agencies - or the fees of the Zionist educational system - *Mizrahim* had in fact often turned to them.

1. Prevention

The bacteriological revolution of the 1880s broadened the understanding of the mechanisms behind the propagation of disease. The connection between environmental conditions and social relations was identified as one of the main pathways through which disease propagated. As a consequence of this conceptual conquest, public health policy makers insisted on the importance of eradicating habits of hygienic inefficiency. To limit the incidence of disease, individuals had to be made conscious of the social impact of their personal behaviour upon collective health. They had to be made responsible for the maintenance of health of the whole community.¹⁹ These ideas developed across Europe in the first years of the 20th century. They had

¹⁸ E. Shohat, "Sephardim in Israel: Zionism from the Standpoint of its Jewish victims", *Social Text*, 19/20, Fall 1988, pp. 1-35. Id., "The invention of the Mizrahim", *Journal of Palestine Studies*, 29 (1), Autumn 1999, pp. 5-20.

¹⁹ D. Porter, *Health, Civilization and the State...*, p. 143.

been instrumental for the campaigns to establish a unified health service in England before the First World War. In Palestine too they were at the foundation of medical provision and public health.

In Palestine, prevention was not a monopoly of the Zionist medical agencies. It was part of the culture of all medical service providers. The GDH had organized prevention through measures of public health and through legislation. Missions too had subscribed to this approach. In the Zionist field, prevention in towns was in the hands of the HMO. KH mainly focused on the prevention of malaria in rural Palestine.

With the exception of the Order of St. John (OSJ), both the GDH and the missions considered prevention as something to be dispensed from above to an ignorant and poverty stricken population. The GDH pointed the finger at the lower and less educated classes of the population. They had failed to acknowledge the “the importance in disease of nursing, suitable diet and sick accommodation.”²⁰ Missions too concentrated on the “less educated and less civilised classes of the population, especially in rural districts.”²¹ The OSJ called into the picture the general low cultural level of the population. This had made the problems caused by trachoma “practically insoluble.”²² In the case of measles, living standards were recognized as the “conditions which ensure its spread.”²³ General sanitary conditions were considered responsible for the outbreak of typhoid fever of 1925. They were also presented as the main causes of a whole list of other diseases which ranged from plague to tuberculosis, from malaria to mumps, from scarlet fever to puerperal fever and so on.²⁴

Poor living conditions affected Jews as well as other population groups. The difference between the Christian, the Moslem and the Jewish communities was made by the ways in which prevention was applied by their respective medical providers. The GDH focused on prevention through public health and legislation. It did not intervene directly among the population with educational

²⁰ PRO, CO 733/130/5, 1927, Health Department *Annual Report*, 1925.

²¹ MEC, J&EM b. 58, f. 2, 1930.

²² KOSJ, Report of the Committee for 1925, London [1926], pp. 7-8.

²³ PRO, CO 733/144/12, 1926.

or medical programmes. Some private medical agencies, like the OSJ, addressed the problem in a more pragmatic way. In 1932, Col. J. C. Streathearn – Warden of the Order and Honorary Consulting Ophthalmic Surgeon of the Government – had envisaged a scheme to educate the women of the poorest villages to domestic hygiene. Their education was conceived here as the pre-condition to contain the propagation of infections.²⁵

The contempt of British administrators and of missionaries towards the local lower classes reproduced in Palestine a well-established pattern of colonial cultural and social attitudes.²⁶ For Zionist medical agencies too the idea of prevention was not disconnected from colonialism. However, the presumed civilizing mission of Zionism came from a tradition other than the imperial one. It did not mean to extend civilization to the natives in order to dominate over them. It rather wanted to demonstrate its own cultural superiority in order to exclude the local population from the national community it was building in Palestine. Building a nation and the civilization of its members were therefore two sides of the same coin.

The HMO founded and developed its network of medical activities on the idea that prevention is “the advance guard of civilisation.” Hadassah regarded prevention as the natural and logical outgrowth of the spirit of investigation which had led to the development of medicine.²⁷ The HMO also

²⁴ *Ibid.*

²⁵ RH, MSS. Brit. Emp. S 284, b. 13, f. 1, J. C. Streathearn, *Memorandum on the problem of Blindness in Palestine*, 30th November 1932. “In brief, my scheme is as follows. A good type girl from fifteen to sixteen years of age (when they become marriageable) should be selected, one from each of the smaller villages and two or more of the larger ones. They should be brought to Jerusalem (...) and housed in a suitable building in the Old City. The girls would retain their own clothing, sleep on mattresses on the floor and do all the work (cleaning, washing, cooking, sewing etc.) of the place. In fact they would live the lives to which they are accustomed, but in everything they should be taught to do these things and whatever else is required in their village lives better tactfully influenced to leave undone certain things that are at present done in the villages. They should be taught very elementary hygiene, the rudiments of home nursing and first aid (with special emphasis on what not to do). (...) No attempt should be made to teach them reading and writing. The course of training would last about five months when the girls would be returned to their villages and be expected to carry out a certain prescribed duty there.”

²⁶ MEC, Bowman; MEC, Emery; MEC, Norman; MEC, Perowne. RH, MSS. Brit. Emp. S 284 (Chancellor); MSS Brit. Emp. S 278 (R. O. Williams); RH, MSS Brit. Emp. S 382 (Flora and Sidney Moody).

²⁷ E. M. Bluestone, *Health and Homeland*, “The Palestine Bulletin”, 27th April 1930.

conceived prevention as the only possible instrument to establish in Palestine a community composed of aware and healthy individuals. Its preventive policies reflected the idea of the inevitable mutual relationship between different factors: disease, the environment, social behaviour and collective health.

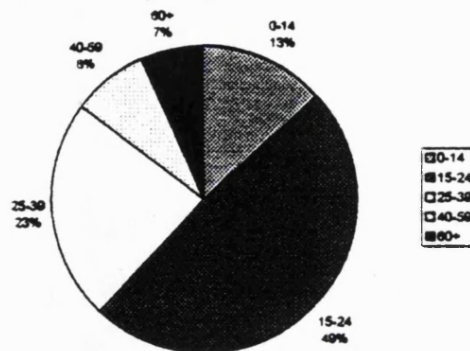
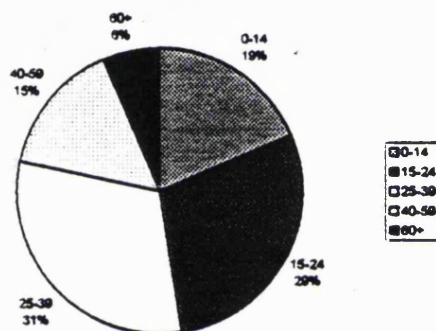
This wide-ranging preventive work was not only focused on individuals and families. Since the preventive policies of the HMO aimed at making the environment a healthier place, they also included Jewish settlements and towns. These were then represented and portrayed as exemplary settings where the culture of health dominated. Here the Zionist project could prosper. Here the regenerated Jews could live and raise children. Sanitary standards would make Jewish towns distinct from Arab urban centres. *Kibbutzim* and the other rural settlements were presented as “islands of health and civilization”²⁸ in a perceived ocean of disease and barbarity. Prevention also went beyond medical contexts. It was extended to society and to social relations. Here it could be used to contain perceived deviant behaviour.²⁹

a) *Educating Jews to health.* In order to dominate the propagation of disease, at the beginning of the 1930s the HMO conducted a general survey on the *yishuv*. The results confirmed that conditions existed to reduce the incidence of disease and to prevent it from spreading. The survey also demonstrated that, because of age, occupation and gender distribution, the *yishuv* could have been receptive to programmes aimed at education to prevention.

Immigrant Jews were young. Most of them were comprised in an age group which ranged between 14 and 40. Such a young *yishuv* should not have been so susceptible to illness, at least in theory. As the charts below indicate, after 1932 there was a rise in the average age of Jews in Palestine. This may be attributed, among other factors, also to the arrival of the German *alyia*.

²⁸ HDS, b. 56, f. 5, 1934.

²⁹ M. Simoni, “At the roots of division...”

8. Jewish immigrants by age group (1928-31).³⁰9. Jewish immigrants by age group (1932-39).³¹

The classification of this young *yishuv* by occupations pointed even more clearly at the possibility that a country-wide programme of prevention and health could be successful. Most Jews were relatively educated. In Palestine they worked as agricultural labourers, construction builders and businessmen. Many of them were also employed in the liberal professions. As for gender percentages, all age-groups showed a substantial balance between

³⁰ Elaboration of data from S. N. Eisendstadt, *The Absorption of Immigrants. A Comparative Study based mainly in the Jewish Community in Palestine and the State of Israel*, Routledge, Kegan & Paul Ltd., London, 1954, p. 35.

³¹ Ibid.

men and women.³² The absence of heavy industries in Palestine contributed to limit the risk of occupational disease and of accidents.

The “primitive housing conditions” in which Jews lived after their immigration to Palestine were then invoked to explain the high incidence of disease. The HMO regarded this as one of the main causes for infant mortality and for the susceptibility to disease of young children. As Dr. Yassky wrote in 1930:

The housing conditions in Palestine are worse than in other countries and the social strata of the Yishuv are different and poorer in the economic sense. In Palestine there are many individuals without a family, and a very large number live in houses where conditions are worse than primitive. It is sufficient to call to mind the housing conditions in the Kibbutzim of the chalutzim and the conditions in the urban quarters in which the poorest of the Oriental Jews have settled.³³

From a medical point of view, the living standards of Jews in Palestine seemed an urgent issue to be addressed in both the rural and the urban setting.

There existed two possible approaches to introduce prevention into Jewish behaviour. The first had been experimented by the HMO since the arrival of the first three American nurses in Palestine in 1913. It consisted in bringing health to the people. The home visits of the HMO nurses represented the main point of a system which continued to function during the 1920s. The second approach was the result of the territorial expansion of the *yishuv*. It was the outcome of its increased population and of the wider availability of medical structures in both number and in kind. Hospitals, health centres, clinics and local ambulatories became places which Jews were encouraged to attend. Here they could obtain not only medical cures. They could also receive training in prevention. The medical centres of the HMO had in fact been conceived as places which embodied that ideology of health which Zionism was building. This network of prevention was coordinated by the ‘Central Department for

³² CZA, J 113, Address by Dr. Yassky before the Jerusalem branch of the Jewish medical society, 13th February 1934. In the age group 0 to 10 years old there were 254 males and 247 females per thousand inhabitants; only 77 and 75 males and females per thousand inhabitants were counted among the population in the age group 10-15 years old; there were equally only 133 males and 142 females per thousand in the age group 40-60 years old and 62 Jewish males and 71 Jewish females among those aged 6 and over.

Preventive Medicine of the Knesset Israel'.³⁴ Following the second devolution of the HMO in 1936-37 – as analysed in chapter one – the *Vaad Leumi* took over the management of this department on a national scale.

Figures for hospital attendance in the 1930s reveal an increase in the presence of Jews in both absolute and relative terms. In 1932, 15,034 Jews had been admitted to the different Jewish hospitals existing in the country.³⁵ In 1935, the memorandum prepared by the government of Palestine for the Peel Commission revealed that Jewish attendance to Jewish hospitals had risen to 22,282 admissions p.a. The number of children which came under the supervision of the Department of Hygiene of the HMO rose from 25,340 in 1930 to 27,979 in 1931. In the same year there were 7,318 expectant mothers registered at the health and welfare centres of the HMO. They provided for more than 8,000 children all over the country. The number of visits to the HMO clinics had reached the number of 543,754 in 1930.³⁶ Only counting the polyclinics of the HMO in the main towns of Palestine, there had been 419,757 visits in 1933. This figure included the visits obtained in the structures of KHA.³⁷ In 1935, the number of out-patients in Jewish medical institutions had reached the extraordinary figure of 682,099 treatments. Jews attended medical centres twice as much as non Jews. In the same year there had been in fact 304,287 non Jewish out-patients.³⁸ In 1938 571,814 Jews had attended voluntary hospitals as out-patients. As the chart below shows, the attendance of the Jewish community had in 1938 increased exponentially in comparison to that of the other communities.

³³ Ibid.

³⁴ HDS, b. 56, f. 4, 1934.

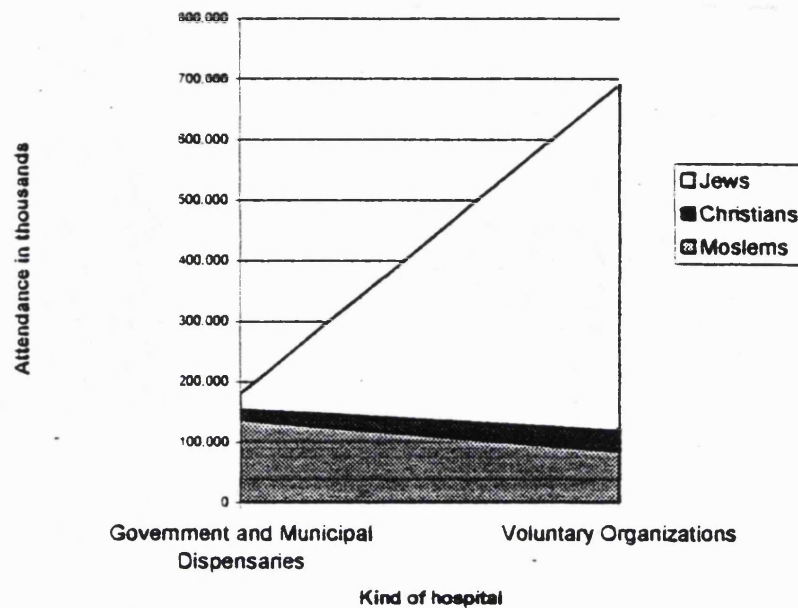
³⁵ CZA, J 113, Address by Dr. Yassky before the Jerusalem branch of the Jewish medical society, 13th February 1934.

³⁶ HDS, b. 57, f. 5, 1933.

³⁷ HDS, b. 32, f. 14, 1933.

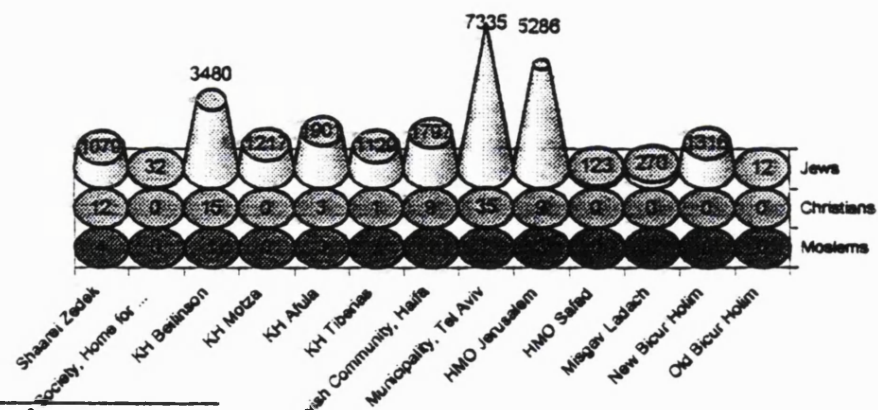
³⁸ Colonial n. 133..., p. 139.

**10. Out-patients attendance in Government Hospitals
and in Voluntary Organizations classified by religion (1938).³⁹**



As indicated in the three following charts,⁴⁰ by 1938 attendance to hospitals and health centres had also developed as completely separate for the three communities living in Palestine. Jews attended only Jewish medical structures. Moslems and Christians made use of governmental and missionary institutions.

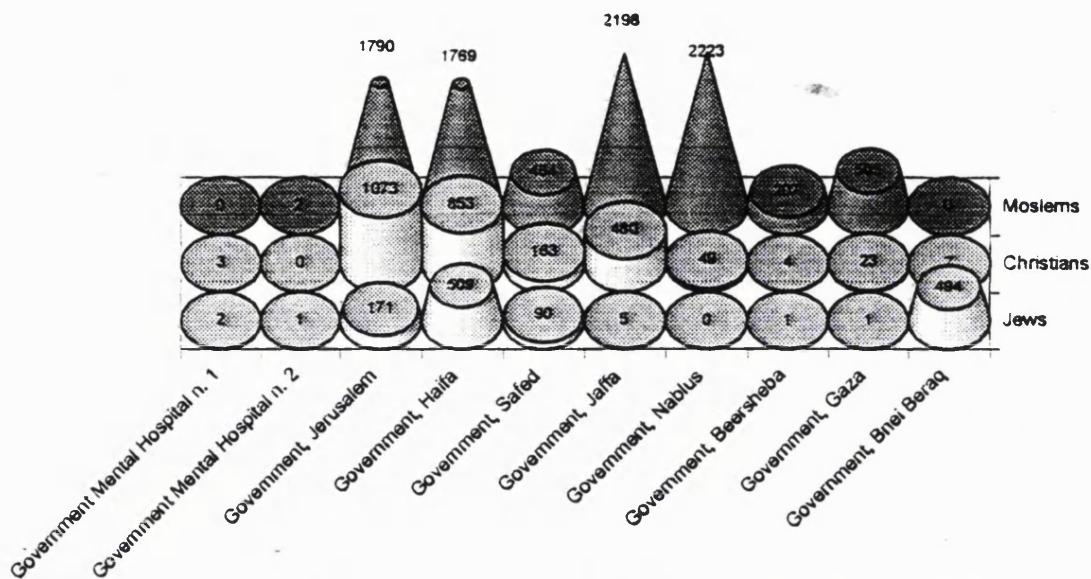
11. Number of visits in Jewish Hospitals classified by religion, 1938



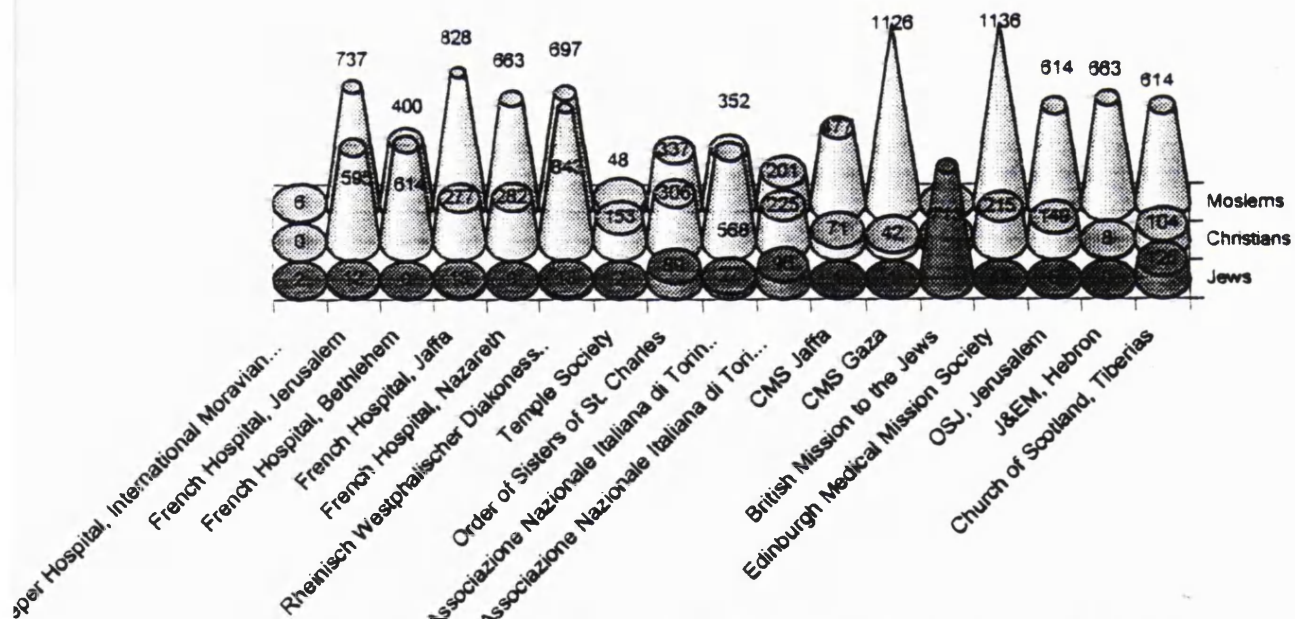
³⁹ Elaboration of data from PRO, CO 733/ 399/24, 1938.

⁴⁰ Elaboration of data from *Ibid.*

12. Number of visits in Governmental Hospitals classified by religion, 1938



13. Number of visits in Missionary Hospitals classified by religion, 1938



The high figures of Jewish attendance to Jewish medical structures can be explained by looking at the ways in which the Zionist agencies involved with

the health of the *yishuv* constructed a culture of health. From the late 1920s onwards KH, the HMO, the *Vaad Ha-Briut*, the 'Hebrew Medical Association', the 'Committee on Public Health' of the Jewish Agency and the Zionist agencies concerned with health embarked upon a vast and sweeping action to inculcate in the Jewish immigrants the idea that disease could be prevented. They considered prevention as the culmination of their rational and scientific approach to the organization of health. Rationality and science would defeat disease. They would lead Jews to dominate the environment, be it the malarious swamps of rural Palestine or the unsanitary quarters in towns. In this respect, prevention could offer an important spring board for a regeneration founded on values believed to be universal.

Prevention became therefore a notion which carried a practical utility. It also had a strong ideological base. In order to make its advantages readily understood and adopted, it was detached from the realm of medical and high culture. Columns and health sections on the daily national newspapers, the organization of health weeks, education in schools, exhibitions and specialized courses were some of the means which turned prevention into the new way of Jewish life.

In her work on malaria, Sandra Sufian has analysed this extensive work of propaganda in relation to this particular disease, considered then as the greatest enemy of the Jewish immigrant.⁴¹ Most of the sources that she surveyed and analysed did not limit the message to the prevention of malaria. They also focused on a whole series of other diseases which were considered avertable through education to a healthier lifestyle. These last two elements would have made the environment healthier too. This exercise in propaganda complemented the administrative, social and practical work of the Zionist medical agencies. In order to lead the nation to health, it was not sufficient to offer medical provision. The HMO and KH also needed a responsive population which could maintain the results achieved through medical cures. This strategy also aimed at reducing expenses for medical provision.

⁴¹ S. Sufian, *Healing the Land...*, p. 264.

Propaganda was considered to represent an investment which would bear its fruits in the long-term.

