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“We Are Far More Advanced”

*The Politics of Ill and Healthy Babies
in Colonial Palestine*

Vena Winifred Ellen Rogers, a British nurse, is especially prominent in Palestine Department of Health records given the length of her service as a matron and superintendent of midwifery for the Jerusalem District, which included Jerusalem, Hebron, Bethlehem, Ramallah, El-Bireh, and their villages. Government and non-Jewish “government-aided” maternity and infant welfare centers in the Jerusalem District were accountable to Rogers, who in turn answered to the British senior medical officer (SMO).¹

In rare moments, Palestinian thoughts and feelings forcefully interrupt the supremacist rhetoric of empire in the Department of Health archival record. A startling conflict that unfolded over multiple documents from 1933 captures the tensions between colonizers and colonized around the politics of healthcare and mortality in Mandate Palestine.² The interaction involved the sole registered full-time Palestinian infant welfare nurse in the Ramallah Infant Welfare Centre (IWC), Alice Butros, Superintendent Rogers, and G. W. Heron, the director of health, over the treatment of an ill baby named Yasmin.

¹ Senior medical officers in Mandate Palestine districts were white British male physicians until 1946, when two Palestinian SMOs were appointed (Sufian 2015, 127), and supervised usually male Palestinian medical officers. The British director of the Department of Health or the director of medical services ranked above the SMO. Rogers’s office was in Watson House, a clinic in the Silsileh neighborhood of the Old City that had served as the home of Lady Watson, wife of Brigadier General C. F. Watson, the chief administrator of Palestine during most of the 1920s. The Order of St John seems to have leased out the building to Lady Watson and later to the Department of Health’s Maternity and Infant Welfare Centre. Government of Palestine (hereafter GOP), Department of Health, Infant Welfare Centre – Bab-el-Silsileh, Jerusalem, June 1940–November 1946. File location in catalog: 00071706.81.D1.30.56. Israel State Archives.

² GOP, Department of Health, Infant Welfare Centre – Ramallah, December 1924–September 1944. File location in catalog: 00071706.81.D0.98.37. Israel State Archives.

Ramallah . 135
17. 7. 33

Dear Miss Rogers

Just a few lines to tell you that they refused that baby again at the Hospital & that they asked them to pay 10 PT daily when they cannot afford to pay anything. & that the baby is still suffering & has to stay suffering until she dies & that she is getting worse. I don't see what is the use of an Infant W.C. when we cannot help a baby in this state.

Yours sincerely
Nurse Alice

Figure 1.1 Letter from Alice Butros to Vena Rogers, July 17, 1933, Ramallah. Courtesy of Israel State Archives

My curiosity about Butros was initially captured by Rogers's fruitless attempts in November 1933 to find a shop in Jerusalem that could repair the destroyed face of a demonstration doll Heron had given to her earlier that autumn "for teaching" purposes. The documentation on the series of events begins with a spirited English-language handwritten letter dated July 17, 1933, from "Nurse Alice" in Ramallah to "Miss Rogers" in Jerusalem (see Figure 1.1):

Dear Miss Rogers

Just a few lines to tell you that they refused that baby again at the Hospital & that they asked them to pay 10 PT daily when they cannot afford to pay anything & that the baby is still suffering & has to stay suffering until she dies & that she is getting worse. I don't see what is the use of an Infant W.C. [Welfare Centre] when we cannot help a baby in this state. Yours sincerely

Nurse Alice.

A handwritten letter follows dated July 24, 1933, from Rogers to Heron in the Department of Health office in Jerusalem. Rogers tells him she visited the IWC in Ramallah on the "19th" and

saw a baby. T. 40² for over two weeks. name Yasmin: complaint right hip very swollen, pain acute, no inflammation. child's condition bad – Dr. Hourani [the

medical officer in Ramallah] had sent them to the Government Hospital Clinic in Jerusalem but money was asked. As the mother was too poor to pay the child was not seen.