The press represented one of the main instruments to convey the message that a healthy environment, prevention and the construction of a strong nation were necessarily intertwined. Newspapers and magazines maintained regular columns and sections on health.⁴² From 1931 *Davar* published a column called *Smirat briutech(a)* (Guard your Health); *Ha-Aretz* had a weekly column entitled *Briutenu* (Our Health); *Ha-Boker* also printed a health supplement. Here various physicians discussed topics which included pregnancy, eugenics, typhus, deviant children and the relationship between environment and health. More specific publications also dealt with health issues. The 'Committee on Public Health' of the Jewish Agency published its own magazine, *Ha-Briut Ha-Am* (The Health of the Nation). Between 1932 and 1935 a journal called *Briut* (Health) was published on a national scale. Its subtitle testified of its civilizing intents: "Bi-weekly journal for health, hygiene and enlightening." *Shaarei Briut* (The Gates of Health) circulated between 1932 and 1934. The main focus of this journal remained prevention of malaria and its national significance.

Lectures given by physicians were a second possible means to disseminate notions of prevention and of health among the population. They were usually delivered in Hebrew or in English. They addressed questions which ranged from tuberculosis to tooth disease, from eye infections to general sanitation, also including women's issues.

A third crucial way to familiarize the population with health issues and to demonstrate the advantages of prevention over treatment were the 'health weeks' sponsored by the HMO. 34,090 people attended the first one in 1924. 4,880 of them were children. Other health weeks are recorded to have taken place in 1925, in 1932 and in 1936. Pamphlets were printed and distributed for free to the participants. Most of them emphasized the relationship between

⁴² This and the following paragraphs on propaganda rely extensively upon the material collected and analysed in *Ibid.*, pp. 241-302.

hygiene, environment, personal behaviour and the strengthening of the national community. Granting 'certificates of health' to children who attended courses at the HMO welfare stations was another aspect of this work of mentality formation. Children were in fact seen as those who could contribute to change the hygienic and health habits of the parents. The latter were there referred to as having been 'converted' to the idea of health.⁴³

The public interest for health issues was also witnessed by the growing number of publications dealing with sanitation, family health, hygiene, first aid, sexuality, pregnancy and prevention in general. Many of these books were published (or paid for) by the Straus Health Center and/or by the HMO.

There was a fourth way in which medicine and health were considered helpful to the regeneration of the Jews. Most of the above mentioned journals, pamphlets and books were in Hebrew, a language which had not yet incorporated most of the contemporary medical terminology. The publication of at least two professional medical journals contributed to integrate into this re-constructed language the necessary theoretical and practical terms which modern medicine needed and which Hebrew still lacked. *Ha-Refua* (Medicine) began publications in 1920; in 1929 it became a regular bi-monthly and in 1937 it was turned into a monthly journal. From 1935 KH edited its own magazine, *Medical Leaves*.⁴⁴ The publication of this scientific and specialist literature in Hebrew showed how medicine could also be integral part of the Zionist nationalist project. These journals contributed to the creation and consolidation of a scientific community. They favoured a continuous exchange of information between physicians. At the same time they provided them with the opportunity to maintain a lively scientific debate on medical issues.

Matters of personal and family hygiene were re-shaped in mandatory Palestine both to advance the civilising mission of Zionism and to create a healthy community. The network of the HMO in society had proved an

⁴³ HDS, b. 53, f. 2, 1935.

⁴⁴ Available in very few libraries. I could consult some issues of *Medical Leaves* at the Medical Library of the University of California Los Angeles.

invaluable instrument for this purpose. As we have seen in chapter two, the medical networks were also rooted in the territory.

As vital centres of the Zionist network, cities too had to become places where the ideals of prevention and health would be enforced. I now turn to prevention as a principle of urban organization and of Zionist settlement in towns. Here Tel Aviv will be analysed as an exemplary case. It set in fact the pattern for other cities with a Jewish majority to follow. Here, public health policies were meant to draw a precise boundary line between the areas which had been civilized by Zionism through health and those which had remained 'Oriental'.

b) *Living in healthy Jewish cities.* In mandatory Palestine there was one Jewish city: Tel Aviv. Haifa, Jerusalem, Safed, Tiberias were all important centres of Jewish settlement, each in its own way. However, they could not claim the same uniqueness of Tel Aviv as the first entirely Jewish city in the world. Tel Aviv stood as a symbol under many respects. To use an expression of Hannah Arendt, it accorded itself "rights against the past." It represented the rejection of the diaspora. It equally refused the negative image of the European city life.⁴⁵ From the point of view of health too, Tel Aviv was ideally meant to stand against life in the *shtetlach* of Eastern Europe. There unsanitary conditions and overcrowding had represented some of the reasons for epidemics, disease and mortality. As Tel Aviv grew out of Jaffa – which remained a predominantly Arab town – it became a symbol of the difference which divided two neighbouring worlds growing apart.

As a reporter for the French newspaper *Excelsior*, Albert Londres travelled in 1929 to Palestine. The following year he published in Paris a memoir, with the title *The Wandering Jew Has Arrived*. Here he wrote a number of interesting observations about Palestine under the mandate. In his pages, Tel Aviv is presented as the ultimate stage for the normalization of the Jews.

⁴⁵ On Tel Aviv see J. Schlör, *Tel Aviv...* See also G. Raz, *Saskin: A Retrospective. Photographs. 1905-1945*, Tel Aviv Museum of Art, Tel Aviv, 2003.

Tel Aviv! The only city in the world made a 100% of Jews. (...) Under my eyes a revolution was taking place. Where are the caftans, the long beards, the curly locks? Here are the Jews, their heads uncovered. They are un-bearded. Their shirts are open on their chests. They walk with sounding steps. They no longer go along walls. You might have thought that Tel Aviv, such a young city, would be just a handful of houses. You might have expected a small town you could grasp with one glance. Gradually, a feeling of surprise fills your mind. Where you thought you would find the end of the world, starts an alley. Rows of houses follow other houses. Here is a field. But not a provisional one. There are trees on it. The hill of spring has been designed with no dullness. It is not an American chessboard. Streets, squares, alleys, roads cross each other with imagination. All is clear, wide, sunny and white. All is pervaded by happiness. One can feel the stubborn determination to forget the ghetto.⁴⁶

Londres conveyed to the European reader the image of an altogether rationally planned, harmonious and healthy city. He reported Tel Aviv to be full of dentists and doctors ("one on each floor") and to "enjoy excellent health."⁴⁷

Despite the idealistic intentions of its founders and despite the descriptions of some enthusiastic visitor, Tel Aviv was not in such good shape. At the beginning of the 1930s, the HMO reported on the alarming health conditions of the city. Typhoid, dysentery, tuberculosis, enteric fevers and other infections were all rife in Tel Aviv.⁴⁸ In this situation – and because of the symbolic significance of this city – the HMO embarked in a programme in three stages to reclaim the environment and the health of its population. During the first half of the 1930s, this plan continued to oscillate between idealism, hope in future development and a reality which remained harsh. However, by 1938 the HMO had brought Tel Aviv to enjoy better health than any other city in Palestine.⁴⁹

The first stage of the plan consisted in turning the municipality into an autonomous manager of its own health. I have analysed some of the

⁴⁶ A. Londres, *Ho incontrato l'Ebreo Errante. 1929: da Londra a Gerusalemme*, ECIG, Genova, 1997, pp 150-151. [Original edition *Le Juif Errant est arrivé*, Paris, 1930]. Translation of the author from Italian.

⁴⁷ *Ibid.*, p. 151.

⁴⁸ HDS, b. 56, f. 4, 1930.

⁴⁹ PRO, CO 733/384/4, 1938.

administrative implications of this process in chapter one. The second stage consisted in making the inhabitants of Tel Aviv aware of the medical implications of their social behaviour. In order to be independent, each Jew living in Tel Aviv had to feel responsible for the health of the other. The network of local medical and welfare institutions – combined with work among children – covered this second aspect. The third point of the HMO programme included the prompt adoption of the new pieces of legislation enacted by the British government. These made health work possible in a legislative and cultural framework which valorized health as an idea. The public works of sanitation promoted by the government represented another important element.⁵⁰

In the expectations of health policy makers, the destiny of Tel Aviv was, first of all, to become a “health resort.” In this way the city would have attracted “in the future the inhabitants of Palestine and foreigners.” Tel Aviv was also meant to constitute an example for those who could not yet adopt ideal standards of hygiene and of life, beginning from the pioneers. In this sense the city had a “responsibility toward our halutzim who live as best as they can in barracks and tents in the cities and in the Judean colonies and are exposed to epidemics.” The development of Tel Aviv as a healthy place was also a necessity for the generational perpetuation of the Zionist settlement. It was fundamental not “to endanger the lives of the thousands of children who are growing up in our city and of those who will arrive.” Most of all, Tel Aviv could not be allowed to become “an ‘oriental’ city with the many dangers to health bound up with this term.”⁵¹

The Oriental city which the Zionist medical agencies feared was so close as to be often referred in early British documents as a single settlement: Jaffa-Tel Aviv. In the Zionist perception the two towns stood opposed one to the other. If progress in medical organization had become a signifier of civilization, the antithesis between Tel Aviv and Jaffa also represented the

⁵⁰ PRO, CO 733/130/5, 1927; PRO, CO 733/131/5, 1927; PRO CO 733/140/2, 1927; PRO CO 733/144/18, 1927; PRO CO 733/204/5, 1931; PRO CO 733/223/4, 1932; PRO CO 733/225/4, 1932; PRO CO 733/240/9, 1933; PRO GO 733/257/3, 1934.

tangible opposition between civilization and the lack of it.⁵² Shafiq al-Hout defined the difference between the two cities in the late 1930s “of about a thousand years of history.”⁵³

Tel Aviv has been examined here as one example of the Zionist approach to the construction of a healthy city. In the same way, Jaffa is presented in the documentation examined as an exemplary case for an Arab town which did not develop into a healthy environment. Incidence of disease and rates of propagation remained here higher than in its neighbouring Jewish town. Its sanitary conditions were also worse.⁵⁴

Two factors can provide a possible explanation for this phenomenon. In the first place, Arabs did not have an image of their past to reject, as the Jews did. They did not need an ideology to lead them to regeneration, either through manual work or through health. Secondly, they could only count on one of the three elements which had helped to make Jewish towns healthier places. Decentralization and devolution had failed in Arab towns because of lack of equal administrative instruments. Autonomy also had failed because of a legislation which was set on western parameters. No horizontal networks of institutions existed to educate Arabs to prevention, with the exception of small committees run by groups of women.⁵⁵ The GDH did not promote education as a policy to teach prevention. All that Arab towns were left with were the works of public health and sanitation promoted by the British administration. These represented an important advancement in the conquest of hygiene. However public works were only one factor out of the three upon which Jews could count. Arabs also did not have a system of medical insurance.

⁵¹ HDS, b. 56, f. 2, *On the transfer of the Tel Aviv hospital to the municipality*. 12th January 1931.

⁵² See R. Kark, *Jaffa. A City in Evolution, 1799-1917*, Yad Ben-Zvi Press, Jerusalem, 1990, pp. 211-214.

⁵³ M. Nofal, F. Turki, H. A. Shafi, I. Bushnaq, Y. Sayigh, S. Al-Hout, S. A. Jayyusi, S. A. Budeiri, “Reflections on the Al-Nakba”, *Journal of Palestine Studies*, 28 (1), Autumn 1998, pp. 5-35, p. 23.

⁵⁴ PRO, CO 733/133/18.

⁵⁵ ISA, M 838, 529; PRO, CO 733/144/12; ISA M 842, 1042; ISA M 839, 677. See also E. Fleischmann, “The Emergence of the Palestinian Women’s Movement 1929-39”, *Journal of Palestine Studies*, 29 (3), Spring 2000, pp. 16-32.

Until Col. Heron remained at the head of the GDH, the British government did not envisage any such scheme for the Arab population. After the publication of a report on malnutrition among Arab children in November 1942, John McQueen - the successor of Heron – began to set the conditions for the establishment of an autonomous Arab medical system. Acknowledging the value of the model introduced into the country by the HMO, he issued a circular to all District Commissioners urging the formation of local welfare committees. These were seen as the possible starting points for the development of a country-wide Arab system of medical provision.⁵⁶

In all its contradictions and symbolism, Tel Aviv embodied most of the ideological and cultural issues which were involved in the operation of rendering towns healthy places. The HMO followed the same three steps – devolution and autonomy, education and sanitation – for constructing Haifa, Tiberias and Jerusalem as healthy Jewish towns.

In Tel Aviv and in Jerusalem the re-educated, regenerated and healthy new Jewish individual found him/herself to share the urban space with Mizrahi Jews. They were seen as perpetuating in Palestine that Jewish past which Zionism wanted to escape from. They were perceived as outsiders to the values and norms of the Zionist civil society. In this respect, Mizrahi Jews represented a challenge to those medical agencies which had so extensively contributed to forge civil society through administrative and social networks and through ideology. Through medical provision and through hygiene programmes, they were in the 1930s brought closer to its values and norms.

2. Civilisation

⁵⁶ ISA, M 130 E/SW/3/48. Department of Social Welfare, *Annual Report 1944*. The Government Printer, Jerusalem, 1945.

Mizrahi Jews⁵⁷ epitomized the stubborn persistence in Palestine of the old-type Jews against which Zionism intended to react.⁵⁸ Already during pre-statehood years, Yemenite, Kurdish, Moroccan and Persian Jews came to embody in Palestine the “myth of the arrested development” of the Orient.⁵⁹ Fascinating and apparently unchanged since Bible times, they represented the difference between the familiar and the unusual for those European Jews who perceived them to embody the antithesis of their own way of life.⁶⁰ They were seen as backward, irrational, superstitious, unhygienic.

Medical services had represented an important way to integrate Jews coming from different cultural and social contexts. Western Jews were a diversified combination of dissimilar histories. Through them a new evolving national identity was being created in these years.⁶¹ As Jews, *Mizrahim* were to be tentatively included in this identity, despite the perceived Arabness of their lifestyle and system of values. However, these had to be made compatible with those shared by civil society. In this context too, medical criteria established the norms through which *Mizrahim* could eventually be incorporated into the new Zionist moral order. The latter also dictated the pace of an integration which remained partial and incomplete.

Welfare and medical work among *Mizrahim* was in this respect conceived as a civilizing mission within Judaism itself. It is here that emerged the colonial drive of Zionism. In this case in fact prevention and medical

⁵⁷ The term ‘Mizrahi’ was adopted in the 1990s to replace Ashkenazi terms such as ‘Oriental Jews’, (normally used before statehood), Eurocentric ones such as Sephardim (a term of the 1950s and 1960s) or the more condescending *Bnei edot ha-Mizrach* (Descendants of Oriental Ethnicity), employed in the late 1960s and 1970s. Such terms grouped in one stereotyped definition all Jews who did not have an Ashkenazi cultural background: Yemenite, Persian, Moroccan and Kurdish Jews who immigrated to Palestine before statehood and Iraqi, Lybian, Tunisian Jews who immigrated in different *alyot* after 1948.

⁵⁸ Yemenite Jews began to immigrate to Palestine in 1882. This first wave settled mainly in Jerusalem. Here they faced a difficult integration, especially from an economic point of view. In 1908 their number had reached 2,500. In that year a second immigration wave from the Jewish villages of Yemen brought to Palestine another 2,000 Jews. These mainly turned to agricultural work. At the end of the First World War there were in Palestine 4,500 Yemenite Jews. By the outbreak of the Second World War their number had grown to 28,000. See Y. Nini, *The Jews of the Yemen, 1800-1914*, Harwood Academic Publishers, Chur, 1991, p. 8.

⁵⁹ E. W. Said, *Orientalism...*, p. 307.

⁶⁰ T. Parfitt, *The Road to Redemption. The Jews of Yemen 1900-1950*, E. J. Brill, Leiden, New York, Köln, 1996..

⁶¹ R. Wistrich and D. Ohana (eds.), *The Shaping of Israeli Identity. Myth, Memory and Trauma*, Frank Cass, London, 1995.

provision were used not only to effectively limit the propagation of disease. They were also employed to civilize *Mizrahim* into the new Jewish nation, albeit as second class citizens. In this respect, health became a means to remark Zionist superiority over the pattern of life developed in the diaspora. Teaching *Mizrahim* prevention and providing medical services became ways for the HMO to consolidate its own image as a bearer of civilization. This situation set the cultural and social precedent for the policies of discrimination which *Mizrahim* would suffer in Israel in later years.

Already in mandatory Palestine, they were perceived as outsiders. The first element which relegated *Mizrahim* outside the boundaries of civil society was their lifestyle. Medical agencies considered the conditions in which they lived to fall below the lowest standard ever considered acceptable. Filth, overcrowding and lack of hygienic facilities in their houses made them rank lower than the poorest immigrant from Europe. The living conditions of the latter were considered to be a consequence of recent immigration. They were therefore seen as temporary. In the case of *Mizrahim*, miserable and unhygienic conditions were seen as the reproduction in Palestine of centuries' old habits. They were thus seen as permanent, unless they would be eradicated. The perpetuation of these conditions in a new setting where the regeneration of the Jews was sought also through hygiene and health was perceived as a provocation to Zionist medical work and to cultural uniformity.

The predominance of the family among *Mizrahim* represented a second important difference between the two groups. Jews from Europe had generally immigrated individually. Already in the mandatory period, *Mizrahim* had come to Palestine as families. Zionism was celebrating the process of Jewish normalization through the consolidation of horizontal linkages – peer solidarity, welfare organization and agricultural communities. Once in Palestine most of the social, economic and political functions which had belonged to the Jewish family in the diaspora were diluted into civil society.⁶²

⁶² M. Simoni, *Ideali comunitari ed il superamento della famiglia ebraica. Dallo shtetl al kibbutz (1900-1956)*, Unpublished Tesi di Laurea, Università di Firenze, 1993-94.

The permanence of vertical values among *Mizrahim* - such as family solidarity before free association, and of kinship before peer cohesion - was perceived as a critical distinction. It was received as a challenge to the cultural and social system upon which Zionism relied in order to reach statehood. In this sense, they were considered extraneous to the values of a national movement building networks of participation as the signifiers of a new national identity.

Mizrahim represented a challenge for one more reason. Unable to afford the medical insurance schemes - or the school fees - of the Zionist institutions, they often made use of missionary agencies for their own health and education, or for those of their children.

By their very existence, way of life and social behaviour, *Mizrahim* demonstrated that the Zionist civil society was not as homogenous as its members wanted to believe. In order to make it more coherent, social behaviour, family structure and missionary welfare were seen as the three factors which needed to be changed. I now turn to analyse some aspects of this process.

a) *Defeating the Evil Eye*. For *Mizrahim* to be civilized into Zionist civil society, their mental habits had to be re-shaped. Their fatalist approach to disease had to be changed. Science, rationality and order would have to substitute prayers, incantations and fear of the evil eye. These factors would have limited the spread of disease. They would have turned *Mizrahim* into responsible members of the collectivity. Science, rationality and order would have also granted them the opportunity to access the numerous resources which were gradually becoming available to Jewish immigrants in an increasingly networked *yishuv*.

In this context, lack of hygiene, disease and poverty were all part of one general discourse. The HMO addressed it from different angles. Backwardness, superstition and fatalism had in fact to be attacked simultaneously in their economic, cultural and social aspects.

Mizrahim were the poorest among Jews. In 1930 the Chief Rabbi of the *Mizrahi* community - Rabbi Meir - enquired with the HMO as to which categories of patients this medical organization treated for free. The reply of the HMO was compiled under seven headings. Free treatment was granted according to census, to family status, or according to both.⁶³ The efforts of the HMO to involve increasing numbers of Jews and larger groups of society in its network emerged also from the subsidies it offered to the poor. As the picture below shows, in 1928 almost sixty per cent of patients were treated for free in the HMO's structures.

Illustration n.3: Patients in Hadassah Hospitals in 1928
according to scale of fees.⁶⁴



⁶³ HDS, b. 30, f. 12, 23rd March 1930. Those entitled to receive free treatment were: "those without any means or property, orphans to the age of 15, aged people 60 and widows without means, day labourers having been unemployed for more than 30 days successively, unmarried persons or heads of families without children (whose family income was less than LP 2 a month or 100 mils per day), heads of family with one or two children (when family income was less than LP 3 a month or 120 mils per day), heads of families with three or more children (when family income was less than LP 4 a month or 150 mils per day). See also illustration n. 4.

⁶⁴ Private collection.

Either on account of family status or census, *Mizrahim* were generally included in the category of those who received free treatment, together with Jews of the Old *Yishuv*. Their inclusion was also made on grounds that they simply would not understand the concept of medical insurance. In 1930 the HMO reported:

As long as eye treatments, especially among the Yemenites and in the schools, will depend upon any payment whatsoever there can be no fruitful results for the anti-trachoma campaign. This was always clear.⁶⁵

Peretz (Jack) Yekutieli still recalled with disbelief after fifty years how the “Sephardics” would simply “not quite understand what it means to take money periodically out of a salary for medical expenses.” He concluded: “it was a little bit above their heads. For Jews it was instead acceptable.”⁶⁶ In the memory of this former medical student escaped from Germany in 1935 - later to become one of the main Israeli epidemiologists and advisor to the Israeli Ministry of Health in the 1960s and 1970s - *Mizrahim* seemed so external to the norms, values and lifestyle of the *yishuv* not be considered part of the national community. His perception generally corresponded to the attitude which most European Jews maintained towards them during this period.

This was especially marked within the Labour movement. KH would not treat them for free. In 1931 KHA had then been organized for rural workers not affiliated to Labour. Many of them were Yemenites who did not share the same orientations, ideological and cultural values of the self-invested political elite of the country.

Mizrahim dwelling in towns were treated by the HMO. The HMO understood its own work among them as an uphill fight against poverty, ignorance and superstition. Pictures taken by nurses and doctors in those years show humiliated *Mizrahim* in their poor, dirty, messy and altogether unhygienic homes. To them the HMO distributed illustrations of what it considered the ideal hygienic conditions of a house. These pictures were often

⁶⁵ HDS, b. 30, f. 11, *Eye treatments at Shivat Zion*, 28th March 1930.

⁶⁶ Interview of the Author with Prof. Peretz (Jack) Yekutieli, Hofit, 31st March 1998.

used also for purposes of propaganda and fund-raising in the US. The ones below are just two examples.

Illustration n. 4. "Conditions: 'Poor'"⁶⁷

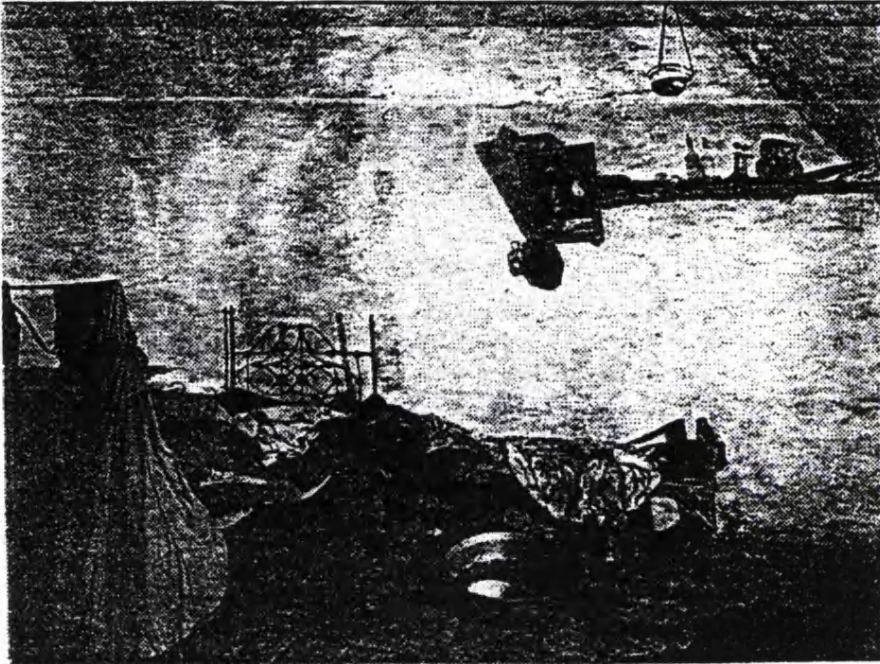
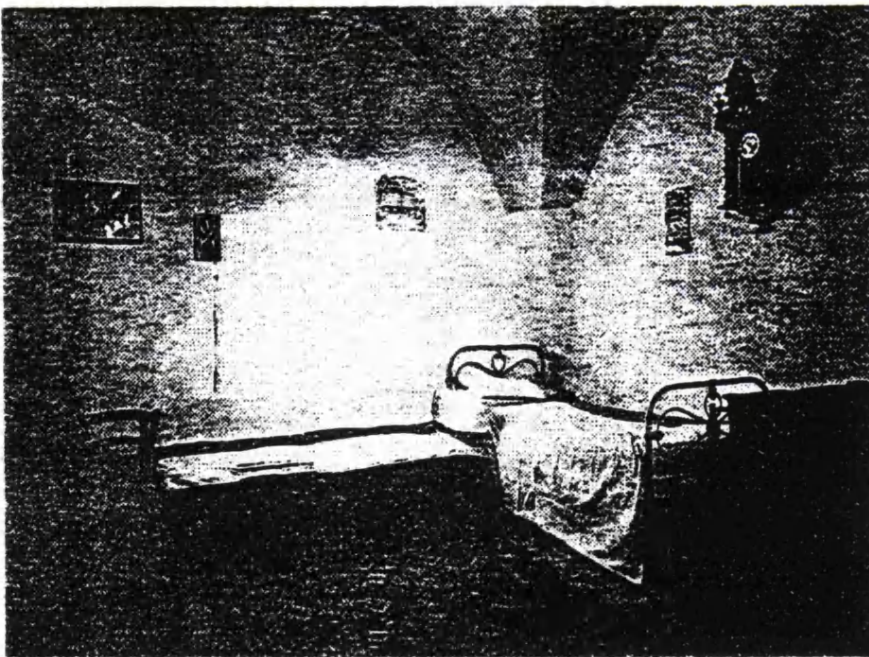


Illustration n. 5. "Conditions: 'Ideal'"⁶⁸



⁶⁷ HDS, HMO Programs, b. 1, Conditions: 'Poor',

At the beginning of the 1930s - when more resources became available following its first devolution of hospitals to the municipalities - the HMO embarked in a radical programme to reclaim the health of this group of Jews. Its work began from the environment in which they lived. *Mizrahim* had to be first of all detached from their homes. This measure was considered necessary to change their low economic status and their medical conditions. This strategy was applied for example to limit the incidence of eye diseases among children. It was also adopted to reshape the cultural and social attitudes of women towards western medicine.

According to the 1931 census, the number of blind people in Palestine accounted for 8,4 per cent of the population.⁶⁹ Such a high percentage was considered to have an impact on the economy of the country. The lack of specialized structures was also seen as affecting the economic status of the blind themselves. As in a vicious circle, poor and unsanitary social conditions, and the lack of a culture emphasising the advantages of prevention, favoured the spread and proliferation of disease. This in turn affected the population in its possibility to work, and therefore to improve its social conditions. Disease and poverty stood in this context in a mutual relationship. Already in 1925, the OSJ had reported:

The vast majority of these blind people are incapable of earning anything and are a charge on their relatives or on the community. They become beggars. In highly civilized communities (...) many of the blinds have become so highly educated as to be able to meet, in a measure, the competition of normal individuals. In Palestine, unless very exceptional circumstances, it is not so.⁷⁰

After 1931, the HMO tried to create in Palestine those exceptional circumstances for Jews who were blind. Education to prevention, specialized cures and vocational training represented some of the means of this wide-ranging work. Medical treatment and education would give the blind the possibility to raise his/her dignity as individuals in a society where work represented one of the main national values.

⁶⁸ Ibid., Conditions: 'Ideal'.

⁶⁹ As reported in KOSJ, *Report of the Committee for 1932*, London, 1933, p. 9

⁷⁰ KOSJ, *Report of the Committee for 1925*, London, 1926, p. 7.

Incidence of active trachoma among children of *Mizrahi* origin was in 1930 as high as fifty per cent.⁷¹ In 1934 the HMO reported:

The majority of children suffering from trachoma come from very poor homes, in the most congested and unsanitary quarters of the city. It is practically impossible to weed out trachoma from these poor families, as the adult members suffering from the disease spread the infection because they are not under treatment. New-born infants are infected by their parents who do not understand the value of eye treatments. Although the children receiving eye treatments are rapidly improving, each school year brings a new batch of first grade pupils infected with trachoma.⁷²

The HMO conducted anti-trachoma campaigns outside the family space. Parents were considered to be the agents of infection, infecting children "soon after birth."⁷³ Better than inside the homes, in schools the HMO could treat this infection and teach hygiene to children. In 1931 alone the HMO inspected between 23,000 and 28,000 school children.⁷⁴ Schools were centres where the national ideology was constructed. Here children could also absorb the principles of hygiene and health lying at the foundation of the new Jewish nation.⁷⁵ Trachoma in Jewish schools throughout Palestine was reduced from 34 per cent in 1918 to 6,3 per cent in 1933.⁷⁶

⁷¹ HDS, b. 33, f. 9, 1934 and HDS, b. 33, f. 14, 1935.

⁷² HDS, b. 33, f. 6, Letter from Miss Goldman to HMO, 5th May 1934.

⁷³ HDS, b. 33, f. 5, *Anti-trachoma campaign in the schools*, 1st June 1934.

⁷⁴ HDS, b. 31, f. 8, *Extract from notes on interview granted to the Va'ad Leumi by His Excellency, the High-Commissioner*, 16th December [1931].

⁷⁵ CZA L 12/129, Beth Sefer Hareali Haibri, (Hebrew Secondary school) Haifa-Palestine In the school's advertisement pamphlet we read: "The Beth Sefer Reali offers a sound Hebrew education combined with the usual curriculum of a secondary high school. Manual training is stressed both as means of character building and a preparation for the pioneer life of Palestine and as a preparation school for the technical training in the Haifa Technical Institute. (...) Its 7 years course corresponds, approximately, to the three upper grades of the American public school in addition to the High school or to an English Secondary School. (...) In physics, mathematics and nature study apparatus is freely used and everything is done to stimulate initiative and voluntary experiment. When possible, these studies are combined with actual work. (...) Drawing, both freehand and mechanical is closely allied with manual training. (...) By these methods the Beth Sefer Reali hopes to educate a generation of Jews with well trained hands and (this is the capital importance) with a wholesome well-balanced attitude toward every type of the physical labor that must go into the rehabilitation of Palestine."

⁷⁶ HDS, b. 33, f. 10, *Ophthalmological work of Hadassah Medical Organization in Palestine*. Memorandum by Dr. Yassky submitted to Vaad Leumi 18th December 1934.

Illustration n. 6: Active trachoma in government schools
and in schools affiliated with the Palestine Zionist Executive.⁷⁷



Educating children was seen as a way to reach parents too. With their very example, children would in fact transmit to them the ideals of health and of prevention which the HMO was disseminating in society. Families were deemed guilty of wasting “years of painful treatment” because of their unawareness of basic rules of hygiene and prevention. This was – among other things – the outcome of not being “properly looked after.”⁷⁸

For this reason, the HMO placed its specialized eye-clinics close to the source of infection. This way it could establish and maintain a continuity between prevention, cure and convalescence. In both urban and rural clinics the HMO provided daily treatment to members of the families suffering from trachoma. In most rural settlements, such work was conducted by KHA under the supervision of the HMO’s circuit ophthalmologist. In cities, specialized eye-clinics were opened in those areas where the disease was most widespread:

⁷⁷ Private collection.

⁷⁸ HDS, b. 33, f. 5, *Anti-trachoma campaign in the schools*, 1st June 1934.

the quarters of the Old City and Nachalat Zion in Jerusalem, the Yemenite quarter in Tel Aviv-Jaffa.

Illustration n. 7. Blind Jews at the Western Wall (1935).⁷⁹



In 1934 alone, 6,579 new cases were registered in the eye-clinics of Jerusalem, Safad and Tiberias with an average 70,000 visits performed on the patients by the ophthalmologic staff. In 1935 Hadassah maintained nine eye clinics, two in Jerusalem, one in Tel Aviv, one in Tiberias, one in Safed and four in the Yemenite quarters of various colonies. One was available in "Mahaneh Yehuda, a Yemenite settlement near Petach Tikva." In 1935 this small village was considered to be "one of the places most seriously affected by trachoma."⁸⁰ It also maintained general ophthalmic clinics attached to the hospitals and physicians who travelled around the colonies.⁸¹

⁷⁹The copyright of this picture is of Elia Photo Service, Jerusalem, Old City.

⁸⁰HDS, b. 33, f. 14, 1935.

⁸¹HDS, b. 34, f. 10, *Government Grant for Jewish Health Services*. Report of conversation with Mr. Hathorn Hall, representing the High Commissioner, held on 27th December 1935.

As in other medical situations, also in the case of ophthalmic diseases the presence of specialized clinics was considered essential to maintain and enhance the territorial continuity of the Zionist project. Medical structures had been conceived as means to establish territorial presence and to limit the influence of missionary work among Jews. Where no Zionist medical structures existed, missions could in fact still reach the Jewish population. The OSJ had for example treated in 1927 an equal number of Christians and Jews, just below 4,000.⁸² After the HMO took control of medical provision among *Mizrahim* in 1931, the number of Jews treated by this organization had dropped to half the following year.⁸³ As the GDH increasingly delegated the provision of medical services, the number of Arabs attending the OSJ clinics increased dramatically. In 1934 only about a thousand Jews were being treated by the OSJ, whereas the number of Arabs had reached the figure of 16,000.⁸⁴ By 1935, registration of Mizrahi Jews in the HMO ophthalmic clinics had increased by 60 per cent.⁸⁵ Such growth left no doubt as to the success of the work of the HMO for the progressive inclusion of this group of Jews into the structures of the *yishuv*, into its culture and into its overall mentality.

The HMO saw the environment where *Mizrahim* lived as the centre where superstition, poverty and disease reinforced one another. However, for its battle to be efficient in both its medical, cultural and social aspects, the HMO had to reach the institution which ruled over such environment.

The family represented the core of the *Mizrahi* culture and social organization. It could not be limited so that its members would be freer to join Zionist civil society. However, it could be reshaped. Its members could be educated separately so that the family as a whole could benefit from the advantages of health. Inside the family, women represented the guardians of its purity and of its social acceptability – at least within the *Mizrahi* community.

⁸² KOSJ, *Report of the Committee for 1927*, London, 1928, p. 7.

⁸³ KOSJ, *Report of the Committee for 1931*, London, 1932, p. 10.

⁸⁴ KOSJ, *Report of the Committee for 1934*, London, 1935, p. 12.

⁸⁵ CZA, F 49/2665, 1935.

After children, women became targets of the policies of education and prevention promoted by the HMO. This organization aimed at making “every one of them, sound mentally and socially, (...) take a place into the new life of the community.”⁸⁶

b) Attempts to reform unhealthy families. The Jewish family - as it had developed in the diaspora - had temporarily been demoted within the *yishuv*.⁸⁷ Health had been constructed in Palestine for individuals. It was an ideology that emphasized the moral and social responsibility of the singles in front of the collectivity. Its shared values were meant to guarantee the strength and perpetuation of the community as both a collective of individuals and as a network of associations. In this respect too civil society had taken over some of the functions of generational continuity of the family.

The survival of the family among *Mizrahim* represented a challenge to Zionist health authorities, for these families were ‘familist’, too closed within themselves. They were also identified as the main factor perpetuating unsanitary and unhygienic habits to new generations.

This group of Jews was reached through *ad hoc* medical policies and welfare programmes. The HMO moulded its ideology of health on their cultural and social organization. The young and single Jewish immigrant had represented the typical patient among European Jews. Among *Mizrahim* it was considered necessary “to regard as a unit of treatment not the patient itself, but the family.”⁸⁸ The family became the focus of preventive and medical activities in order to transform their living standards and to raise them from poverty. As Martha Nussbaum has demonstrated for different contexts, poverty and gender inequalities are strictly connected.⁸⁹ In this respect too the HMO had an extensive impact on the structure of the *Mizrahi* family. It questioned the gender inequalities existing within it. As we shall see, it introduced a number

⁸⁶ HDS, b. 56, f. 6, 1938.

⁸⁷ M. Simoni, *Ideali comunitari* ...

⁸⁸ HDS, b. 33, f. 10, *Ophthalmological work of Hadassah Medical Organization in Palestine*, Memorandum by Dr. Yassky submitted to Vaad Leumi, 18th December 1934.

⁸⁹ M. Nussbaum, *Women and Human Development. The capabilities Approach*, Cambridge University Press, Cambridge, 2000.

of elements which tried – but failed - to alter and re-shape its internal functioning. The HMO also used its professionals - doctors, and nurses in particular - to bring into the *Mizrahi* homes the example - and the undiscussed advantages - of a life founded upon principles of hygiene and health.

The existence of a network which connected and coordinated medical and welfare work proved vital to approach *Mizrahi* families - and women inside them in particular. Throughout the whole decade, four organizations of women - the HMO, WIZO, the PJWA and HNI - engaged in a vast and coordinated work which reshaped the life of *Mizrahim*. In 1930 the HNI had settled an agreement with WIZO for cooperation in welfare work in the broadest terms.⁹⁰ In the same 1930, WIZO united its forces with the welfare branch of the HMO.⁹¹ These three organizations were then joined by the PJWA. The HMO addressed medical issues; it taught hygiene; it influenced conceptions of sexuality, pregnancy and motherhood. The PJWA fought for the abolition of child marriage.⁹² HNI and WIZO dealt with social welfare, housekeeping and domesticity.⁹³ These three organizations gave a determinant contribution to the mission of civilization already undertaken by the HMO. They established baby creches, milk stations and kindergarten. They managed playgrounds. They organized vocational schools. WIZO, HNI and the PJWA did not focus on *Mizrahi* women alone. They really operated to make “women the instruments for raising the general cultural level of the population.”⁹⁴ However, their involvement was limited to the social aspects of medical issues. For this reason an analysis of their activities has not been included here. A second reason for their absence is that the work of these organizations of women would open up an entire new chapter on the relationship between gender and nationalism.

⁹⁰ CZA, F 49/143.

⁹¹ CZA F 49/2871, 14th July 1933; CZA F 49/144.

⁹² ISA, J 202/35.

⁹³ CZA, F 49/2678.

⁹⁴ CZA, F 49/2665, The Palestine Executive of WIZO to the Conference of WIZO, Jerusalem, June 1931.

I would like to open here a brief parenthesis about one of the paradoxes embedded in the work of these organizations originally founded by Zionist women to promote the welfare of other women in Palestine. In most 19th and 20th century processes of western state-building, women have been offered inclusion into citizenship through the provision of education, health and welfare.⁹⁵ The medical and welfare network which operated in Palestine relied substantially upon their work. This framework discloses a new perspective on the relationship between gender and nationalism in mandatory Palestine. It reveals how the male-oriented values of the movement were internalized by Zionist women.⁹⁶ Secondly, it shows how health and welfare were used in order to frame motherhood in a national perspective. In the third place, it points at schools, welfare centres, hospitals orphanages - and other social structures established by Zionist women - as the main sites where a gender-oriented culture was transmitted to new generations.⁹⁷ These three aspects of the history of this period have only in part been studied. I have addressed in more detail some of their implications elsewhere.⁹⁸ Suffice it to mention here that the mission of civilization through welfare undertaken by these associations of Zionist women among Mizrahi families carried profoundly ambivalent connotations. It affected the two sides in the same measure. It changed their mutual perceptions. It also made both Mizrahi and Zionist women ultimately subordinated in the highly gendered and patriarchal new state founded in 1948. This emerged out of the very same civil society which the associations of Zionist women had so extensively contributed to create.

At the beginning of the 1930s the state was still not in sight and the work of social construction of the Zionist organizations still aimed at rendering civil society compact and uniform. The work of HMO among *Mizrahim* to reform the family should be, for now, placed in this context. This medical agency

⁹⁵ N. Yuval-Davis, *Gender and Nation*, Sage Publications, London, Thousand Oaks, New Delhi, 1997.

⁹⁶ M. Mc Cune, "Social workers..."

⁹⁷ P. Bourdieu, *Masculine Domination*, Polity Press, Cambridge, 2001.

⁹⁸ M. Simoni, *Orientalism and gender...*

pinned all its hopes to civilize the Mizrahi family on its central - and weakest - character: the woman.

Despite their effective marginality in society, Mizrahi women really stood at the centre of that social system. Inside the family, the division of roles was apparent in the separation of the male and the female spheres. Women ruled over the private one. Here they were regarded as guardians of tradition, a model which could be traced back to an agrarian and patriarchal family type. Mizrahi women also transmitted cultural values and social norms to children. They guarded the purity of the household. Often illiterate, they were considered as “its most traditional and backward elements.”⁹⁹ Because of their centrality inside the family - both as mothers and as wives - they came to play a pivotal role in the schemes of the HMO.

Instruction in hygiene represented the first step in the programmes of the HMO to re-educate Mizrahi women. A clean home would improve the environment in which they lived.¹⁰⁰ It would therefore reduce the incidence of disease among this population group. As children had been detached from their environment in the case of ophthalmic infections, women too were invited to leave their homes. They were encouraged to look for medical assistance in hospitals. Just after the beginning of its work among Mizrahi families, the HMO could report that those women “who used to refuse to attend hospitals had begun to appreciate their advantages over their homes.” Those “who would by no means permit themselves to be examined by a male physician, now insistently refuse to be delivered at home.”¹⁰¹ Women were also invited to enrol, attend and participate in the educational and preventive activities conducted in the welfare stations of the HMO. In 1935, the HMO reported:

By practice and preaching, by precept and example, the devoted Hadassah nurses have won more and more women over to registering in the stations in their pre-natal period, submitting to the supervision of the doctors and nurses during that time, being taught

⁹⁹ HDS, b. 33, f. 10, *Ophthalmological work of Hadassah Medical Organization in Palestine. Memorandum by Dr. Yassky submitted to Vaad Leumi, 18th December 1934.*

¹⁰⁰ *Ibid.*

¹⁰¹ HDS, b. 30, f. 9, 1930.

to make layettes for their babies instead of swaddling them in all manner of rags from the minute they come into the light of the day. being persuaded, where possible to give birth to their babies in hospital or, failing that, being taught to prepare a clean, though improvised, place for delivery, with the help of Hadassah's outside obstetrical service instead of on a pile of dirty rags on the floor and with the assistance of the old women of the neighbourhood, supplemented with prayers and incantations.¹⁰²

Two characters filled the stage in the descriptions of the HMO. On the one hand stood the nurse, wise, devoted and patient. On the other the Mizrahi universe. The backwardness of this world seemed to be encapsulated in the character of the mother. She was often described as timorous, superstitious, wide-eyed and wondering. In most of her life "charms and incantations" were "thought effective against toothache." In this representation of two worlds apart, mothers submitted to the instructions of the nurses. However, they seemed imprisoned in a cultural system which hindered any possibility of hygienic, rational and scientific advancement. After carefully listening to instructions on how to treat newborn infants, they would then ask "blessings for the loving care bestowed on their children for four years."¹⁰³

The voices of *Mizrahi* women in their difficult dealing with such an intrusive medical and welfare system seem to have been seriously under-recorded. The insistence of the Zionist associations on the necessity to re-educate them - and to reshape the family in which they lived - along Zionist values seems to suggest that Zionism did encounter some resistance in its self-imposed and tentative mission of civilization.

The policy of detaching patients from their environment constituted a successful measure in the case of children. It helped their socialization among peers. It also allowed them to receive an education through which they could obtain a job. In this way they would be able to raise their own and their family's standard of life.

The bet of the HMO on Mizrahi women proved successful only to a certain extent. Health work among them fulfilled the medical expectations of

¹⁰² HDS, b. 53, f. 2, 1935.

the HMO. Incidence of infectious disease was reduced. Pregnancy and childbirth could now be controlled in medical centres. Women could be monitored in welfare centres and in hospitals. Nira Yuval-Davis and others have analysed the nationalist implications of forms of medical control over women's reproductive functions for other historical contexts.¹⁰⁴ As a result of the engagement of the HMO, sanitary and hygienic conditions had overall improved inside Mizrahi homes. However, the use of health as a way to advance the culture of the Mizrahi family proved to be a failure. The family – in its vertical relationships – continued to maintain its crucial role among this group of Jews. Women remained central to its internal organization. Gender inequalities continued to predominate inside it. Taken as a whole, this group of Jews also remained poorer than the rest of the *Yishuv*.

The promotion of health among *Mizrahim* represented a cultural battle in one more sense. Many of them had in fact turned to missionary agencies to obtain medical services. In this way they had placed themselves and their children outside the boundaries of a civil society which had already begun to regard national and religious belonging as one. I now move on to this last aspect of health work of the HMO among *Mizrahim*.

c) *Claiming Mizrahim into civil society.* The Zionist territorial network had been conceived – among other things – as a way to prevent the attempts of missionary agencies to reach Jews through the provision of health and of education. Missionaries were perceived as interfering with Zionist work. They were also seen as a threat to the cultural uniformity of Zionist civil society, in both cultural and in religious terms.

¹⁰³ Ibid.