The notation “T. 40²” likely refers to Yasmin’s body temperature in degrees Celsius, which converts to 104.3 degrees Fahrenheit.³ Rogers continues,

Dr. Hourani was not there on my visit to the Centre. So I gave the mother a note to the Clinic stating she was poor and the following day I telephoned the M.O. [medical officer] i/t Clinic saying the baby would be there early. I attach the letter I received later from the Ramallah Infant Welfare nurse. Is it possible for something to be done to help in such cases as this?

The archives are silent on the matter for four months, until a November 23, 1933, handwritten letter from Rogers to Heron titled provocatively: “Subject: Ramallah Demonstration Doll.” She informs him that the face of a demonstration doll he had issued for pedagogical purposes around September 27, 1933, was “damaged” by “the nurse Alice Butros.” Indeed, its face was “smashed,” she explains. Rogers adds: “I have taken it to several shops in Jerusalem but am unable to get it repaired. Can you have something done to it?” Heron replies to Rogers a week later that he tried but is unable to fix the demonstration doll, which he returns to her.

We know from Butros and Rogers’s correspondence that Yasmin’s mother, who lived in the distant town of Ramallah, had repeatedly tried to get the child, suffering pain and a high fever for two weeks, treated at the Jerusalem Hospital Clinic. They likely determined Yasmin needed hospitalization (“pay 10 PT *daily*”), and she was refused admission more than once because her “mother was too poor to pay”: “they refused that baby again at the Hospital & . . . they asked them to pay 10 PT daily when they cannot afford to pay anything.”

We don’t know whether baby Yasmin was ever seen in the Jerusalem Hospital Clinic. It is highly likely she died of her illness, as did tens of thousands of ill Palestinian infants and children during the British Mandate. We can assume Nurse Alice was familiar with the limited British commitment to medical care for Palestinians and unsurprised by the clinic’s unwillingness to admit the ill Yasmin without payment of

³ Dr. Herman Staats guessed the likely meaning of this notation in an email exchange (January 12, 2019).

the daily fee. Department of Health records do not reveal when between late September and late November the angry Nurse Alice "smashed" the doll's face.

I conjecture that Alice Butros damaged the doll on her way out of the Ramallah IWC because she quit, transferred, or was fired. The 1930 Department of Health list of licensed healthcare providers in Palestine includes an Alice Butros in the midwives' section (license no. M. 341) whose address is "c/o the Government Hospital" in Haifa. This listing provides evidence that Butros was an experienced nurse who had either transferred or been reassigned to the Ramallah IWC in the early 1930s (GOP 1930). The Department of Health continues to list Butros as a licensed nurse midwife, but affiliated with the Ramallah IWC, in January 1935. Her name does not appear on Department of Health lists published in July 1936 and May 1938, however (GOP 1936, 1938).⁴

The doll symbolizes and materializes, I argue, colonial prioritization of pedagogical training for Palestinian girls and women over the funding needed for preventative healthcare and treatment. Its destroyed face, moreover, viscerally captures Nurse Alice's sense that the situation was untenable. Although the municipality of Ramallah was required to pay the costs of the IWC and her salary through community "fundraising" and "local subscription," Nurse Alice was bound by British colonial rules in Palestine.⁵ The archives show frequent turnover of the Palestinian nurses who worked in the Ramallah IWC from the 1920s through the 1940s (no more than one was employed at a given time).

As this chapter explores, lack of British investment in healthcare for Palestinians was systemic and endemic to a colonial ecology segmented by nationality, religion, and "race."⁶ Palestinians disproportionately

⁴ These lists, which were published in Jerusalem as thick pamphlets divided by category of medical profession, were not annually released or necessarily comprehensively up to date when they were published, especially for midwives.

⁵ GOP, Department of Health, Infant Welfare – Regulations, December 1921–February 1935. File location in catalog: 00071706.81.D1.32.B2. Israel State Archives.

⁶ British "Notification of Birth" forms required "nationality" (citizenship, *al-jinsiyya*), "religion" (*al-mathhab*), and "race" (*al-unsur*) for the mother and father. Arabs and Armenians typically wrote "Palestinian" for nationality irrespective of religion, even if they were born in Damascus, Beirut, Saida (Sidon), or "Turkia." Some Jews wrote "stateless" under the nationality/citizenship category, sometimes with their former country (e.g., Austria), and others wrote

died very young of poverty, hunger, and disease during the thirty years of British colonial rule, a rate overdetermined by colonial austerity in healthcare and infrastructure provision and systemic extraction from the native population. During the same period, Zionist health and science institutions, funded mainly by investments from Western Jewish communities, improved Jewish infant, child, and maternal health in Palestine guided by a racial demographic impulse and social medicine philosophy. Palestinian elites, in turn, recognized that healthcare and health status were political and crucial to the Zionist enterprise.

Developmental Infra/Structures and Health Consequences

The Treaty of Versailles and the League of Nations mandates (based on the ideology of European “trusteeship” over certain populations) imposed some pressure on colonial governments to “invest in public health programmes,” as did the League’s putative interest in the “health situation in Africa,” but did not translate into substantial investments. Differing priorities, population composition, perceived health dangers to European bodies, and indigenous demands in various colonial settings determined British healthcare policies in mandate colonies (Von Tol 2007, 111–112; Lindner 2014, 219, 209). Ulrike Lindner finds that “colonial health policy” in tropical Africa mostly reified “racial demarcation lines” (Lindner 2014, 208, 219). This was also true in Mandate Palestine, intensified by the additional factor of Zionist settler-colonialism.

The League of Nations unambiguously “endorsed a settler project” in Palestine by validating the idea of a “Jewish National Home” (Norris 2013, 11; Norris 2017, 278). Article 11 of the Palestine Mandate gave the British colonial “Administration of Palestine” authority to “safeguard the interests of the community in connection with the development of the country” and “full power to provide for public ownership or control of any of the natural resources of the

“Palestinian,” even if they had been born in Poland, or simply “German.” Arabs born before 1918 wrote or were required to write “Syrian.” The given choices for “religion” were “Moslem,” “Jew,” “Christian,” or “Other” (*ghayr thalik*). For “race,” the options given were “Arab, Jewish, or Other Race”; some wrote in “Armenian.” GOP, Department of Health, Notification of Birth, 1939–1948. File location in catalog: 00071706.81.D3.A9.DF. GOP, Department of Health, Birth Certificates, 1944–1947. File location in catalog: 00071706.81.D3.AA.51. Israel State Archives.

country or of the public works, services and utilities established or to be established therein." It allowed colonial authorities to "introduce a land system appropriate to the needs of the country, having regard, among other things, to the desirability of promoting the close settlement and intensive cultivation of the land."

Article 11 conjured a "Jewish Agency" with the right "to construct or operate, upon fair and equitable terms, any public works, services and utilities, and to develop any of the natural resources of the country, in so far as these matters are not directly undertaken by the Administration." The Jewish Agency, which was not formally established until years later, was the only non-British institution the British colonial government recognized as a competing authority (Seikaly 2016, 5).⁷ Article 16 of the Palestine Mandate limited British interference "with the enterprise" of religious and charitable bodies "of all faiths in Palestine" unless "required for the maintenance of public order and good government."⁸

British colonial authorities in Palestine quickly promulgated ordinances that truncated independent Palestinian initiatives and stripped all governing autonomy from Palestinian political bodies such as municipalities, which had had significant local authority under Ottoman rule (al-Barghuthi 1932).⁹ Instead of existing in "dual" or

⁷ "The Jewish Agency for Eretz Yisrael was established in 1929 to act on behalf of the World Zionist Organization in relation to the British Government, the administration in Palestine, and the League of Nations." Chaim Weizmann was elected president of both. In 1920, "the Allied Forces Council (preceding establishment of the League of Nations) approved the British Mandate in Palestine based on [Article 2 of] the Balfour Declaration to support the building of a 'Jewish national homeland' and establish[ed] that in order to fulfill the declaration's promises, a 'Jewish Agency' shall also be formed to 'advise the Government of Palestine on economic and social issues, as well as other matters.'" The World Zionist Executive, established in 1920, acted as this "Jewish agency," working "through the financial institutions of the World Zionist Organization" (Knesset webpage: www.knesset.gov.il/lexicon/eng/wz_o_eng.htm).