¹⁰⁴ N. Yuval-Davis, *Gender and Nation*, Sage Publications, London, Thousand Oaks, New Delhi, 1997, pp. 26-37. See also D. Kandyoti, "Identity and its discounts: women and the nation", *Millennium*, 20 (3), Winter 1991, pp. 429-443. For a discussion of the relationship between nationalism and control over the women's bodies see B. Ehrenreich and D. English, *Complaints and Disorders: The Sexual Politics of Sickness*, Writers and Readers Publishing Cooperative, London, 1976. M. A. Rosaldo, and L. Lamphere (eds.), *Women Culture and Society*, Stanford University Press, Stanford CA, 1974, pp. 67-87.

Zionism considered *Mizrahim* as ignorant Jews which could easily be convinced to another faith. Missions too saw *Mizrahim* as a “stream of ignorant and needy.”¹⁰⁵ As the *yishuv* became progressively more organized, they represented the only group of Jews which missions could reach. European Jews in fact received the missionary “as a mentally rather unbalanced crank” trying “to dope the colonist with propaganda.”¹⁰⁶

Until the mid-1930s, when the HMO began to extend its network to cover for the needs of all Jews in Palestine, missions still found a space to operate in the gaps left open by the Zionist system. Both *Mizrahim* and Jews of the Old *Yishuv* were often treated by various missions operating in the country. Anglican missions had for example provided food, shelter and medical assistance to Jews returning to Hebron after the riots of 1929.¹⁰⁷ As we saw in chapter two, the English Mission hospital provided for more than a thousand poor Jews at the beginning of the 1930s. Scottish missions operated in the villages and smaller centres of the North where the HMO or KH had not yet arrived.¹⁰⁸

Zionist institutions and Jewish newspapers used a strong language when they addressed such a thorny question. *Mizrahim* attending non-Jewish institutions were seen as breaking the cultural unity which Zionist welfare agencies were trying to build. *Mizrahim* in missionary schools represented the living proof that the values of the Zionist civil society were not as articulated and mature to be inclusive of all Jews living in Palestine.

In 1919 the Hebrew newspaper *Ha-Yom* labeled *Mizrahim* attending mission hospitals and schools as a “social disease which has developed in Jerusalem.”¹⁰⁹ In 1926 several articles appeared on the *Jewish Chronicle*. They tried to raise an awareness among Jews in London of the danger of loosing

¹⁰⁵ MEC, J&EM b. 58, f. 2, *Statement with regard to the Jerusalem Medical Mission*, 1925.

¹⁰⁶ Yale Divinity Library Archives, Yale University, New Haven CT, Church of Scotland, *Report on Jewish Missions for 1934*, Submitted by the Jewish Mission Committee, Edinburgh, 1935, p. 15.

¹⁰⁷ MEC, J&EM b. 59, f. 1, Letter from I. M. Scott Moncrieff to Rev. J. Macdonald Webster, 9th January 1932.

¹⁰⁸ MEC, J&EM, b. 58, f. 2, *Medical Work*, [1935].

¹⁰⁹ MEC, J&EM b. 60, f. 3, *Translation of an article in the most prominent position in the Hebrew newspaper Hyom (sic) (Le Jourr)*, 19th December 1919, signed: Abraham Almaleh.

“one backward, albeit important, tribe of the Jewish people for ever.”¹¹⁰ In 1926 Helen Bentwich - wife of the British Attorney General - published an article on the case of Mizrahi children raised in missionary schools. Writing on the Women's Supplement of the *Jewish Chronicle*, Helen Bentwich composed her picture:

A mission school of the London Jews' Society is in the neighbourhood, ever ready to seize hold of the Jewish children and bring them up in the Christian faith. In these rat-infested hovels, around these evil-smelling doorways, sit the children - listless, pale, ignorant of play and games of any kind, spending hour after hour sitting still, often in the dark, losing energy and vitality at this early age. Many are the children of professional beggars - mostly they belong to Moroccan, Persian, Yemenite, Baghdad or Aleppo Jewish families.¹¹¹

Almost all the Mizrahi Jewish communities were presented here as one, united by their poverty, backwardness and ignorance. In 1932, the HNI warned the readers of its bulletin about the dangers of leaving Jewish children to the care of missions. Children treated in missionary hospitals or educated in missionary schools had in fact become “so demoralised that they can never be considered as useful members of our community.”¹¹²

As in the case of ophthalmic diseases, Zionist organizations considered it necessary to reach children before parents. In this case, the HMO envisaged specialized structures for rehabilitation.¹¹³ Here Mizrahi children could receive psychological support and vocational training. The combination of these two elements was meant to eventually favour their reintroduction into Zionist civil society as fully-fledged members. In these schools children could also receive an education founded on Zionist values. The latter would eventually detach them from their parents and their home environment. Otherwise, they would have remained “human material which is degenerating, (...) causing much

¹¹⁰ I. Seigler Bension, “Women's work in Palestine”. *The Jewish Chronicle. The Jewish Chronicle Women's Supplement*, 5th February, 1926 - 5686.

¹¹¹ Mrs.[H.] N. Bentwich, “Jerusalem Kindergarten and Day Nursery”, *The Jewish Chronicle. The Jewish Chronicle Women's Supplement*, 21st May 1926 - 5686.

¹¹² CZA F 49/2467, Mrs. Smoira, “Report of the Histadruth Nashim,” *Pioneers and Helpers*, n. 2, November 1931-August 1932, p. 20.

¹¹³ ISA, M 274 T/256/35, 1935.

material and spiritual harm to the community.”¹¹⁴ Many of them had in fact become juvenile offenders.

Data on the spread of juvenile delinquency among Jews in Palestine indicated that “the majority were children of the Oriental community and children from the streets.”¹¹⁵ Most cases were “due to neglect, faulty bringing up, poverty as an educating factor, unhappy family life, attendance to missionary institutions, etc.”¹¹⁶ Poverty, family and missions were seen as three of the factors which had led to Mizrahi children to social marginalization.

In order to claim them into civil society, many children were removed from their families.¹¹⁷ Here in fact they “were driven to commit misdemeanours by their mothers because of poverty and bad and unhealthy habits.”¹¹⁸ As a result of an investigation - and by recommendation of the ‘Social Service Department’ of the HMO, in 1935-36 the ‘Social Welfare Council’ of the *Vaad Leumi* placed 930 children from Jaffa in schools. Only between the beginning of April and the end of October 1936, thirty-six children were taken from their families and placed in Zionist institutions for “moral, spiritual and working reconstruction.”¹¹⁹ Here children would get rid of the “nefarious teachings received by missions.” Here they could “learn the social value of a sense of responsibility, duty, genuine freedom; they will be given good education and taught a trade.”¹²⁰

The adoption of such radical policies towards *Mizrahim* already during the 1930s carried medical, cultural and social long-term implications. Re-education, detachment from the original environment and taking away of children from families were to be reproduced on a larger scale with the immigration of greater numbers of *Mizrahim* after 1948. The policies devised

¹¹⁴ HDS, b. 31, f. 12, Letter from Dr. Berachyahu to Mrs Persitz, 17th February 1930.

¹¹⁵ HDS, b. 49, f. 8, Letter from Mrs (Rose) Samuel W. Halperin to Mrs. (Zippora) Robert Szold, Chairman, Palestine Committee Hadassah NY, 10th March 1936.

¹¹⁶ HDS, b. 31, f. 12 Letter from Dr. Berachyahu to Miss Szold, 16th June 1932.

¹¹⁷ *Ibid.*, 14th June 1932.

¹¹⁸ HDS, b. 49, f. 8, Letter from Mrs (Rose) Samuel W. Halperin to Mrs. (Zippora) Robert Szold, Chairman, Palestine Committee Hadassah NY, 10th March 1936.

¹¹⁹ *Ibid.*

¹²⁰ HDS, b. 56, f. 6, 1938.

in the 1930s were only to set the precedent for similar policies to follow in later years.

By the end of the decade, such practice had become institutionalized through the establishment of at least one specialized centre for the re-education of (mainly) Mizrahi children. Established by the 'Department of Social Service' of the *Vaad Leumi*, it took the name of *Kfar Awodah le-Naarim* (Village for the Work of Youth).

The relationship between Zionist institutions and *Mizrahim* during these years disclosed one of the most ambiguous traits of Zionism. Medical and social provision - as it was dispensed among this group of Jews - represented the embodiment of such ambiguity. Confronted with its 'internal Other', Zionism revealed its colonial aspect. *Mizrahim* continued to represent the mirror in which the new Jew believed s/he could see a reflection of his/her past.

Conclusions

The foundation of the State of Israel brought the gradual transformation – and the ultimate disappearance – of those horizontal networks of associations which had played such a vital role in the consolidation of civil society during the Mandate. After leading the *yishuv* to statehood, Zionist associationism diminished and much of it dissolved into the state. Despite the many traumatic events which led to the emergence of the State of Israel, the transition from civil society to state did not constitute a rupture. On the contrary, it occurred under the flag of continuity. Before withdrawing from the scene, civil society transferred its institutions, its administrative structure, its ideology and its collective ethos to the state. This can also contribute to explain why the State of Israel was “up and running on the 15 May 1948,”¹ to use an expression of David Vital.

The *Vaad Ha-Briut* was restructured to become the first nucleus of the Israel Ministry of Health. The *Vaad Ha-Hinuch* followed suit for the organization of the Ministry of Education. The Jewish Agency continued to undertake functions of organization and coordination of Jewish immigration. It now works directly together with the Ministry of Absorption. The HMO remained a private medical organization operating in co-operation with the Ministry of Health. In the new political context - where the public dimension dominated over the private - KH took the centre-stage of medical provision, completing a course which had begun soon after the construction of its major hospital in Petach Tikva. The *Histadrut*, originally founded as a trade union, had already evolved into an economic giant under the Mandate. By 1940 it was able to coordinate the last phases of state-building. In the State of Israel, KH continued to be run under its aegis. As the one gained membership, influence

¹ D. Vital, “From ‘State within a State’ to State”, in E. Karsh (ed.), *Israel: the First Hundred Years, Volume I. Israel's Transition from Community to State*, Frank Cass, London-Portland, OR, 2000, pp. 32-42, p. 32.

and power, the other grew in numbers, financial possibilities and outreach. In 1993 this medical organization insured seventy per cent of the Israelis.² In many respects the *Histadrut* had represented one of the pillars of Zionist civil society during the Mandate. Together with the army,³ it became also the political ring where generations of Israeli (Labour) leaders were forged, from David Ben Gurion to Itzhak Rabin.

The 'dense' networks which had been organized from above were integrated into the structure of the state – in its medical or welfare branches. Those associations which had been part of the 'loose' network generally disappeared. Some like *Tipat Halav* – were integrated into the wider public framework. Few, if any, grassroots movements and associations developed in the first years of the state, either in the medical, in the welfare or in other fields.

The system of values which had kept Zionist civil society united in its functions of institution- and state-building was also incorporated into the new Israeli identity. This reposed in the new institutional framework the ideological coherence and rigidity which had belonged to Zionist associationism in its formative years. As civil society had shaped and demanded the cultural uniformity of its members for national purposes, the new state reproduced and enhanced this embedded nationalism.

The centralising and imposing national ethos which dominated in Israel in the 1950s – *mamlachtyiut*, or statalism – embodied the shift from the Zionist semi-voluntary framework to the binding obligation of the state, or – to use the words of Gershon Shafir and Yoav Peled – the shift from foreign rule to sovereignty.⁴ Rather than discarding the nationalist values which had belonged to civil society, *mamlachtyiut* was constructed and developed as an even stricter and more rigid instrument of ideological and political control. It became a banner under which the functions of boundary demarcation of civil

² S. Shvarts, *Kupat Holim Ha-Clalit, the General Sick Fund. Its development as a major factor in the health services in Eretz Israel, 1911-1937*, [Hebrew], Ph.D. Thesis, Ben Gurion University of the Negev, Beersheba, 1993 [n.p., in the English abstract].

³ U. Ben Eliezer, "Parachuting into politics": Military-political nexus and legitimation for war in Israel", Paper presented at the 4th Mediterranean Social and Political Research Meeting, Florence 19-23 March 2003, Mediterranean Programme, RSC, IUE.

⁴ G. Shafir and Y. Peled, *Being Israelis*, p. 18.

society were protracted into the state. Under *mamlachtyiut*, all was centralized; all was subordinated to the needs of the state. In such a context, civil society - either as a space for negotiation or as a normative system - was suffocated by the requirements of statehood. Here the family was gradually rehabilitated as one of the main centres - if not *the* centre - where the Jewish and the national(istic) values of Zionism were framed into a new Israeli identity which could be transmitted to new generations.

Other traits which had belonged to Zionist civil society during the Mandate were incorporated as part of the national cultural framework: the sense of exclusiveness, the strong boundaries, the generalized construction of the Jewish Diaspora as an entirely negative phenomenon. Well before Israelis, Jews in Palestine had perceived their community as small, weak, under siege and under permanent threat of disappearance.⁵ This feeling had contributed to keep civil society united when the British represented the 'enemy.' After 1948 - when an enemy existed in the reality - it was not difficult to re-shape this framework to fit the new political situation. This collective feeling evolved into what became later known as the 'Masada syndrome.'⁶ Other factors certainly played an important role in the construction of Israel as a community under siege: the arrival in Israel of the survivors of the *Shoa*, the relatively small numbers of the Israeli population and the war of 1948 are just three of them. The existence of such enemy represented in post-1948 Israel a central element to subordinate any form of associationism to the needs of the state.

An open civil society, which embodied progressive values of reform, which could be inclusive, which emphasized the need to negotiate with the state, which defended civil rights and which aspired to some forms of (Jewish) multiculturalism, began to develop in Israel only after 1967. Slowly, throughout the 1970s and 1980s, networks of associations grew to negotiate progressively more complex issues: human rights, questions of land, the inclusion of *Mizrahim* into the body politic of the nation, the shortcomings of a juridical system which had inherited British features (common law and lack of

⁵ B. Kimmerling, *The Invention and Decline of Israeliness...*, p. 91.

⁶ N. Ben-Yehuda, *The Masada Myth Collective Memory and Myth Making in Israel*, University of Wisconsin Press, Madison, London, 1995.

a written constitution) in a republican framework, the role of women in a male-oriented and military society, that of non Jewish immigrant workers, up to the environmental questions raised and addressed from the 1990s onwards.⁷

Most of the organizations of the present Israeli civil society deal with the question of Palestinians. Some of them – ‘Physicians for Human Rights’ (PHR, 1987) or the ‘Israel-Palestine Centre for Research and Information’ (IPCRI, 1989) for example - see medical and welfare work as a way to build horizontal networks of participation *between* Israelis and Palestinians in the framework of transnationally shared values. When the Rabin government cut by fifty per cent the health budget for the occupied territories during the First *Intifada*, PHR protested vigorously.⁸ PHR represents just one of the many examples of civil society as a negotiator between individuals and state in a perspective which goes beyond national borders. Its accusation of the Israeli drastic measures went hand in hand with a strong denounce of the bureaucratic and inefficient hospital management of the Palestinian National Authority.

The state and its inhabitants have still to be defended both in Israel and in Palestine. Still, the experience of the past fifty years seems to have taught to some that social services, medical provision and education can represent better investments for security than other means. Henrietta Szold had expressed the very same concepts to the Peel Commission in 1937.

Zionist civil society in mandatory Palestine expressed the values of nationalism and of exclusiveness as its members strove to shape a new identity through social and political interaction. It remained a closed entity for two reasons. In the first place, it represented a challenge against a Jewish past which was seen as individualist and familist. Zionism saw these two latter elements as partially responsible for the permanence of anti-Semitism. The normalization of the Jew had not only to pass through health or manual work. It also had to go through his/her becoming a social and political individual, a citizen.

⁷ M. Simoni, “Sustainability and Peace. Civil society in Israel/Palestine after Oslo”, forthcoming in *Quaderni del CESD, Proceedings of the workshop “The role of civil society in the South Bank of the Mediterranean”*, VIU, Venezia, 8-14 June 2003.

⁸ www.phr.org.il

In the second place, Zionist associationism remained in this period self-centred also because it represented, from 1933 onwards, one of the few means to guarantee Jewish survival. The CBF, the Youth Alyia, the AJP all contributed to it. As the situation in Europe deteriorated, other organizations and other programmes were set up for this purpose. The Alyia Bet programme for Jewish illegal immigration from Europe was one of them.⁹

Interaction through civil society did not only represent a collective experience which gave meaning to a process of social transformation. It also constituted a central means to influence the political reality of mandatory Palestine.

In this context, the organization of a system of public health and medical provision represented one of the central instruments of the Zionist movement to combine the rejection of the Jewish past, the construction of the new Jew, his/her social participation and the creation of political conditions which could lead to the establishment of a state.

Health represented in this respect a conceptual notion, a political process, a social behaviour and a practical undertaking. As a notion, it helped to build the exclusiveness of the Jewish community in Palestine. It also helped the Zionist immigrant break with the Jewish past. As a political process, it became an instrument to construct a citizen who could feel s/he belonged to a national healthy community. As a social behaviour it was used to prevent and limit the propagation of disease. It was also employed to establish a substantial homogeneity in Jewish lifestyle. As a practical undertaking it became the central instrument to reclaim the environment and the land.

Health played one more function. It controlled, sheltered and protected the nation at war. When the 1936-39 riots broke out, physicians and nurses came to be regarded as the "first soldiers in our battle for survival."¹⁰ On the same day the riots began, Dr. Kliegler wrote to the central administration of the

⁹ D. Ofer, *Escaping the Holocaust: Illegal Immigration to the Land of Israel (1939-1944)*, Oxford University Press, New York, 1990.

¹⁰ HDS, b. 33, f. 17, 1936.

HMO in New York. His words connected the short past of Zionist presence in Palestine to the long future of its struggle to stay.

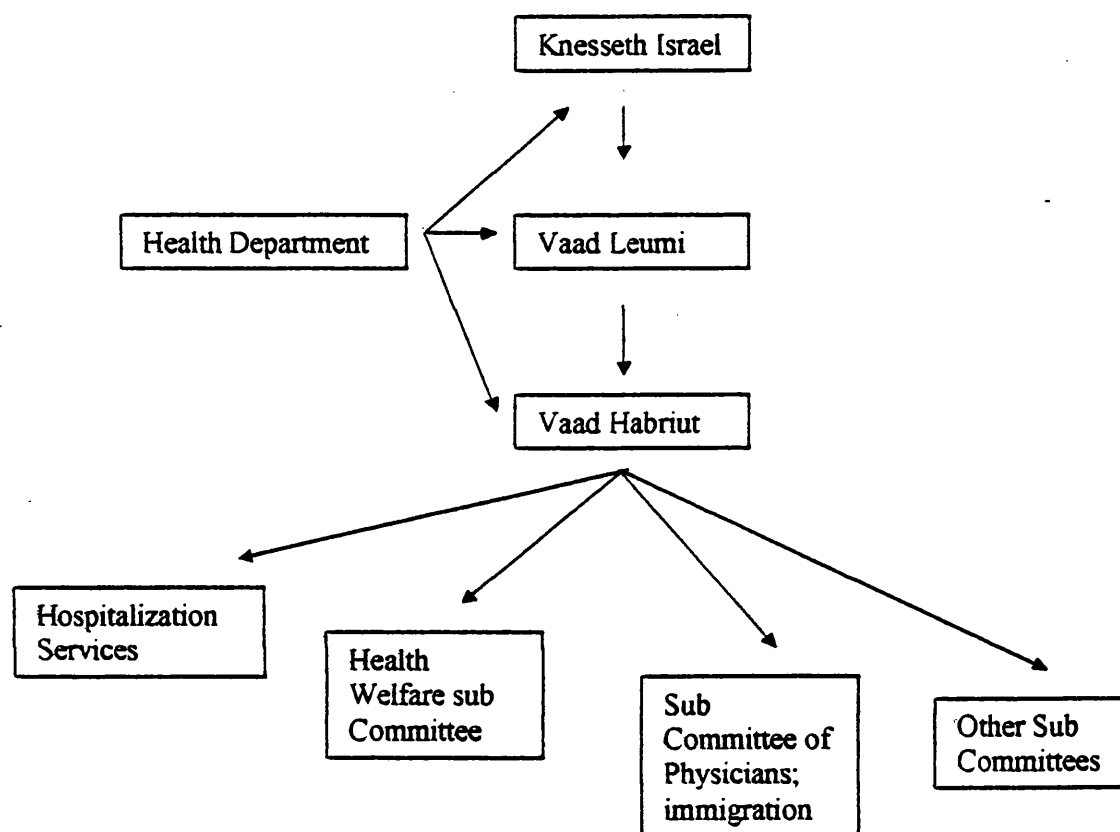
Meanwhile the Arabs have become restive and have once again shown their capacity for destruction. What it means to us here I need not tell you. It is not just the loss of life but the jamming of the whole mechanism of life here - traffic, trade, communications, a stoppage of work. Added to this there is the nervous strain, the feeling of insecurity. The hidden doubts and the realization that the road ahead of us is still long and stormy and the task arduous. The people are behaving splendidly and are showing marvellous self restraint. But no one knows when the nerves will snap. We may have to relive (sic) the dark days of 1929-30 But there is solidity and determination and that is a great deal. After the dizziness of prosperity comes (sic) the sobering influences of reality - and the hard struggle ahead of us. Yours, Jack.¹¹

¹¹ HDS, b. 56, f. 6, Letter from Dr. I. Kligler to Mrs. Rose Jacobs, 15th April 1936.