⁸ "The Palestine Mandate," Avalon Project: Documents in Law, History and Diplomacy. Yale Law School Lillian Goldman Law Library: https://avalon.law.yale.edu/20th_century/palmanda.asp.

⁹ The 1864 Ottoman Provincial Law called for application of "Istanbul's municipal model to the provincial cities and towns of the empire." The details were fine-tuned in an 1867 law and formally amended and published as the 1877 Municipality Law, which was translated into Arabic "and published in full length in Beirut's press." Municipalities were required to address "urban planning, market control, health, public morality, and public welfare." Jens Hanssen

parallel political-economic sectors, Palestinians and Zionists existed in exploitive and extractive *relations*, as did British colonizers and Palestinians (Zu`bi 1984, 91, 107). British colonizers and Zionists were unequal colonial partners, yes, but Palestinians and their lands, labor, natural resources, and very lives were the grounds of colonial and settler-colonial exploitation and extraction for both parties.

Jacob Norris makes the case that British colonial authorities had “earmarked” Palestine for “developmental” colonialism by the end of the first decade of the twentieth century (Norris 2013, 11). Led by the “new imperialists,” the “age of colonial development” aimed to develop resources and build infrastructure that strengthened the metropolitan economy (Norris 2013, 2; Norris 2017, 269, 272). For the British government, Palestine was economically valuable in a number of ways. Most importantly, Haifa, already linked by railroad to Baghdad during the Ottoman period, would provide a “Mediterranean coastal outlet” for products from “Mesopotamia,” which the British also hoped to colonize (and ultimately did) (Norris 2013, 11; Norris 2017, 272, 274). Significant as well was wealth from Dead Sea mining, which extracted potash, bromine, and potassium salts in joint British-Zionist ventures developed during the Mandate (Norris 2017, 277). Palestine in addition provided a captured market for British products and was a major source of “custom duties” on imports and exports (Asad 1976, 6, table 1). London was most likely to approve “development” projects in colonial Palestine that showed “benefit [to] British industry” and “British imperial interests” (Norris 2013, 14; Norris 2017, 270). Palestinians were explicitly excluded from such projects, and certainly so for rural people, who were understood as “incapable of keeping pace with the changes introduced by Zionism” (Norris 2013, 12).

British “imperialist ambition” aligned with the settler-colonial ambitions of the Zionist movement in Palestine. For one thing, British imperialists understood European Jews as classic mediators for British economic interests (Norris 2013, 10; Norris 2017, 270). A number of prominent new imperialists “viewed Zionist migration to Palestine as the key to realizing” the land’s “developmental potential,” just as they encouraged British (including Jewish) migration to

argues that advocates of “hygiene and medicine” and Arab and Ottoman “scientific traditions and medical epistemologies” were eager to take up this mandate in Bilad ash-Sham (Hanssen 2005, 115–118).

"white dominions" (Norris 2017, 273). British developmentalists argued that "Jewish colonization" had already helped the "Palestinian Arabs" with "its modern intensive methods of agriculture, its scientific appliances, its western ideas of hygiene and business methods" (Norris 2017, 273).¹⁰

The British colonizers prioritized keeping British bodies safe and healthy in an environment they considered climatically and politically hostile. In the words of a British surgeon in Jerusalem to the Royal Geographical Society in 1917, "efficient sanitary authority with powers" of enforcement was necessary for the "successful colonization of Palestine" (quoted in Sufian 2015, 115). Colonial authorities emphasized health policies that sustained the economic and military dimensions of rule by serving the basic health needs of British military, police, and civilian forces. Oriented to eradicating contagious diseases, Mandate authorities selectively "constructed the sewage and drainage systems" and "invested in drying up swamps [and] education for hygiene" (Abu-Rabia 2005, 421). They understood and treated the colonized as "vectors" rather than "victims" of disease and illness, to use Mary-Ellen Kelm's analysis of settler-colonial medical approaches to First Nation peoples in early twentieth-century North America (Kelm 2005, 382).