Appendix

Diagram.n. 1

The administrative structure of Knesseth Israel
with regard to health.¹



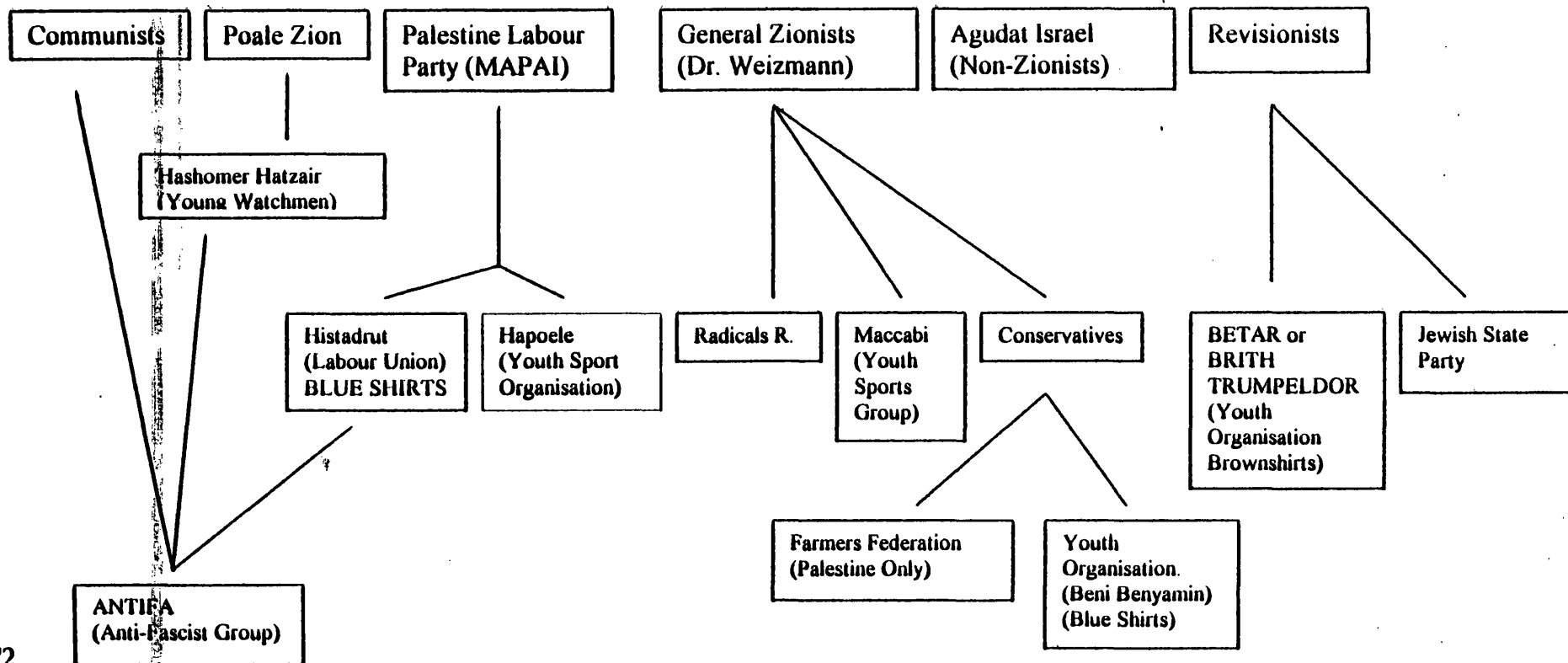
¹ HDS, b. 56, f.5, enclosure to letter from H. Yassky to Mrs. Robert Szold, Chairman, Palestine Committee of Hadassah, 19th December 1935.

Diagram n. 2

Jewish Political Parties
(Source: MEC, Tegart, b. 1, f. 3)

Left

Right



Who's Who¹

Arlosoroff Chaim: (1899-1933). Born in Romny, Ukraine, to a middle class family, Arlosoroff moved to Berlin with his family in 1905. After graduating from his *Gymnasium*, he went on to study economics at the University of Berlin. By that time, he was one of the main leaders of *Ha-Poel Ha-Tzair* in Germany and editor of the journal *Die Arbeit*. It was in this journal that his first articles appeared, next to essays of Buber, Gordon and Landauer. In 1919 he published his first major treatise, *Die jüdische Volksozialismus*. He visited Palestine in 1921. After his return to Europe, he was instrumental in moving the Third World Conference of *Ha-Poel Ha-Tzair* to adopt an explicitly socialist programme. His political rise within the Zionist movement was rapid. At the 1923 Zionist Congress, he was elected to the Zionist Actions Committee, mainly on his record as the author of an influential memorandum on the finances of the Jewish Agency. In 1926 he was sent from Palestine in a delegation to the League of Nations in Geneva. After 1931 he was appointed Head of the Political Department of the Jewish Agency. He held this position until he was assassinated in 1933.²

Beilinson Moshe: (1899-1936): Born in Russia, he settled in Palestine in 1924. He chaired the Supervisory Committee of KH between 1929 and 1936.

Bluestone Ephraim Michael (1891-1979): Dr. Bluestone received his B.S. and M.D. from Columbia's College of Physicians and Surgeons in 1916. During the First World War he served as First Lieutenant in Laboratory Service of Medical Corps of US Army in France. Upon his return, he worked at Mt. Sinai Hospital in New York (1920-1926). From February 1926 to September 1928 he worked as Director of the HMO in Palestine. In later years, he became Chair of Medical Reference Board of Hadassah at the Hebrew University (1939-1950). Between 1928 and 1950 he was also the Director of the Montefiore Hospital for chronic diseases, New York. A scholarship in his name was established at Columbia University on his 80th birthday.

Bowman Humphrey (1879-1960): Educated at Eton (1892-1898) and at New College, Oxford (1898-1902), Bowman graduated in modern history. He then worked in education as Director of Egyptian Students in England (1913-1914). He was then appointed Inspector of Schools for the British Department of Education in Sudan (1911-1913). Between 1918-1920 he directed the Department of Education in Iraq. From 1920 to 1936 he was

¹ Unless otherwise indicated, biographical information has been found in the *Encyclopedia Judaica* and in the *Who's Who*.

² S. Avineri, *Arlosoroff*, Peter Halban, Weidenfeld & Nicholson, London, 1989.

Director of Education in Palestine.³ He was also the leader of the Scout movement in Palestine.

Halprin Rose: She served as the National President of the HMO for two terms. Between 1934 and 1939 she lived with her family in Jerusalem. During this time, she served as liaison between Hadassah in the United States and in Palestine. She sat on the building committee of the HU-Hadassah hospital in Jerusalem. It was during her second presidency that the decision was made to open the Hebrew University-Hadassah Medical School. In 1946, Mrs. Halprin was elected to the Executive of the Jewish Agency for Palestine. She served on the Executive of the Jewish Agency for more than 20 years.

Heron George Wykeham: Col. Wykeham Heron headed the Government Department of Health. His tenure of office lasted from 1920 to 1944, a record rivalled only by that of Humphrey Bowman, his colleague at the head of the Department of Education. These two men, Anglo-centric and authoritative, shared the belief that the Imperial system of administration would have suited Palestine as it had suited the rest of their colonial world. Heron had worked as a physician at Westminster Hospital in 1904-1905. He then served with the Egyptian government from 1908 until 1920, when he became the Director of Medical Services in Palestine. In 1926 he was knighted by the Order of St. John in Jerusalem. He appears to have been a strenuous worker, "very single-minded," shy, authoritative and "fierce, at least according to his son."⁴ He was also quite detached from the British social milieu of receptions and dinners, of formal and informal gatherings. He was not in the least appreciated in Zionist circles, against whom he continued a silent and fierce sabotage. Zionist leaders often accused him of anti-Semitism, and his loyalty always remained for the Arab population. He seems to have never overcome the feeling of ultimately "having thrown the Arabs down the river."⁵ With his long tenure of office, he contributed to shape British health policies. Heron's Anglo-centric and colonial attitude was also responsible for the missed opportunity to develop a medical system for the Arab population which could parallel the Zionist one.

Katzenelson (Nissan) Avraham: (1888-1956): Born in Byelorussia, he settled in Palestine in 1924, where he studied as a physician. Between 1931 and 1948, he directed the health department of the Zionist Executive. He was a member of the Mapai Party, and the Israel Minister to Scandinavian countries from 1950 to 1956.⁶

Kligler, Jacob (Jack) Israel: (1889-1944): Bacteriologist, was born in Ukraine and settled in Palestine in 1920. He became a leading public figure in public health and malaria control.⁷

³ MEC, Bowman, Curriculum 2nd January 1932.

⁴ Interview of the author with Col. Heron's niece, Mrs. Joanna Page, London, 9th December 1997. Col. Heron did not leave any written documents, diaries or letters that I could find. A letter from his grandson in Australia also suggests he never kept a diary or wrote a memoir. Letter to the Author, 28th July 1997.

⁵ Interview Page.

⁶ S. Schvarts, *The Workers' Health Fund*..., p. 321.

⁷ Ibid.

Jacobs Gell Rose (1888- ?): Mrs. Jacobs served Hadassah from the early years, under the leadership of Henrietta Szold and Alice Seligsberg. Early in 1914, Rose married Edward Jacobs. The Jacobs lived in various southern communities for the following four years, where Rose organized Hadassah chapters - including Columbus, Georgia and Chattanooga, TN. Back in New York by 1918, Rose became a member of the National Board of Hadassah. In 1918 she became a member of the National Board of Hadassah. When Henrietta Szold moved to Palestine in 1920, Rose, then vice-president, became the acting head of Hadassah. She also participated in the International Zionist Conference in 1922, as a delegate. It was during her second term as National President of Hadassah, 1934 to 1937, that Hadassah built the Rothschild-Hadassah University Hospital on Mt. Scopus and that began the Youth Aliya project. In 1937 Rose Jacobs was elected to the Executive of the Jewish Agency of Palestine. In 1938-39, she participated to the London roundtable conference on Arab-Jewish relations as a member of the Jewish Agency.

Lindheim Irma (1886-1978): She assumed the position of National President of Hadassah in 1926, and served until 1928. She was at the same time a vice-president of the Zionist Organization of America and a member of the Actions Committee of the World Zionist Organization. Mrs. Lindheim became affiliated with the Labor Group of the Zionist movement in 1930. In 1932 she helped organize the League for Labor Palestine and in 1933 became a member of the *Histadrut*. In 1933 Mrs. Lindheim settled in a *kibbutz* in Palestine, where she remained until, 40 years later she had to go back to the US for health reasons. Among her projects in Palestine - and later Israel - were the development of playgrounds and recreational activities, (with Bertha Guggenheimer) and the creation of Palestine Fellowships in 1935 which permitted American college students to study and travel in Palestine.⁸

Magnes Judah Leon: (1887-1948). He was chancellor (1925-35) and first president (1935-48) of the HU. He served as secretary of the American Zionist Federation (1905-1908) and later became the president of the Community of New York City from its founding in 1908 to its demise in 1922. He left for Palestine in the same year. He was active in raising funds for the university, in securing the donation of several personal libraries and in the development of various departments, especially the Institute of Jewish Studies which opened in 1924. One of the Chairs of Bible carries his name as well as the press of the university. He helped in the HMO programme Youth Alyia. He was also the head of an Emergency Council of Hadassah for Palestine and chairman of the Middle East Advisory Council of the JDC.

Peel Commission: Lord Peel (the grandson of Sir Robert Peel) was the chairman of the Commission sent to investigate on the causes of the outbreak of the Great Arab Revolt in 1936; he had served twice as Secretary of State for India; Sir Horace Rumbold, the vice-chairman, had been the British Ambassador in Berlin until 1933; Sir Lucas Hammond had served in Bihar and Assam; Sir William Morris Carter had served in Africa; Sir

⁸ <http://www.hadassah.org>

Harold Morris was the Recorder of Folkstone. The last member of the commission was Professor Reginald Coupland, Beit Professor of Colonial History at Oxford.⁹

Perowne Henry Stewart: (1907-1989), son of the Bishop of Worcester, he studied at Corpus Christi, Cambridge, and Harvard. He joined the Palestine Government Education Service in 1927 and the administrative service in 1930. He became Assistant District Commissioner for Galilee in 1934. He then left Palestine for Malta (1934), Aden (1937), Baghdad, (1941), Barbados (1947-51) and Cyrenaica (1950-51). In 1951 he retired. As an archaeologist he discovered ancient city of Aziris in 1951. His diplomatic career continued as the adviser of the UK delegation to the UN Assembly, Paris, in November 1951. He went back to Jerusalem in 1952 as Assistant to the Bishop for refugee work in Jerusalem. In his numerous publications Perowne dealt with different aspects of the Roman colonization of the Middle East.

Seligsberg Alice (1873-1940): Educated at Barnard College, Columbia University, and at the University of Berlin. In 1913 she began to be involved with Hadassah. At the same time she founded 'The Fellowship House', a social and placement center for New York City orphan children. In 1918 she became the administrative head of the American Zionist Medical Unit. In 1919 she also became the Executive Director of the Orphans Committee of the JDC in Palestine. From 1921 to 1923 she worked as the National President of the HMO, when Henrietta Szold moved to Palestine in 1920. In 1922 she was appointed Executive Director of the 'Jewish Children's Clearing Board' of New York, a position she held until 1936.¹⁰

Szold Henrietta (1860-1945): In 1877 Henrietta graduated from Western High School and became its temporary principal. In 1888 she helped organize the Isaac Levinsohn Literary Society. At her suggestion, the Society opened a night school for immigrants in 1889. Here she organised courses of English and 'Americanization' for Russian Jews who had been arriving in Baltimore since 1881. Henrietta taught and supervised this program until 1893. Henrietta became a Zionist in the 1890s. In 1907 she joined a women's Zionist group, the Hadassah Study Circle. She took a six month leave of absence from the Jewish Publication Society, and visited Palestine in 1909-1910, a trip that would change Henrietta's (and Palestine's) life. On her return to New York, Henrietta resumed her involvement with the paid and volunteer activities she had been connected with six months earlier. She also became secretary of the Federation of American Zionists. Eventually, in 1912, she brought together the women from the study group with other women. The Hadassah Chapter of the Daughters of Zion became known as simply, "Hadassah". From the beginning, the purpose of this group was twofold: to foster Zionist ideals through education in the US and to begin public health programmes in Palestine. Henrietta Szold was elected the first president. She spent the following fourteen years directing the expansion of this small, local study group into a national fundraising and membership

⁹ I. Black, "A judgement of Salomon that could not save Palestine", *The Guardian*, 7 July 1987.

¹⁰ <http://www.hadassah.org>

organization. From 1912 to 1926, the history of Hadassah and the life of Henrietta Szold were closely intertwined. In 1913 Henrietta began touring the U.S. on behalf of Hadassah. She also became head of the Zionist Organization's Department of Education in 1916. Henrietta was closely involved with the organization of the American Zionist Medical Unit, which left for Palestine at the close of World War I in 1918. The Unit settled into a hospital building built by the Rothschild family outside the walls of the old city of Jerusalem in the 1880s. The building soon became known as the Rothschild-Hadassah Hospital. It was the first incarnation of Hadassah hospital. It is used today by the Hadassah College of Technology. In 1920 Henrietta moved to Palestine to take personal charge of Hadassah's programmes. In 1918 she had started what soon became known as the Henrietta Szold-Hadassah School of Nursing. This institution operates today at the Hadassah Medical Center at Ein Karem. In October 1934, Henrietta Szold laid the cornerstone of the new Rothschild-Hadassah University Hospital on Mount Scopus. In 1926 Henrietta resigned as president of Hadassah and was named honorary president. In 1927 she became a member of a three person executive of the World Zionist Organization as head of Health and Education. In 1931 she became a member of the executive committee of the *Vaad Leumi*. In 1933, ready to retire at the age of 73; she became director of Youth Alyia. Henrietta spent the rest of her life coordinating Hadassah's Youth Alyia projects from Palestine.¹¹ A town, Kfar Szold, exists in her name.

Szold Falk Zip (?-1979): A graduate of Bryn Mawr College, she began her public career as a social worker in Bloomfield, N.J. There, she organized a district nursing service. She also opened evening public schools for young workers. Zip married Robert Szold, an influential lawyer active in the Zionist movement. In 1920, Mrs. Szold sponsored a branch for young Zionist women, which later became known as Junior Hadassah. One of the leaders of Hadassah for more than four decades, she held virtually every important post in Hadassah. She was National President 1928 to 1930.¹²

Yassky Haim (1896-1948): Medical administrator in Palestine. Born in Kishniev, Bessarabia, Yassky took part in underground Zionist activities and in Jewish self-defense in Odessa. He went to Palestine in 1919, just before his final medical examinations. After working as a sanitary inspector, he went to Geneva. Here he completed his medical studies and specialized in ophthalmology. He joined the HMO in 1921. In 1924 he successfully dealt with endemic trachoma in Judea and earned wide recognition. Appointed director of HMO in 1931, he was instrumental in building the Rothschild-Hadassah University Hospital on Mount Scopus (1934). He developed plans for the Jerusalem Medical School and for the immigrant medical service. Yassky was killed by Arabs in the ambush of April 13, 1948, while leading staff and colleagues in a convoy from the city to Mount Scopus. The Hadassah hospital in Beersheba and the chair of social medicine at the Hebrew University-Hadassah Medical School were named after him.

¹¹ Ibid.

¹² Ibid.

Glossary of Hebrew Terms¹

Achid	Homogenous/Joint	אחד
Alyia	Immigration	עליה
'Am	People	עם
Amami/t	Popular	עממי/ת
Aretz	Land	ארץ
Avoda	Work	עבודה
Ba-	In	ב-
Bana	To build	בנה
Bari	Healthy	בריא
Ben	Son	בן
Bikur	Visit	בקור
Boker	Morning	בוקר
Briut	Health	בריאות
Davar	Word/Leader	דבר
Derech	Way	דרך
Ed-a/ot	Origin/s/Ethnicit-y/ies	עד-ה/ות
Ezra	Help	עזרה
Ha-	The	ה-
Hadadi/t	Mutual	הדדי/ת
Hadash	New	חדש
Halav	Milk	חלב
Haluka	Distribution/Charity	חלוקה
Halutz/im	Pioneer/s	חלוץ/ים
Hinuch	Education	חינוך
Histadrut	Organisation	הסתדרות
Hol-e/im	Ill	חול-ה/ים
Hygiena	Hygiene	היגיינה
Iom	Day	יום
Isha/Nashim	Woman/Women	אישה/נשים
Ivri	Hebrew	עברי
Karka	Land/Soil	קרקע
Kehill-a/ot	Communit-y/ies	קהיל-ה/ות
Kfar	Village	כפר
Kibbush	Conquest	כיבוש
Kibbutz/im	Communal settlement/s	קיבוץ/ים
Kupa	Till/Fund	קופה
Knesset	Assembly	כנסת
Leumi	National	לאומי

¹ The transliteration of Hebrew terms into English does not follow a philological standard, but common use.

Mamlachtiyut	Statism	ממלכתיות
Mas	Tax	מס
Medina	State	מדינה
Mizrahi	Easterner/s	מזרחי/ים
Moshav	Co-operative settlement	מושב
N-aar/earim	Youth	נער/ים
Ozar	Treasure	אוצר
Po-el/-alim	Workers/s	פועל/ים
Refua	Medicine	רפואה
Rofe/im	Doctor/s	רופא/ים
Salal	To Pave	סלל
Shaar	Gate	שער
Smira	Guard	שמירה
Tipa	Drop	טיפה
Tzair	Young	צעיר
Tzedek	Justice	צדק
Vaad	Committee	ועד
Yishuv	Settlement/Jewish community in mandatory Palestine	יישוב
Zioni	Zionist	ציוני

References

Primary Sources

Cambridge, University Library.

Stanley Baldwin, First Earl Baldwin of Bewdley.

E. 1. Vol.95, Imperial 40

Smuts papers

Microfilm 689, volume 24, 1921, letter n.318;
Microfilm 690, volume 25, 1922, letter n.170; 277; 279
Microfilm 696, volume 31, 1925, letter n.12;
Microfilm 697, volume 32, letter n.71; 108;
Microfilm 705, volume 40, letter n. 2; 4;175;183;
Microfilm 709, volume 44, letter n.5; 6;
Microfilm 710, volume 45, letter n.1;
Microfilm 713, volume 48, letter n. 57;
Microfilm 719, volume 54, letter n.6; 148;177; 180; 187;
Microfilm 721, volume 56, letter n. 12;
Microfilm 723, volume 58, letter n. 8; 9; 10.

Templewood Papers.

Part X, File 7: X: 7 (5i); X:7 (5v);

Part X, File 8: X: 8 (3); X: 8 (5); X: 8 (6); X:8 (27).

Central Zionist Archives, Jerusalem

A 187

A 187/12

A 187/13 A

A 187/17

F 31/12

F 48/43

F 49/143

F 49/2467

F 49/2665

F 49/2678

F 49/2868

F 49/2871

F 49/2872

F 49/2874

J 113

L 12/129

L 13/120
S 48/43

Hadassah Medical Organization Archives, New York
HMO Programs, b. 1

Series 2, Box 27, folder 4, 5, 7, 9, 10;
Box 28, folder 2, 3, 7, 11, 12;
Box 29, folder 1, 7, 8, 9, 11, 12;
Box 30 folder 1, 3, 5, 6, 8, 9, 11, 12, 13, 14;
Box 31, folder 2, 4, 6, 8, 9, 12, 14;
Box 32, folder 4, 7, 10, 11, 12, 14;
Box 33, folder 1, 2, 3, 4, 5, 6, 7, 9, 10, 14, 17;
Box 34, folder 1, 4, 6, 8, 10, 12, 13;
Series 5, Box 37, folder 1, 2, 3;
Series 6, Box 38, folder 1;
Series 8, Box 40, folder 1, 2, 3;
Series 9, Box 41, folder 1, 2;
Series 15, Box 47, folder 1;
Series 17, Box 49, folder 1, 3, 5, 6, 7, 8;
Series 20, Box 52, folder 1, 2, 3, 4;
Series 21, Box 53, folder 1, 2, 5
Series 22, Box 54, folder 1, 2;
Series 23, Box 55, folder 1, 5, 6;
Series 24, Box 56, folder 1, 2, 3, 4, 5, 6;
Series 25, Box 57, folder 5, 6, 7;
Series 34, Box 69, folder 1;
Series 36, Box 71, folder 1, 2;
Series 37, Box 72, folder 1, 2;
Series 39, Box 74, folder 1;
Series 42, Box 79, folder 8;
Series 43, Box 80, folder 3, 4;
Series 60, Box 100, folder 1;
Box 198;
Jewish Agency Series, Box 3, folder 6;
Box 4, folder 34, 35, 37, 38;
Box 5, folder 39, 40, 41.

International Missionary Council, Geneva

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25.56.06

Israel State Archives, Jerusalem

J 202/35
M 4/42 M 224
M 54/14
M 125 E/83/31

M 130 E/SW/3/48
M 274 T/265/35
M 294, K/85/31; K/179/31
M 321 M/260/33
M 324 M/9/42
M 349 OP/381/46; OP/395/46
M 365/POL/1/46
M 838, 458; 529
M 839, 677
M 842, 1042
M 1012 663/8
M 1505 2/26
M 1511 5/8/A
M 1512 5/72
M 1513 5/103
M 1532 15/18
M 1533 15/18
M 1534 15/132
M 1552/25/18
M 1561 33/57; 33/102
M 1566 43/110
M 1563 36/1
M 1576 45/30
M 1576 54/4; 54/5; 54/6; 54/12; 54/18; 54/27; 54/30; 54/32
M 1577 54/30; 54/42; 54/45
M 1587 58/20/1
P 65 390/3065
POL/151/D
RG 10 11/70/35 M 321
RG 65 P/392/3117

**Jerusalem and the East Mission Archive, Middle East Centre, St. Antony's
College Oxford**

Box 1, folder 5;
Box 37, folder 1;
Box 45, folder 5;
Box 58, folder 2, 3, 9;
Box 59, folder 1;
Box 60, folder 3;
Box 61, folder 1, 3, 4.

Jewish Joint Distribution Committee, New York

Series 21/32, n. 262, n. 267, n. 272;
Series 33/44, n. 746, n. 752, n. 754, 758, n. 759, n. 761, n. 779.

Knight Order of St John in Jerusalem, London

Report of J. T. Woolrych Perowne on his recent visit to the Ophthalmic Hospital, 1922.

Report of the committee for 1924, 1925, 1926, 1927, 1930, 1931, 1932, 1934.

Report of J. T. Woolrych Perowne on his recent visit to the Ophthalmic Hospital, 1928.

A Short Sketch of the Growth of the Ophthalmic Hospital in Jerusalem.

Minutes of the Chapter General of the Order held on Friday 21st February 1936 at St. John's Gate, Clerkenwell, London, EC1, f. 213.

Mahon Lavon, Histadrut Archives, Tel Aviv

IV-243-2

Middle East Centre, St. Antony's College, Oxford.

E. Bickersteth, Box 1, folder E;

Box 3

H. Bowman, Box 2, file 1;

Box 2, file 2;

Box 2, file 3;

Box 2, file 6;

Box 4A;

Box 4B.

BM 2/2/30

Diary.

S. P. Emery, Box 1, file 1; 2, 3, 4, 5

Box 2 file 4;

Box 3, file 1.

W. J. Farrell. The Distribution of educational Benefits in Palestine.

E. D. Forster, Folder 1.

F. W. Forster-Turner, Box 1.

T. L. Hodgkin, *George Antonius, Palestine and the 1930s*, George Antonius Memorial Lecture, St. Antony's College, 1981.

C. Klingeman, 1 Folder.

D. A. Norman, Box 1.

H. S. Perowne, Box 2, file C, D, E, F, G, H, I;

A. L. F. Smith, Box 1, file 3;

Tegart b. 1, f. 3

Thames Television, Box.2, file 3

Public Record Office, London.

PRO CO 732/39/7.

CO 732/40/9.

CO 732/42/6; 732/42/7; 732/42/8; 732/42/19; 732/42/22.

CO 732/43/11.

CO 732/45/10.

CO 732/46/2; 732/46/3; 732/46/6; 732/46/7.

CO 732/47/1.
CO 732/48/6, 732/48/7.
CO 732/54/6.
CO 732/60/6.
CO 732/62/16.
CO 732/64/1.
CO 732/65/6.
CO 732/66/6; 732/66/12.
CO 732/69/2, 732/69/3.
CO 732/70/2.
CO 732/71/3; 732/71/4.
CO 732/72/6.
CO 732/74/2; 732/74/5; 732/74/6.
PRO CO 733/130/5.
CO 733/131/5.
CO 733/132/2; 733/132/3; 733/132/6; 733/132/7.
CO 733/133/11; CO 733/133/18.
CO 733/134/7; 733/134/9; 733/134/12.
CO 733/136/4; 733/136/5; 733/136/10.
CO 733/137/11; 733/137/17.
CO 733/139/1, 733/139/5.
CO 733/140/2.
CO 733/141/18.
CO 733/144/8; 733/144/12; 733/144/18.
CO 733/146/12.
CO 733/147/6.
CO 733/155/6; 733/155/13.
CO 733/159/8.
CO 733/162/9.
CO 733/165/2.
CO 733/168/12.
CO 733/171/2.
CO 733/174/3.
CO 733/184/8; CO 733/184/9.
CO 733/186/1.
CO 733/188/6.
CO 733/192/13.
CO 733/204/3; 733/204/5.
CO 733/205/10.
CO 733/208/6; 733/208/8; 733/208/9.
CO 733/209/8, 733/209/9.
CO 733/220/7; 733/220/9.
CO 733/222/4.
CO 733/223/4; 733/223/9; 733/223/14.
CO 733/225/4.
CO 733/226/4; 733/226/13.
CO 733/227/7.
CO 733/234/6.
CO 733/235/3.

CO 733/240/2; 733/240/9.
CO 733/241/7; 733/241/14.
CO 733/242/13.
CO 733/253/3.
CO 733/257/3.
CO 733/261/6; 733/261/12.
CO 733/277/1.
CO 733/281/15.
CO 733/282/3; 733/282/12.
CO 733/284/1.
CO 733/287/4; . CO 733/287/5.
CO 733/301/2; 733/301/4; 733/301/10.
CO 733/302/3.
CO 733/303/5.
CO 733/306/9.
CO 733/323/13.
CO 733/328/10.
CO 733/337/9.
CO 733/340/3; 733/340/26.
CO 733/350/24.
CO 733/351/1.
CO 733/355/6.
CO 733/375/3; 733/375/6.
CO 733/380/10.
CO 733/384/4.
CO 733/392/16.
CO 733/399/23; 733/399/24.
CO 733/401/9.
CO 733/442/12.
FO 141/688/7238.
FO 371/15331.
FO 371/16928.

Rhodes House, Oxford

MSS Brit. Emp. S 278

MSS Brit Emp. S. 284, box 11, folder 7
box 15, folder 1

MSS Brit Emp. S 382, box 1, folder 3

MSS Brit Emp. S. 400, box 129, folder 2, folder 43

University College London, London

Mocatta Pamphlet Collection. FC 14.

Yale Divinity Library

HR 525-3

- Church of Scotland, *Report on Jewish Missions for 1926*, Submitted by Jewish Mission Committee, Edinburgh, 1927
Church of Scotland, *Report on Jewish Missions for 1930*, Submitted by Jewish Mission Committee, Edinburgh, 1931
Church of Scotland, *Report on Jewish Missions for 1931*, Submitted by Jewish Mission Committee, Edinburgh, 1932
Church of Scotland, *Report on Jewish Missions for 1932*, Submitted by Jewish Mission Committee, Edinburgh, 1933
Church of Scotland, *Report on Jewish Missions for 1934*, Submitted by Jewish Mission Committee, Edinburgh, 1935
Church of Scotland, *Report on Jewish Missions for 1935*, Submitted by Jewish Mission Committee, Edinburgh, 1936
The Church and Jewry. Report of the Church of Scotland's Jewish Mission Committee, 1938
One Hundred Year After, Centenary Report of the Church of Scotland's Jewish Mission Committee, Edinburgh, 1938
The Palestine Village Mission, *Report for 1935*
The Palestine Village Mission, *Report for 1936*

Interviews

- Mrs. Johanna Page, London, 9th December 1997
Miss Nada Rizq, London, 16th December 1997
Miss Dorothy Morgan, Wontage, 17th December 1997
Miss Alice (Shulamit) Honegsberg, Wolvercote, 2nd January 1998
Mrs. Carmela Fryer, Meopham, 15th January 1998.
Prof. Peretz (Jack) Yekutieli, Hofit, 31st March 1998
Dr. Haider Abdel Shafi, Gaza, 1st April 1998
Dr. Ibrahim Daqqaq, East Jerusalem, 12th April 1998
Dr. Tayseer A. Maswada, Hebron, 13th April 1998.
Prof. Israel Pade, Zahala, 16th April 1998.

Electronic Sources

<http://www2.haaretz.co.il/eng>

<http://www.hadassah.org>

<http://ourworld.compuserve.com/palestinepolice/ppsite.htm>

<http://www.phr.org.il>

<http://www.tipa.co.il>

Primary Published Sources

Command Papers

- Cmd. 1500, *Final Draft of the Mandates for Mesopotamia and Palestine*, HMSO, London, 1921.

Cmd. 3530, *Report of the Commission on the Palestine Disturbances of August 1929*, HMSO, London, 1930. (Shaw).

Cmd. 3686, *Palestine: Report on Immigration, Land Settlement, and Development by Sir John Hope Simpson*, HMSO, London, 1930. (Hope Simpson).

Cmd. 3692, *Statement of Policy by His Britannic Majesty's Government in the United Kingdom, October 1930*, HMSO, London. (Passfield).

Cmd. 5479, *Report of the Palestine Royal Commission, Presented by the Secretary of State for the Colonies in Parliament by Command of His Majesty*, HMSO, London, 1937. (Peel).

Other Official Publications

Board of Control, *Suggestions and Instructions for the Arrangement, Planning and Construction of Mental Hospitals*, HMSO, London, 1941.

Colonial n. 48, *Palestine Commission on the disturbances of 1929. Minutes of Evidence*, 3 voll., HMSO, London 1930.

Colonial n. 133, *Palestine Royal Commission. Memoranda prepared by the Government of Palestine*, HMSO, London, 1937.

Colonial n. 134, *Palestine Royal Commission: Minutes of Evidence*, HMSO, London, 1937.

Department of Health, *Annual Report 1935, 1936, 1937*, Government Printing Press, Jerusalem, 1935, 1936, 1937.

Department of Social Welfare, *Annual Report 1944*, The Government Printer, Jerusalem, 1945.

Government of Palestine, *First Report on Agricultural Development and Land Settlement in Palestine* by Lewis French, Jerusalem, 1931 (French Report)

League of Nations, Malaria Commission, *Reports on the Tour of Investigation in Palestine in 1925*, Geneva, September 1925.

Newspapers and Weekly Magazines

"The Jewish Chronicle", 1926-1928.

"The Palestine Bulletin", 1929, 1930.

"Palestine Weekly", 1927-1931.

"Palestine Post", 1938.

Secondary sources

- Abboushi W. F., "The road to rebellion. Arab Palestine in the 1930s", *Journal of Palestine Studies*, 6 (3), Spring, 1977, pp. 23-46.
- Abu-Manneh B., "The Rise of the Sanjak of Jerusalem in the Late Nineteenth Century", in Pappé I. (ed.), *The Israel/Palestine Question*, Routledge, London and New York, 1999, pp. 41-51.
- Allon G., "The Mission motif in American Zionism", *American Jewish History*, 75 (4), June 1986, pp. 363-385.
- Amit I., "Economic and Zionist ideological perceptions: Private initiative in Palestine in the 1920s and 1930s", *Middle Eastern Studies*, 36 (2), April 200, pp.82-102.
- Anderson B., *Imagined Communities, Reflections on the Origins and Spread of Nationalism*, Verso, London New York, 1991.
- Anheier H., Glasius M., Kaldor M., "Introducing global civil society", in Id. (eds.), *Global Civil Society 2001*, Oxford University Press, Oxford, 2001.
- Antonovsky A. (ed.), *The Sociology of Health and Health Care in Israel*, Transaction Publishers, New Brunswick and London, 1990.
- Aronoff M. J., *Power and Ritual in the Israeli Labor Party: a Study in Political Anthropology*, M. E. Sharpe, Armonk NY, 1993.
- Avineri S., *Arlosoroff*, Peter Halban, Weidenfeld & Nicholson, London, 1989.
- Baggot R., *Health and Health Care in Britain*, St. Martin Press, Macmillan, New York, 1994.
- Baratz J., *A Village by the Jordan. The Story of Degania*, Harvill Press, London, 1954.
- Barromi J., "L'assassinio di Rabin", *Nuova Storia Contemporanea, Quaderni* Numero speciale, supplemento al n. 3/98, anno II, maggio 1998, pp. 137-152.
- Bauer Y., *From Diplomacy to Resistance: A History of Jewish Palestine 1939-1945*, Jewish Publication Society of America, Philadelphia, 1973.
- Bayart J. F., "Civil Society in Africa" in P. Chabal (ed.), *Political Domination in Africa: Reflections on the Limits of Power*, Cambridge University Press, Cambridge, 1986, pp. 109-125.
- Ben-Arieh Y. and Davis M. (eds.), *Jerusalem in the Mind of the Western World, 1800-1948, With Eyes towards Zion V*, Praeger, Westport, 1997.

- Ben-Artzi Y., *Me-Germania le-Eretz Israel*, Yad Yitzhak Ben Zvi, Jerusalem, 1996. [Hebrew].
- _____, *Early Jewish Settlement Patterns in Palestine, 1882-1914*, Magnes Press, Hebrew University, Jerusalem, 1997.
- Ben-Eliezer U., *The Making of Israeli Militarism*, Indiana University Press, Bloomington and Indianapolis, 1998.
- _____, "Parachuting into politics': Military-political nexus and legitimization for war in Israel", Paper presented at the 4th Mediterranean Social and Political Research Meeting, Florence 19-23 March 2003, Mediterranean Programme, RSC, IUE.
- Ben-Porat A., *Between Class and Nation. The Formation of the Jewish Working Class in the Period before Israel's Statehood*, Greenwood, New York, London, 1986.
- Ben-Yehuda N., *The Masada Myth Collective Memory and Myth Making in Israel*, University of Wisconsin Press, Madison, London, 1995.
- Bentwich N., "The legislation of Palestine, 1918-1925" *Journal of Legislation and International Law*, III, 8 (I), 1926, pp. 10-13.
- _____, *The Hebrew University of Jerusalem 1918-60*, Weidenfeld & Nicolson, London, [1961].
- _____ and H., *Mandate Memoirs*, Hogarth Press, London, 1965.
- Berkowitz M., *Western Jewry and the Zionist Project, 1914-1933*, Cambridge University Press, Cambridge, 1997.
- _____, "Doubled Trouble. A call to investigate the Life and After-lives of De Vriendt and De Hann", in *Arnold Zweig-Sein Werk in Kontext der deutschsprachigen Exilliteratur*, Jahrbuch für Internationale Germanistik, Reihe A, Band 49, Verlag Peter Lang, Bern, Berlin, Frankfurt am Main, New York, Paris, Wien, 1999, pp. 111-124.
- Bethnall N. B., *The Palestine Triangle. The Struggle Between the British the Jews and the Arabs 1935-48*, Futura Publications, London, 1980.
- Bettelheim B., *The Children of the Dream*, Thames and Hudson, London, 1969.
- Biger G., "European influence on town planning and town building in Palestine, 1850-1920" *Urbanism Past and Present*, 9 (1984), pp. 30-35.
- _____, *An Empire in the Holy Land. Historical Geography of the British Administration in Palestine, 1917-1929*, St. Martin's Press, New York, 1994.

- Black L., "A judgement of Salomon that could not save Palestine", *The Guardian*, 7 July 1987.
- Bobbio N., *Saggi su Gramsci*, Feltrinelli, Milano, 1990.
- Bogen E., "Tuberculosis among Jews", *Medical Leaves*, III (1), 1940, pp. 124-129.
- Bolotin F. N. (ed.), *International Public Policy Sourcebook, Vol. 2, Education and the Environment*, Greenwood Press, New York, Westport CT, London, 1989.
- Boltanski L., *Les Cadres: la formation d'un groupe social*, Editions de Minuit, Paris, 1982.
- Bourdieu P., *Masculine Domination*, Polity Press, Cambridge, 2001.
- Bowden T., "The politics of the Arab rebellion in Palestine 1936-39", *Middle Eastern Studies* 11 (2), May 1975, pp. 147-174.
- _____, *The Breakdown of Public Security. The Case of Ireland 1916-1921 and Palestine 1936-1939*, Sage Publications, London, 1977.
- Braungart R. G., "Historical and generational patterns of youth movements: a global perspective", *Comparative Social Research*, 7 (3), 1984, pp. 3-62.
- Brenner L., "Zionist-Revisionism: The years of Fascism and Terror", *Journal of Palestine Studies*, 13 (1), Fall, 1983, pp. 66-92.
- Bridgman Perkins B., "Shaping Institution-based Specialism: early twentieth century economic organization of medicine", *Social History of Medicine*, 10 (3), December 1997, pp. 419-435.
- Budeiri M., *The Palestine Communist Party 1919-1948: Arab and Jews in the Struggle for Internationalism*, Ithaca Press, London, 1979.
- Bulmer M. (ed.) "Aspects of ethnic division in contemporary Israel. Special Issue", *Ethnic and Racial Studies*, 21 (3), May 1998.
- _____, "Conceptualizing fractured societies: the case of Israel", in Bulmer M. (ed.) "Aspects of ethnic division in contemporary Israel. Special Issue", *Ethnic and Racial Studies*, 21 (3), May 1998, pp. 383-407.
- Bynum W. F., "Medicina e Società", in M. D. Grmek (ed.), *Storia del Pensiero Medico Occidentale*, Vol. 3, Dall'Età Romantica alla Medicina Moderna, Editori Laterza, Roma-Bari, 1998, pp. 451-492.
- Caplan N., *Futile Diplomacy*, vol I, Frank Cass, London, 1983.
- _____, *Futile Diplomacy*, vol II, Frank Cass, London, 1986.

- Catusse M., *L'entrée in politique des entrepreneurs marocains: formation d'une categorie sociale et reforme de l'ordre politique dans le cadre de la liberalisation economique*, EUI Working Papers, RSC, n. 2001/25, San Domenico (Fi), 2001.
- Chabal P. (ed.), *Political Domination in Africa: Reflections on the Limits of Power*, Cambridge University Press, Cambridge, 1986.
- Cohen J. and Arato A., *Civil Society and Political Theory*, MIT Press, Cambridge, MA, 1992.
- Cohen M. N., *Health and the Rise of Civilization*, Yale University Press, New Haven and London, 1989.
- Cohen Michael J., "The British White Paper on Palestine, May 1939", *The Historical Journal*, 19 (3), 1976, pp. 222-260.
- _____, *Churchill and the Jews*, Frank Cass, London, 1985.
- _____, "American influence on British policy in the Middle East during World War Two: First attempts at coordinating allied policy on Palestine", *American Historical Quarterly*, 67 (1-4), Sept. 1977-June 1988, pp. 50-70.
- _____, *Palestine, Retreat from the Mandate. The Making of British Policy, 1936-45*, Elek, London, 1978.
- _____, "The genesis of the Anglo-American Committee on Palestine, November 1945: A case study in the assertion of American Hegemony", *The Historical Journal*, 22 (1), 1979, pp. 185-207.
- _____, *Palestine to Israel from Mandate to Independence*, Frank Cass, London, 1988.
- _____, "British Strategy in the Middle East in the Wake of the Abyssinian Crisis, 1936-39", in Cohen M. J. and Kolinsky M., *Britain and the Middle East in the 1930s. Security Problems, 1935-39*, Macmillan in association with King's College London, London, 1992, pp. 21-40.
- _____. and Kolinsky M. (eds.), *Britain and the Middle East in 1930s. Security Problems, 1935-39*, MacMillan in association King's College London, London, 1992.
- _____, *Demise of the British Empire in the Middle East Britain's Responses to Nationalist Movements, 1943-55*, Frank Cass, London, 1998.
- Cohen Mitchell J., *Zion and State. Nation, Class and the Shaping of Modern Israel*, Basil Blackwell, Oxford, 1987.
- Comaroff J. L. and Comaroff J. (eds.), "Introduction" in *Civil Society and the Political Imagination in Africa: Critical Perspectives*, University of Chicago Press, Chicago, 1999, pp. 1-43.

- Corsi P. and Weindling P. (eds.), *Information Sources in the History of Science and Medicine*, Butterworth, London, 1983.
- Cordova A. and Herzog H., "The cultural endeavour of the Labor Movement in Palestine: A study of the relationship between Intelligentsia and Intellectuals", *YIVO Annual of Social Science*, 17, 1978, pp. 238-259.
- Cosmacini G., *Medicina e sanità in Italia nel Ventesimo Secolo. Dalla "Spagnola" alla II Guerra Mondiale*, Editori Laterza, Roma-Bari, 1989.
- Cromer R., *The Hospital of St. John in Jerusalem*, [n.p.h.], Cambridge, 1961.
- D'Antonio E., "Aspetti della rigenerazione ebraica e del sionismo in Cesare Lombroso", *Società e Storia*, 24 (92), aprile-giugno 2001, pp. 281-309.
- Davis P. R. and McGregor J. A., "Civil society, international donors and poverty in Bangladesh", *Commonwealth and Comparative Politics*, 38 (1), 2000, pp. 47-64.
- Davis U., *Citizenship and the State. A Comparative Study of Citizenship Laws in Israel, Jordan, Palestine, Syria and Lebanon*, Ithaca, Reading, 1997.
- Della Seta S., "La situazione socio-territoriale in Palestina ed il primo insediamento ebraico precedente al mandato britannico", *Storia Contemporanea*, 15 (2), aprile 1984, pp. 181-211.
- _____, "Primi sviluppi nell'assetto socio-territoriale della Palestina in seguito all'instituzione del mandato britannico e all'incremento della colonizzazione ebraica", *Storia Contemporanea*, 16 (4), agosto 1985, pp. 687-714.
- Derrida J., "Deconstructing the Other", an interview with Jacques Derrida, in Keney R. (ed.), *Dialogues with Contemporary Continental Thinkers*, University of Manchester Press, 1984.
- Dieckhoff A., "Les trajectoires territoriales du Sionisme", *Vingtième Siècle*, 7 (21), 1989, pp. 29-44.
- Divine D. R., "Zionism and the transformation of Jewish Society *Modern Judaism*, 20 (3), October 2000, pp. 257-276.
- Donnison J., *Midwives and Medical Men. A History of the Struggle for the Control of Childbirth*, Heineman Educational Books, London, 1977.
- Doron A. and Kremer R. M., *The Welfare State in Israel*, Westview Press, Boulder, San Francisco, Oxford, 1991.
- Doumani B., *Rediscovering Palestine. Merchants and Peasants in Jabal Nablus, 1700-1900*, University of California Press, Berkeley London, 1995.

- _____, "Rediscovering Ottoman Palestine: writing Palestinian into history", in Pappé I. (ed.), *The Israel/Palestine Question*, Routledge, London and New York, 1999, pp. 11-40.
- Edelheit A. J., *The Yishuv in the Shadow of the Holocaust Zionist. Politics and rescue aliya, 1933-1939*, Westview Press, Boulder Oxford, 1996.
- Efron J. M., *Medicine and the German Jews. A History*, Yale University Press, New Haven and London, 2001.
- Ehrenreich B. and English D., *Complaints and Disorders: The Sexual Politics of Sickness*, Writers and Readers Publishing Cooperative, London, 1976.
- Eisenstadt S. N., *The Absorption of Immigrants. A Comparative Study based mainly in the Jewish Community in Palestine and the State of Israel*, Routledge, Kegan & Paul Ltd., London, 1954.
- Elboim-Dror R., "Israel Education Policy", in Bolotin F. N. (ed.), *International Public Policy Sourcebook, Vol. 2, Education and the Environment*, Greenwood Press, New York, Westport CT, London, 1989, pp. 79-96.
- _____, "British Educational policies in Palestine", *Middle Eastern Studies*, 36 (2), April 2000, pp. 28-47.
- Elon A., *Jerusalem City of Mirrors*, Little, Brown and Company, Boston Toronto London, 1989.
- Esping-Andersen G., *Social Foundations of Postindustrial Economies*, Oxford University Press, Oxford, 1999.
- Ficarra B. J., "Disease to death during the Crusades", in Wasserman M. and Kottek S., *Health and Disease in the Holy Land. Studies in the History and the sociology of Medicine from Ancient Times to the Present*, Lewiston NY, 1996, pp. 135-156.
- Flapan S., *Zionism and the Palestinians*, Croom Helm, London, 1979.
- Fleischmann E., "The emergence of the Palestinian Women's Movement 1929-1939", *Journal of Palestine Studies*, 29 (3), Spring 2000, pp. 16-32.
- Foot H., *A Start in Freedom*, Harper & Row, New York, [1964].
- _____, *The Future of Jerusalem : A Review of Proposals for the Future of the City*, Research Directorate, National Defense University, Washington, DC, 1980.
- Foucault M., *La nascita della clinica*, Einaudi, Torino, 1969. [*Naissance de la clinique. Une archéologie du regard médical*, Presses Universitaire de France, Paris, 1963.]

- _____, *Sorvegliare e punire. Nascita della prigione*, Einaudi, Torino 1976.
[*Surveiller et punir. Naissance de la prison*, Editions Gallimard, Paris, 1975].
- Frankel J., *Prophecy and Politics. Socialism, Nationalism and Russian Jews, 1862-1917*, Cambridge University Press, Cambridge, 1981.
- Frascani P., *Ospedale e società in età liberale*, Il Mulino, Bologna, 1986.
- Fraser T. G., *Partition in Ireland, India and Palestine. Theory and Practice*, Macmillan, London, 1984.
- _____, "A crisis of leadership: Weizmann and the Zionist reaction to the Peel Commission's Proposals, 1937-8", *Journal of Contemporary History*, 23 (4), October, 1988, pp. 657-680.
- Friedman I., *The Question of Palestine, 1914-1918*, Schoken Books, New York, 1973.
- Freund A., "The problem of Tuberculosis in Palestine", *Medical Leaves*, (1939), pp. 38-43.
- Friesal E., "British Officials and the situation in Palestine, 1923", *Middle Eastern Studies*, 27 (2), 1987, pp.194-210.
- _____, "Through peculiar lens: Zionism and Palestine in British diaries, 1927-31", *Middle Eastern Studies*, 29 (3), July 1993, pp. 419-444.
- Galnoor I., *The Partition of Palestine Decision Crossroads in the Zionist Movement*, University of New York Press, Albany, N.Y. State, 1995.
- Gavish D., "An account of an unrealized aerial cadastral survey in Palestine under the British Mandate", *The Geographical Journal*, 153 (1), March 1987, pp. 93-98.
- _____, and Kark R., "The cadastral mapping of Palestine, 1858-1928", *The Geographical Journal*, 159 (1), March 1993, pp. 70-80.
- Gay R., "Danke Schön, Herr Doktor. German Jews and Palestine", *The American Scholar*, Autumn 1989, pp. 567-577.
- Gelber Y., *Jewish-Transjordanian Relations 1921-1948*, Frank Cass, London Portland OR, 1997.
- Gellner E., "Civil society in historical context", *International Social Science Journal*, 129, 1991, pp. 495-510.
- _____, *Conditions of Liberty. Civil Society and Its Rivals*, Hamish Hamilton, London, 1994.

- _____, "The importance of being modular", in Hall J. A. (ed.), *Civil society, Theory, History, Comparison*, Polity Press, Cambridge, 1995, pp. 32-55.
- Gidal N. T., *Henrietta Szold. A Documentation in Photos and Text*, Gefen Publishing House, Jerusalem, 1997.
- Giladi D., *Ha-Yishuv be-tqufat ha-alyia ha-revi'it (1924-1929): behinah kalkalit u-politit, (The Yishuv at the Time of the Fourth Alyia (1924-1929): Economic and Political Analysis*, Hebrew), 'Am Oved, Tel Aviv, 1973.
- Gilbert M., *Jerusalem in the Twentieth Century*, Chatto & Windus, London, 1996.
- _____, *Israel. A History*, Doubleday, London, 1998.
- Gilman S. L., *Difference and Pathology: Steretypes of Sexuality, Race and Madness*, Cornell University Press, Ithaca London, 1985.
- _____, *The Jews' Body*, Routledge, London and New York, 1991.
- _____, *Franz Kafka. The Jewish Patient*, Routledge, London and New York, 1995.
- Gilmour D., "The unregarded prophet: Lord Curzon and the Palestine question", *Journal of Palestine Studies*, 25 (3), Spring 1996, pp. 60-68.
- Ginsborg P., *A History of Contemporary Italy. Society and Politics 1943-1988*, Penguin Books, London, New York, 1990.
- _____, "Family, civil society and the state in contemporary European History: Some methodological considerations", *Contemporary European History*, 4 (3), November 1995, pp. 249-273.
- Giordano P., *Il principio di capacità economica di assorbimento. I Britannici e l'immigrazione ebraica in Palestina (1925-1937)*, Unpublished Ph.D. thesis, Università di Firenze, Firenze, 1999.
- Glynn G., (ed.), *Tidings from Zion. Helen Bentwich's Letters from Jerusalem 1919-1931*, I. B. Tauris Publishers, London New York, 2000.
- Goldscheider C. and Zuckerman A. S., *The Transformation of the Jews*, The University of Chicago Press, Chicago and London, 1984.
- Gordon A. D., *Kitvei*, Tel Aviv, [n.p.h], 1930.
- Gorni Y., *Zionism and the Arabs 1882-1948: A Study of Ideology*, Clarendon University Press, Oxford, 1987.

- Greenstein R., *Genealogies of Conflict: Class, Identity and State in Palestine/Israel and South Africa*, Wesleyan University Press, University Press of New England, Hanover, N.H., 1995.
- Grmek M. D. (ed.), *Storia del pensiero medico occidentale*, Vol. 3, Dall'Età Romantica alla Medicina Moderna, Editori Laterza, Roma-Bari, 1998.
- Haim Y., *Abandonment of Illusions. Zionist political Attitudes toward Palestinian Arab Nationalism, 1936-39*, Boulder, Colorado, 1983.
- Halevi N., "The political economy of absorptive capacity: Growth and cycles in Jewish Palestine under the British Mandate", *Middle Eastern Studies*, 19 (4), October 1983, pp. 456-469.
- Hall J. A. (ed.), *Civil society, Theory, History, Comparison*, Polity Press, Cambridge, 1995.
- Halpern B. and Reinhartz J., *Zionism and the Creation of New Society*, Oxford University Press, New York Oxford 1998.
- Hammami R., Hilal J. and Tamari S., *Civil Society and Governance in Palestine*, EUI Working Papers, RSC, n. 2001/36, Badia Fiesolana, San Domenico (Fi).
- Hancock W. R., *Survey of British Commonwealth Affairs*, vol. I, Oxford University Press, London, New York, Toronto, 1937.
- _____, *Survey of British Commonwealth Affairs*, vol. II, Oxford University Press, London, New York, Toronto, 1942.
- Hardie F. and Herrman I., *Britain and Zion, The Fateful Entanglement*, Blackstaff, Belfast, 1980.
- Held I. W., "Medical Germany in liberal days", *Medical Leaves*, 1937, pp. 70-75.
- Herbert G., "Crossroads: Imperial priorities and regional perspectives in the planning of Haifa 1918-1939", *Planning Perspectives*, 4, September 1989, pp. 313-331.
- Hodgkin E.C. (ed.), *Thomas Hodgkin. Letters from Palestine 1932-36*, Quartet, London, 1986.
- Hoffmann B. (ed.), *The Failure of British Military Strategy within Palestine 1939-1947*, Bar-Ilan University Press, [Ramat-Gan], 1983.
- Horne E., *Job well done. Being a history of the Palestine Police Force 1920-1948*, Palestine Police Old Comrades Benevolent Association, Leigh-on-Sea, 1982.

- Horowitz D. and Lissak M., *Origins of the Israeli Polity. Palestine under the Mandate*, University of Chicago Press, Chicago London, 1978.
- Jabotinsky V., "An Iron Wall: We and the Arabs", *Ravjet*, 4th November 1923.
- Janowsky J. And Gershoni I.(eds.), *Rethinking Nationalism in the Arab Middle East*, Columbia University Press, New York, 1997.
- Jenkins R., "Mistaking 'governance' for 'politics': foreign aid, democracy, and the construction of civil society", in Kaviraj S. and Khilnani S. (eds.), *Civil Society: History and Possibilities*, Cambridge University Press, Cambridge, 2001, pp. 250-268.
- Jones P., *Britain and Palestine, 1914-1948. Archival Sources for the History of the British Mandate*, Oxford University Press for the British Academy, Oxford, 1979.
- Jones S., Kushner T. and Pierce S. (eds.), *Cultures of Ambivalence and Contempt. Studies on Jewish-Non-Jewish Relations. Essays in honour of the centenary of the birth of James Parker*, Valentine Mitchell, London-Portland OR, 1998.
- Kahya E. and Erdermir A. D., *Medicine in the Ottoman Empire*, Nobel Medical Publications, Istanbul, 1997.
- Kalmar I. and Penslar D. J. (eds.), *Jews and Orientalism*, University of New England Press, Hanover NH, 2004.
- Kandyoti D., "Identity and its discounts: women and the nation", *Millennium*, 20 (3), Winter 1991, pp. 429-443.
- Kark R., *Jaffa. A City in Evolution 1799-1917*, Yad Itzhak Ben-Zvi Press, Jerusalem, 1990.
- _____, "The Impact of Early Missionary Enterprise on Identity Formation in Palestine, 1820-1914", draft circulated at the workshop on *Identity Formation and the Missionary Enterprise in the Middle East*, 17-18 November 1999, Watson Institute, Brown University.
- Karsh E., *Fabricating Israeli History. The "New Historians"*, Frank Cass, London, 1997.
- _____, (ed.), *Israel: the First Hundred Years. Vol. I, Israel's Transition from Community to State*, Frank-Cass, London Portland OR, 2000.
- Kass A. M., "Sir Moses Montefiore and Medical Philanthropy in the Holy Land", in Wasserman M. and Kottek S., *Health and Disease in the Holy Land. Studies in the History and the Sociology of Medicine from Ancient Times to the Present*, Lewiston NY, 1996, pp. 207-231.

- Katz J., *Out of the Ghetto: the Social Background of Jewish Emancipation 1770-1870*, Schocken Books, New York, 1978.
- Katz Y., "Ideology and urban development: Zionism and the origins of Tel Aviv, 1906-1914, *Journal of Historical Geography*, 12, 1986, pp. 402-424.
- _____, *Partner to Partition. The Jewish Agency's Partition Plan in the Mandate Era*, Frank Cass, London Portland OR, 1998.
- _____, "The marginal role of Jerusalem in Zionist settlement activity prior to the founding of the State of Israel", *Middle Eastern Studies*, 34 (3), July 1998, pp. 121-145.
- Kaviraj S. and Khilnani S. (eds.), *Civil Society: History and Possibilities*, Cambridge University Press, Cambridge, 2001.
- Keane J., *Civil society, Old Images, New Visions*, Polity Press, Cambridge, 1998.
- Kedourie E., "Sir Herbert Samuel and the Government of Palestine", *Middle Eastern Studies*, 5 (1), January 1969, pp. 44-68.
- _____, *The Chatham House and Other Middle-Eastern Studies*, University Press of New England, London, 1970.
- _____, "'I would use the term despotism...' An interview", in *Middle Eastern Lectures, Number One 1995*, The Moshe Dayan Center for Middle Eastern and African Studies, Tel Aviv University, 1995, pp. 73-84.
- _____, and Haim S. G. (eds.), *Zionism and Arabism in Palestine and Israel*, Frank Cass, London, 1982.
- Keith-Roach E., *Pasha of Jerusalem. Memoirs of a District Commissioner under the British Mandate*, Edited by Paul Eedle, Radcliffe Press, London 1994.
- Khalidi R., *British Policy Towards Syria and Palestine 1906-1914*, Ithaca Press, London, 1980.
- Kiev A. (ed.) *Magic, Faith and Healing. Studies in Primitive Psychiatry Today*, The Free Press of Glencoe, Collier-Macmillan Ltd., London, 1964.
- Kimmerling B., *Zionism and Territory. The Socio-territorial Dimensions of Zionist Politics*, Institute of International Studies, University of California, Berkeley, 1983.
- _____, and Migdal J. S., *The Palestinians, the Making of a People*, Harvard University Press, Cambridge MA, 1993.

- _____, "The formation of Palestinian Collective Identities: The Ottoman and Mandatory periods", *Middle Eastern Studies*, 36 (2), April 2000, pp. 48-81.
- _____, *The Invention and Decline of Israeliness, State, Society and the Military*, University of California Press, Berkeley, Los Angeles, London, 2001.
- King E. J., *The Knights of St John in the British Empire, being the Official History of the British Order of the Hospital of St. John in Jerusalem*, F. E. Robinson & Co., London, 1902.
- Kirkbride A. S., *A Crackle of Thorns, Experiences in the Middle East*, J. Murray, London, 1956.
- Klieman A. S., "The divisiveness of Palestine: Foreign Office versus Colonial Office on the issue of partition, 1937", *The Historical Journal*, 22 (2), month, 1979, pp. 423-441.
- _____, (ed.), *The Rise of Israel, The Royal Commission Report, 1937*, Garland Publishing, New York and London, 1987.
- Kolinsky M., "Premeditation in the 1929 disturbances?", *Middle Eastern Studies*, 26 (1), January 1990, pp. 18-34.
- _____, "The Collapse and Restoration of Public Security", in Cohen M. J. and Kolinsky M., *Britain and the Middle East in the 1930s. Security Problems, 1935-1939*, Macmillan in association with King's College London, Basingstoke, 1992, pp. 147-168.
- _____, *Law, Order, and Riots in Mandatory Palestine, 1928-35*, Macmillan in association with King's College London, Basingstoke, 1993.
- Korczak J., *La Palestine. Notes de voyage et correspondance 1927-1939*, Les Éditions Noir Sur Blanc, Montricher, 2002.
- Kupferschmidt U. M., *The Supreme Muslim Council. Islam under the British Mandate for Palestine*, E.J. Brill, Leiden New York, 1987.
- Lapidus I. M., *A History of Islamic Societies*, Cambridge University Press, Cambridge, 1988.
- Laqueur W., *A History of Zionism*, Schocken Books, New York, 1972.
- Latouche S., *Il pianeta dei naufraghi. Saggio sul doposviluppo*, Bollati Boringhieri, Torino, 1993.
- Lesch A. M., *Arab Politics in Palestine, 1917-1939. The Frustration of a Nationalist Movement.*, Cornell University Press, Ithaca London 1979.

- Levav Y. and Bilu Y., "A Transcultural Review of Israeli Psychiatry", in Antonovsky A. (ed.), *The Sociology of Health and Health Care in Israel*, Transaction Publishers, New Brunswick and London, 1990, pp. 305-334.
- Levin M., *It takes a dream-- the story of Hadassah*, Gefen Pub. House Jerusalem, 1997.
- Levine M., "Conquest through town planning: the case of Tel Aviv, 1921-1948", *Journal of Palestine Studies*, 28 (4), Summer 1998, pp. 36-52.
- Lewis D., *Civil society in non-Western contexts: reflections on the usefulness of a concept*, Civil Society Working Paper n. 13, London School of Economics, October 2001.
- Linz J. and Stepan A., *Problems of Democratic Transition and Consolidation: Southern Europe and Post-Communist Europe*, John Hopkins University Press, Baltimore, 1996.
- Lloyd C., *Multi-causal Conflict in Algeria: National Identity, Inequality and Political Islam*, Queen Elizabeth House Working Paper Series - QEHWPS104, 2003.
- Lockman Z., "Railway workers and relational history: Arabs and Jews in British-Ruled Palestine", *Comparative Studies in Society and History*, 35, 1993, pp. 601-627.
- _____, *Comrades and Enemies. Arab and Jewish Workers in Palestine, 1906-1948*, University of California Press, Berkeley London, 1996.
- _____, "Arab Workers and Arab Nationalism in Palestine: A View From Below", in Janowsky J. and Gershoni I.(eds.), *Rethinking Nationalism in the Arab Middle East*, Columbia University Press, New York, 1997, pp. 249-272.
- _____, "Railway workers and relational history. Arabs and Jews in British-ruled Palestine", in Pappé I. (ed.), *The Israel/Palestine Question*, Routledge, London and New York, 1999, pp. 99-128.
- Londres A., *Ho incontrato l'Ebreo Errante. 1929 da Londra a Gerusalemme*, ECIG, Genova, 1997. [Le Juif Errant est arrivé, Paris, 1930].
- Lowenthal M., *Henrietta Szold. Her life and Letters*, The Vicking Press, New York, 1942.
- MacLeod R. and Lewis M., *Disease, Medicine and Empire. Perspectives on Western Medicine and the Experience of European Expansion*, Routledge, London and New York, 1988.
- Mamdani M., *Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism*, Princeton University Press, Princeton, 1996.

References

- McCarthy J., *The Population of Palestine. Population History and Statistics of the late Ottoman Period and the Mandate*, Columbia University Press, New York 1990.
- McCune M., "Social workers in the Muskelejudentum: "Hadassah Ladies," "Manly Men" and the significance of Gender in the American Zionist Movement, 1912-1928", *American Jewish History*, June 1988, pp. 135-156.
- McKeown T., *The Role of Medicine: Dream, Mirage or Nemesis?*, Oxford University Press, Oxford, 1979.
- McTague J., "Zionist-British Negotiations over the Draft Mandate for Palestine, 1920", *Jewish Social Studies*, 42-43 (4), Summer-Fall 1980, pp. 281-292.
- _____, *British Policy in Palestine, 1917-1922*, University Press of America, Lanham, MD, 1983.
- Mardam Bey S., *La Syrie et la France. Bilan d'une équivoque (1939-1945)*, Éditions L'Harmattan, Paris, 1994.
- Masalha N., *Expulsion of the Palestinians. The Concept of "Transfer" in Zionist Political Thought 1882-1948*, Institute for Palestine Studies, Washington D.C., 1992.
- Mastermann E. W. G., *Hygiene and Disease in Palestine in Modern and in Biblical Times*, London [192?].
- Mattar P., *The Mufti of Jerusalem: Al-Haj Amin Al-Husayni and the Palestinian National Movement*, Columbia University Press, New York, 1988.
- Melman B., *Women's Orient: English Women and the Middle East, 1718-1919, Sexuality, Religion and Work*, Macmillan, London 1995.
- Metzer J., *The Divided Economy of Mandatory Palestine*, Cambridge University Press, Cambridge, 1998.
- Michaelis M., "Italy's Mediterranean Strategy, 1935-39", in Cohen M. J. and Kolinsky M., *Britain and the Middle East in the 1930s. Security Problems, 1935-39*, Macmillan in association with King's College London, London, 1992, pp. 41-60.
- Migdal J. S., *Palestinian Society and Politics*, Princeton University Press, Princeton NJ, 1980.
- _____, *State in Society: Studying How States and Societies Transform and Constitute One Another*, Cambridge University Press, Cambridge, 2001.

- Miller D., *A History of Hadassah 1912-1935*, Unpublished Ph.D. thesis, New York University, New York, 1968.
- Miller Y. N., *Government and Society in Rural Palestine, 1920-1948*, University of Texas Press, Austin, 1985.
- Morris B., *The Birth of the Palestinian Refugee Problem, 1947-1949*, Cambridge University Press, Cambridge, 1987.
- _____, "Refabricating 1948", *Journal of Palestine Studies*, 27 (2), Winter 1998, pp. 81-95.
- _____, *1948 and After. Israel and the Palestinians*, Clarendon Press, Oxford, 1994.
- _____, *Righteous Victims. A History of the Zionist-Arab Conflict, 1881-1999*, Alfred A. Knopf, New York, 1999.
- Mosse G. L., *Ebrei in Germania tra assimilazione ed antisemitismo*, Giuntina, Firenze, 1991.
- Mossek M., *Palestine Immigration Policy under Sir Herbert Samuel, British, Zionist and Arab Attitudes*, Frank Cass, London, 1978.
- Mustard, *Mandate Eretz Israel in the Eyes of British Humour on the Occasion of the Fiftieth Anniversary of the End of the British Mandate in Palestine*, two humorous books by Mustard and Cress illustrated by Blass and A. W. R. Mackenzie, Shimon Rubinstein, Jerusalem, 1998.
- Near H., *The Kibbutz Movement: a History. Origins and growth, 1909-1939*, Vol. I, Oxford University Press ; Washington DC, 1992.
- _____, *The Kibbutz Movement: a History. Crisis and achievement, 1939-1995*, Vol. II, Oxford University Press, 1997.
- Nini Y., *The Jews of the Yemen, 1800-1914*, Harwood Academic Publishers, Chur, 1991.
- Nofal M, Turki F. Shafi H. A., Bushnaq I., Sayigh Y., Al-Hout S., Jayyusi S. A., Budeiri M., "Reflections on al-Nakba", *Journal of Palestine Studies*, 28 (1), Autumn 1998, pp. 5-35.
- Norton A. R. (ed.), *Civil Society in the Middle East*, E. J. Brill, Leiden New York, Köln, 1995.
- Nussbaum M., *Women and Human Development. The capabilities Approach*, Cambridge University Press, Cambridge, 2000.
- Ofer D., *Escaping the Holocaust: Illegal Immigration to the Land of Israel (1939-1945)*, Oxford University Press, New York, 1990.

- Okkenhaug I. M., "The Quality of Heroic Living, of High Endavour and Adventure". *Anglican Mission, Women and Education in Palestine, 1888-1948*, Unpublished Ph.D. thesis, University of Bergen, Bergen, 1999.
- Omissi D., "The Mediterranean and the Middle East in British Global Strategy, 1935-39", in Cohen M. J. and Kolinsky M. (eds.), *Britain and the Middle East in 1930s. Security Problems, 1935-39*, MacMillan in association King's College, London, 1992, pp. 3-20.
- Oppenheimer F., *Merhavyah*, no publishing house indicated, New York, 1914.
- Ortner S. B., "Is female to male as Nature is to Culture?" in Rosaldo M. A., and Lamphere L. (eds.), *Women Culture and Society*, Stanford University Press, Stanford CA, 1974, pp. 67-87.
- Ovendale R., "The Palestine policy of the British Labour Government 1945-46", *International Affairs*, 55 (3), July 1979, pp. 409-431.
- _____, "The Palestine policy of the British Labour Government 1947: the decision to withdraw", *International Affairs*, 56 (1), February 1980, pp. 73-93.
- Owen R. (ed.), *Studies in the Economic and Social History of Palestine in the Nineteenth and Twentieth Centuries*, Macmillan, London, 1982.
- Pail M., "A Breakthrough in Zionist military conceptions: 1936-39", in M. J. Cohen and M. Kolinsky, *Britain and the Middle East in the 1930s. Security Problems, 1935-1939*, Macmillan in association with King's College London, 1992, pp. 190-205.
- Pappè I., "Post-Zionist Critique on Israel and the Palestinians. Part I: The Academic Debate", *Journal of Palestine Studies*, 26 (2), winter, 1997, pp. 29-41.
- _____, "Post-Zionist Critique on Israel and the Palestinians. Part II: The Media", *Journal of Palestine Studies*, 26 (3), spring, 1997, pp. 37-43.
- _____, "Post-Zionist Critique on Israel and the Palestinians. Part III: Popular Culture", *Journal of Palestine Studies*, 26 (4), summer, 1997, pp. 60-69.
- _____, (ed.), *The Israel/Palestine Question*, Routledge, London and New York, 1999.
- Parfitt T., *The Road to Redemption. The Jews of Yemen 1900-1950*, E. J. Brill, Leiden, New York, Köln, 1996.
- Pavone C., *Una guerra civile. Saggio storico sulla moralità nella Resistenza*, Bollati Boringhieri, Torino, 1991.

- Penslar D. J., *Zionism and Technocracy. The Engineering of Jewish Settlement in Palestine, 1870-1918*, Indiana University Press, Bloomington, 1991.
- _____, *Shylock's Children, Economics and Jewish Identity in Modern Europe*, Berkley, California University Press, 2001.
- Pick D., *Faces of Degeneration: A European Disorder, 1848-1918*, Cambridge University Press, Cambridge, 1989.
- Pieraccini P., *Gerusalemme, luoghi santi e comunità religiose nella politica internazionale*, EDB, Bologna, 1996.
- Piselli F. (ed.), *Reti: L'analisi di network nelle scienze sociali*, Donzelli, Roma, 1995.
- Porath Y., "Palestinian Historiography", *Jerusalem Quarterly*, 5, Fall, 1977, pp. 95-104.
- _____, *The Emergence of the Palestinian Arab National movement: from Riots to Rebellion, 1929-1939*, Frank Cass, London, 1977.
- _____, *In search of Arab Unity, 1930-1945*, Frank Cass, London, 1986.
- _____, "Tom Segev's New Mandate", *Azure*, 9, Spring 5760/2000, pp. 23-36.
- Porter D., *Health, Civilization and the State. A History of Public Health from Ancient to Modern Times*, Routledge, London and New York, 1999.
- Porter R. and Wear A. (eds.), *Problems and Methods in the History of Medicine*, Croom Helm, London, New York, Sydney, 1987.
- Putnam R. D., *Making Democracy Work*, Princeton University Press, Princeton, 1993.
- Quartararo R., "L'altra faccia della crisi mediterranea (1935-36)", *Storia Contemporanea*, 13 (4-5), Ottobre 1982, pp. 759-820.
- Quétel C., *Le mal de Naples*, Editions Robert Laffont, Paris, 1986.
- Quickfall D., *Shadows over Scopus. Reflections of an ex Palestine Policeman*, Cromwell, Manchester, 1999.
- Raider M. A., *The Emergence of American Zionism*, New York University Press, New York and London, 1998.
- Ram U., "Postnationalist pasts. The case of Israel", *Social Science History*, 22 (4), Winter 1998, pp. 513-545.

- _____, "The Colonization Perspective in Israeli Sociology", in Pappé I., *The Israel/Palestine Question*, Routledge, London and New York, 1999, pp. 55-80.
- Raz G., *Soskin: A Retrospective. Photographs. 1905-1945*, Tel Aviv Museum of Art, Tel Aviv, 2003.
- Reinharz Y., "Old and New Yishuv. The Jewish community in Palestine at the turn of the twentieth century", *Jewish Studies Quarterly*, 1, 1993, pp. 54-71.
- Reiss N., "British public health policy in Palestine, 1918-1947", in M. Wasserman and S. Kottek (eds.), *Health and Disease in the Holy Land. Studies in the History and the Sociology of Medicine from Ancient Times to the Present*, Edwin Mellen, Lewiston NY, 1996, pp. 301-328.
- Reiter Y., *Islamic Endowments in Jerusalem under British Mandate*, Frank Cass, London, 1996.
- Rosaldo M. A., and Lamphere L. (eds.), *Women Culture and Society*, Stanford University Press, Stanford CA, 1974.
- Rose N., "The debate on partition 1937-38: the Anglo-Zionist aspect. I-The proposal", *Middle Eastern Studies*, 6 (3), October, 1970, pp. 297-318.
- _____, "The debate on partition 1937-38: the Anglo-Zionist aspect. II-The withdrawal", *Middle Eastern Studies* 7 (1), January, 1971, pp. 3-24.
- _____, *The Gentile Zionists*, Frank Cass, London, 1973.
- Rowley C. K., "On the nature of civil society", in Rowley C. K. (ed.), *Classical Liberalism and Civil Society*, Edward Elgar, Cheltenham UK, Northampton MA, 1997, pp. 1-24.
- Sacher M. M., *The Postal Markings of Mandate Palestine 1917-1948*, Royal Philatelic Society, London, 1995.
- Sahlins P., *Boundaries: The Making of France and Spain in the Pyrenees*, University of California Press, Berkeley, 1989.
- Said E. W., *Orientalism, Western conceptions of the Orient*, Penguin Books, London, 1991.
- _____, *The Question of Palestine*, Vintage, London, 1992.
- _____, *Culture and Imperialism*, Vintage, New York, 1994.
- Samuel E., *Handbook of the Jewish Communal Villages in Palestine*, Zionist Organization Youth Dept., Jerusalem, 1945.

- _____, *British Traditions in the Administration of Israel*, Mitchell, London, 1957.
- _____, *Britain's Legacy to Israel*, Leeds University Press, Leeds, 1962.
- _____, *A Lifetime in Jerusalem: The Memoirs of the Second Viscount Samuel*, Vallentine, Mitchell, London, 1970.
- Schlör J., *Tel Aviv. From Dream to City*, Reaktion Books, London, 1999.
- Schwäke N., "Hospitals and European colonial policy in the 19th and early 20th centuries", in Wasserman M. and Kottek S., *Health and Disease in the Holy Land. Studies in the History and the sociology of Medicine from Ancient Times to the Present*, Lewiston NY, 1996, pp. 231-262.
- Segev T., *One Palestine, Complete*, Henry Holt and Company, New York, 2000.
- Seligman, A. B., *The Idea of Civil Society*, Princeton University Press, Princeton, 1992.
- Shafir G., *Land, Labor and the Origins of the Israeli-Palestinian Conflict, 1882-1914*, University of California Press, Berkley Los Angeles London, 1996.
- _____, "Israeli decolonization and critical sociology", *Journal of Palestine Studies*, 25 (3), Spring 1996, pp. 23-35.
- _____, "Zionism and Colonialism. A comparative approach", in Pappé I. (ed.), *The Israel/Palestine Question*, Routledge, New York and London, 1999, pp. 81-96.
- _____ and Peled Y., *Being Israelis. The Dynamics of Multiple Citizenship*, Cambridge University Press, Cambridge, 2002.
- Shambrook P. A., *French Imperialism in Syria, 1927-1936*, Cornell University Press, Ithaca, 1998.
- Shamir R., *The Colonies of Law. Colonialism, Zionism, and Law in Early Mandate Palestine*, Cambridge University Press, Cambridge, 2000.
- Shanks A., *Civil Society, Civil Religion*, Blackwell, Oxford UK and Cambridge MA, 1995.
- Shavit Y., *Jabotinsky and the Revisionist Movement 1925-1948*, Frank Cass, London, 1988.
- Sheffer G., "The images of Arabs and Jews as a factor in British policy towards Palestine", *Studies in Zionism*, (1), Spring 1980, pp. 105-128.

- Shepherd N., *Ploughing Sand. British rule in Palestine, 1917-1948*, John Murray, London, 1999.
- Sherman A. J., *Mandate Days. British Lives in Palestine. 1918-1948*, Thames and Hudson, New York, 1998.
- Shlaim A., *Collusion Across the Jordan: King Abdullah, the Zionist Movement and the Partition of Palestine*, Columbia University Press, New York, 1998.
- _____, "Britain and the birth of Israel", *Contemporary Review*, 253 (?), month 1988, pp. 7-13.
- _____, "The debate about 1948", *International Journal of Middle East Studies*, 27 (3), August 1995, pp. 287-304.
- _____, *The Iron Wall and the Arab World*, Penguin Books, London, 2000.
- Shohat E., "Sephardim in Israel: Zionism from the Standpoint of its Jewish victims", *Social Text*, 19/20, Fall 1988, pp. 1-35.
- _____, "The invention of the Mizrahim", *Journal of Palestine Studies*, 29 (1), Autumn 1999, pp. 5-20.
- Shuval J. T., *Entering Medicine. The Dynamics of Transition. A Seven Year study of Medical Education*, Pergamon Press, Oxford, New York, 1980.
- Shvarts S., *Kupat Holim Ha-Clalit. Yizuva ve itpatchuta kegorem hamerchazei be sherutei. (Kupat Holim Ha-Clalit, the General Sick Fund. Its development as a major factor in the health services in Eretz Israel, 1911-1937, Hebrew)*, Ph.D. Thesis, Ben Gurion University of the Negev, Beersheba, 1993.
- _____, "Kupat Holim and Jewish Health Services During the Mandate", in: Waserman M. and Kottak S. (eds.), *Health and Disease in the Holy Land. Studies in the History and the Sociology of Medicine from Ancient Times to the Present*, Edwin Mellen, Lewiston NY, 1996, pp. 329-360.
- _____, "Health reform in Israel: some aspects of seventy years of struggle (1925-1995)", *Social History of Medicine*, 11 (1), April 1998, pp. 73-88.
- _____, "B'nai B'rith-Sha'Ar Zion Hospital in Jaffa (1891-1921): the first Jewish community hospital in Palestine", *Judaism: A Quarterly Journal of Jewish Life and Thought*, 47 (3), Summer 1998, pp. 358-371.
- _____, de Leeuw L. A., Granit S., "The salaried model in Israel: from Socialist principles to motorcycle maintenance- A historical perspective", *American Journal of Public Health*, 89 (2), February 1999, pp. 248-259.

- _____, *The Workers' Health Fund in Eretz Israel. Kupat Holim, 1911-1937*, The University of Rochester Press, Rochester NY, 2002. [1st ed. Ben Gurion University of the Negev Press, Tel Aviv, 1997, Hebrew].
- Silberstein L. J. (ed.), *New Perspectives on Israeli History. The Early Years of the State*, New York University Press, New York and London, 1991.
- _____, "Others within and others without: rethinking Jewish identity and culture", in Silberstein L. J. And Cohn R. L. (eds.), *The Other in Jewish History. Constructions of Jewish Culture and Identity*, New York University Press, New York, 1994.
- _____, *The Post-Zionism Debates. Knowledge and Power in Israeli Culture*, Routledge, New York London, 1999.
- _____ and Cohn R. L. (eds.), *The Other in Jewish Thought and History. Constructions of Jewish culture and Identity*, New York University Press, New York and London, 1994.
- Simoni M., *Ideali comunitari ed il superamento della famiglia ebraica. Dallo shtetl al kibbutz (1900-1956)*, Unpublished Tesi di Laurea, Università di Firenze, 1993-94.
- _____, "The only little corner of the great British Empire in which no one ever played cricket'. Reciprocal relations in Palestine: Health and Education", in Targarona Borràs J. and Sáenz-Badillos A.(eds.), *Jewish Studies at the Turn of the Twentieth Century*, Proceedings of the 6th EAJS Congress, Toledo, July 1998, Vol. II, Brill, Leiden, Boston, Köln, 1999, pp. 375-383.
- _____, "A dangerous legacy: welfare in British Palestine, 1930-1939", *Jewish History*, 13 (2), Fall 1999, pp. 81-109.
- _____, "At the roots of division: a new perspective on Arabs and Jews", *Middle Eastern Studies*, 36 (3), July 2000, pp. 52-92.
- _____, "La Costruzione di Due Nazioni: Famiglia e Società Civile in Palestina. (1900-1948), *Passato e Presente*, 20, (57), 2002, pp. 125-146.
- _____, "Orientalism and gender in Mandatory Palestine: the case of Mizrahi women", forthcoming in Kalmar I. and Penslar D. (eds.), *Jews and Orientalism*, University of New England Press, Hanover, NH, 2004.
- _____, "Igiene, Orientalismo e Welfare nella Palestina Britannica", forthcoming in *Meridione. Sud e Nord del Mondo*.
- _____, "Medicine and the history of the Arab-Israeli conflict. Theoretical and historiographical issues", forthcoming in *Israel Studies*.
- _____, "Sustainability and Peace. Civil society in Israel/Palestine after Oslo", forthcoming in *Quaderni del CESD*, Proceedings of the workshop

- "The role of civil society in the South Bank of the Mediterranean", VIU Venezia, 8-14 June 2003.
- Simson H. J., *British Rule and Rebellion*, Blackwood and Sons, Edinburgh and London, 1937.
- Sitton S., "Zionist Education in an encounter between the British colonial and the Hebrew cultures", *Journal of Educational Administration and History*, 29 (2), 1997, pp. 108-120.
- Smilansky M., Weintraub S., Hanegbi Y., *Child and Youth Welfare in Israel*, The Henrietta Szold Institute for Child and Youth Welfare, Jerusalem, 1960.
- Smith B. J., *The Roots of Separatism in Palestine. British Economic Policy, 1920-1929*, Tauris, London, 1993.
- [Spiegel M.], *The Hebrew University of Jerusalem, 1925-1950*, (no publishing house indicated), Jerusalem, 1950.
- Stasiulius D. and Yuval-Davis N. (eds.), *Unsettling Settler Societies*, Sage, London
- Stein J. B., "Josiah Wedgwood and the Seventh Dominion Scheme", *Studies in Zionism*, 11 (2), Autumn 1990, pp. 144-155.
- Stein K. W., "The Intifada and the 1936-39 uprising: A comparison", *Journal of Palestine Studies*, 19 (4), Summer 1990, pp. 64-85.
- _____, "A Historiographic Review of Literature on the Origins of the Arab-Israeli conflict", *The American Historical Review*, 96 (5), December 1991, pp. 1450-65.
- Sternhell Z., *The Founding Myths of Israel*, Princeton University Press, Princeton NJ, 1998.
- Storrs R., *The Memoirs of Sir Ronald Storrs*, G. P. Putnam's Sons, New York, 1937.
- _____, *Orientations*, Nicholson & Watson, London, 1943.
- Stoyanovsky J., *Mandate for Palestine*, Longmans & Co., London, 1928.
- Sufian S. M., *Healing the Land and the Nation. Malaria and the Zionist Project in Mandatory Palestine 1920-1947*, Unpublished Ph.D. thesis, New York University, New York, May 1999.
- _____, and S. Schvarts, "'Mission of Mercy' and the ship that came too late: American Jewish Medical relief to Palestine during World War I", in Targarona Borràs J. and Sáenz-Badillos A., (eds.), *Jewish Studies at the*

- Turn of the Twentieth Century*, Proceedings of the 6th EAJS Congress, Toledo, July 1998, Vol. II, Boston, Köln, 1999, pp. 380-389.
- Swedenburg T., *Memories of Revolt. The 1936-1939 Rebellion and the Palestinian National Past*, University of Minnesota Press, Minneapolis London, 1995.
- _____, "The role of the Palestinian Peasantry in the Great Revolt (1936-9)", in Pappé I., *The Israel/Palestine Question*, Routledge, New York and London, 1999, pp. 129-167.
- Talmon Y., *Family and Community in the Kibbutz*, Harvard University Press, Cambridge MA, 1972.
- Targarona Borrás J. and Sáenz-Badillos A., (eds.), *Jewish Studies at the Turn of the Twentieth Century*, Proceedings of the 6th EAJS Congress, Toledo, July 1998, Vol. II, Boston, Köln, 1999.
- Tergit G. [Hirschmann E.], *Sul diretto per Haifa. Impressioni di viaggio in Terra d'Israele 1933-1938*, ECIG, Genova, 1996, p. 20, edited by J. Brüning.
- Tibawi A. L., *Arab Education in Mandatory Palestine. Study of Three Decades of British Administration*, Luzac & Co, London, 1956.
- _____, *British Interests in Palestine 1800-1901. A Study of Religious and Educational Enterprise*, Oxford University Press, 1961.
- _____, *Anglo-Arab Relations and the Question of Palestine 1914-1921*, Luzac, London 1977
- Townshend C., "The defence of Palestine: insurrection and public security, 1936-1939", *English Historical Review*, 103 (409), October 1988, pp. 917-949.
- Trevor D., *Under the White Paper. Some Aspects of the British Administration from 1939 to 1947*, Jerusalem Press, Jerusalem, 1948.
- Troen I. S., "The transformation of Zionist Planning policy: from agricultural settlements to urban network", *Planning Perspectives*, 3, January 1988, pp. 3-23.
- _____, "The transformation of Zionist planning policy, Alternative approaches to building Tel Aviv", *Journal of Urban History*, 18, November 1991, pp. 10-36.
- Tuastad D., *The social capital of Palestinian refugees*, Paper presented at the Third Mediterranean Social and Political Research Meeting, EUI, RSC, 2003.

- Turner B. S., *Weber and Islam*, Max Weber Classic Monographs, Vol. VII, Routledge, London and New York, 1974.
- _____, *Marx and the End of Orientalism*, George & Unwin, London, 1978.
- _____, "Orientalism, Islam and Capitalism", *Social Compass*, 25 (3-4), 1978, pp. 371-94.
- _____, *Medical Power and Social Knowledge*, Sage Publications, London, 1987.
- _____, *Regulating Bodies. Essays in Medical Sociology*, Routledge, London and New York, 1992.
- _____, *Orientalism, Postmodernism and Globalism*, Routledge, London and New York, 1994.
- _____, "The Sociology of Islamic Social Structures", *Sociology*, (33) 1, February 1999, pp. 199-203.
- Vereté M., "Palestine and Israel in the 19th and 20th centuries", *Middle Eastern Studies*, 6 (1), January 1970, pp. 48-76.
- Vital D., "Bread upon waters. The legacy of the British in Jewish Palestine", *TLS*, June 5, 1992, pp. 6-7.
- _____, "From 'State within a State' to State", in Karsh E. (ed.), *Israel: the First Hundred Years, Volume I. Israel's Transition from Community to State*, Frank Cass, London Portland OR, 2000, pp. 32-42
- Waserman M., "Henrietta Szold: American Progressivism, Zionism and Modern Public Health", in Waserman M. and Kottek S. (eds.), *Health and Disease in the Holy Land. Studies in the History and the sociology of Medicine from Ancient Times to the Present*, Edwin Mellen, Lewiston NY, 1996, pp. 263-300.
- Waserman M. and Kottek S. (eds.), *Health and Disease in the Holy Land. Studies in the History and the sociology of Medicine from Ancient Times to the Present*, Edwin Mellen, Lewiston NY, 1996.
- Wasserstein B., *Britain and the Jews of Europe*, Oxford University Press, New York, 1979.
- _____, *The British in Palestine. The Mandatory Government and the Arab-Jewish Conflict 1917-1929*, Blackwell, Oxford 1991.
- _____, *Herbert Samuel. A Political Life*, Oxford University Press, Oxford, 1992.

- _____, "The British in Palestine: Myths and Realities", in *Middle Eastern Lectures, Number One 1995*, The Moshe Dayan Center for Middle Eastern and African Studies, Tel Aviv University, 1995, pp. 29-44.
- Weissbrod L., "Economic factors and political strategies: the defeat of the Revisionists in Mandatory Palestine", *Middle Eastern Studies*, 19 (3) July 1983, pp. 326-343.
- Whitfield L., *Civil society as Idea and Civil society as Process: the case of Ghana*, M.Phil thesis, St. Antony's College and Queen Elizabeth House, 2002.
- Williams D. and Young T., "Governance, the World Bank and Liberal Theory", *Political Studies* 42, 1994, pp. 84-100.
- Wistrich R. S., *The Jews of Vienna in the Age of Franz Joseph*, Oxford University Press, Oxford, 1989.
- _____, and Ohana D. (eds.), *The Shaping of Israeli Identity. Myth, Memory and Trauma*, Frank Cass, London, 1995.
- Yapp M., "The making of the Palestine Mandate", in *Middle Eastern Lectures, Number One 1995*, The Moshe Dayan Center for Middle Eastern and African Studies, Tel Aviv University, 1995, pp. 9-28.
- Yazbah M., "From poverty to revolt: economic factors in the outbreak of the 1936 rebellion in Palestine", *Middle Eastern Studies*, 36 (3), July 2000, pp. 93-113.
- Yekutieli P., "Masterman, Muehlens and Malaria, Jerusalem 1912-1913", *Korot*, 12, 1996-1997, pp. 107-123.
- Yiftachel O., "Ethnocracy: the Politics of Judaizing Israel/Palestine", *Constellations*, 6, (3), 1999, pp. 364-390.
- _____, "Homeland and Nationalism", *Encyclopedia of Nationalism*, Vol. I, Academic Press, Boulder CO, 2001, pp. 359-383.
- Yishai Y., "Politics and Medicine: The Case of Israeli National Health Service", in Antonovsky A. (ed.), *The Sociology of Health and Health Care in Israel*, Transaction Publishers, New Brunswick and London, 1990, pp. 245-251.
- Yuval-Davis N., *Gender and Nation*, Sage Publications, London, Thousand Oaks, New Delhi, 1997.
- Zerubavel Y., *Recovered Roots. Collective Memory and the Making of the Israeli National Tradition*, The University of Chicago Press, Chicago and London, 1995.

References

- Zipperstein S. J., "Haskalah, cultural change and nineteenth century Russian Jewry", *Journal of Jewish Studies*, 34 (2), Autumn 1983, pp. 191-207.
- Zwanger L., *Preparation of Graduate Nurses in Israel, 1918-1965*, Unpublished Ph.D. thesis, Columbia University, New York, 1969.