A continuous source of tension with Palestinians and Zionist organizations was that the government of Palestine "consistently prioritized infrastructural projects above the provision of welfare services" (Norris 2013, 13). Infrastructure projects were not designed to serve the needs of the colonized population as the government, for example, neither built nor maintained sewage and water systems in most Palestinian villages. Transport systems facilitated British labor and military priorities rather than indigenous mobility or advancement. A for-profit electric concession monopoly granted by British authorities early in their rule to Russian Zionist engineer Pinhas Rutenberg privileged his private electricity initiative and Zionist towns and settlements,

¹⁰ Writing about post-World War I Iraq, Sara Pursley argues that British colonial governance is best understood through the "dual mandate" theory associated with F. D. Lugard, a British member of the Permanent Mandates Commission of the League of Nations, which referred to colonial "exploitation of a territory's resources" ("economic development") while protecting "development 'along native lines'" through indirect rule. This agenda would ideally allow the "native labor force" to reproduce itself while avoiding "unruly demands for popular sovereignty and for a share in economic development" (Pursley 2019, 20).

plotted a map of settler-colonial boundaries for a Jewish Palestine, and bypassed Palestinian villages (Meiton 2019).

Palestinians recognized the relationship between the Rutenberg Jewish Hydroelectric Company grid and the strengthening of the Zionist settler-colonial project. The building of the grid in Jaffa led to a mass mobilization of Palestinians in the early 1920s. In 1923, a nationalist circular titled “Beware of the Rutenberg Scheme” and signed by Hafez Tukan, president of the Jaffa Economic Committee, called on “the people of Jaffa” to boycott the grid since it could not be sustained or maintained without municipal taxes and fees: “Rutenberg wants by means of the force of the occupying authority to help himself out of your own money – he having failed in the matter with his own people’s money – and thus get possession of the means of people’s livelihood in the country so that he will subjugate you to his rule by lighting your streets and lanes. What will be the use of electrical lights if you lose your wealth and lands?” (quoted in Jarman 2001, 559–560). It is not surprising that Palestinians involved in the 1936–1939 Revolt targeted the Rutenberg electrical grid (Meiton 2019, 4–5, 20).¹¹

The majority of Palestinians, most of them peasants, were also constrained by extractive local and absentee Arab large landowners (Khalaf 1997, 93). Beginning in 1858, the Ottoman state required registration of land titles for taxation, destabilizing a system that relied on communal forms of land use and landholding. To avoid taxation and conscription under the new legal regime, villagers often registered property in the name of a clan leader or family member not eligible for military service, which in more fertile areas “institutionalized and reinforced pre-existing relations of dependence between indebted cultivators and debt-owning usurers (whether traders or urban notables)” (Asad 1976, 4).

These dynamics intensified and became “more complex” after the devastations of the Great War, which included widespread conscription into the Ottoman army and poverty, hunger, and disease in Palestine. Palestinian revolts during the British Mandate, usually initiated by peasants and the poor, typically targeted landlords, merchants, Zionists, and the British authorities (Khalaf 1997, 95, 96). The

¹¹ Research by Tawfik Canaan found that the Rutenberg grid facilitated the spread of malaria in the 1920s and 1930s by bringing down the level of Lake Tiberias (Nashef 2002).

situation for Palestinian peasants and laborers was made worse by the fact that the Jewish sector "did not seek Arab labor but Arab land," which it could acquire only through "market exchange – a slow and politically unsatisfactory process" until the 1948–1949 war, when Palestinians were expelled en masse and their property stolen (Asad 1976, 8).

Talal Asad argues that the economic situation of peasant Palestinians during the British colonial period is best understood as "the articulation of a capitalist with a non-capitalist mode of production mediated by the British colonial state," in a process that began during Ottoman rule. The Mandate's fiscal structure depended on regressive taxation and debt, which "facilitated the extraction of surplus from the non-capitalist sector, and its partial transfer to the expanding capitalist sector," dominated by Jewish enterprises (Asad 1976, 5–7; also see Khalaf 1997, 94–95).

A British-commissioned project undertaken by Palestinian researchers in 104 villages and by Zionist researchers in seven settlements run by the Jewish Agency indeed found in a self-serving 1930 report that the "Arab farmer is paying more than his share of taxation" to the colonial government. Peasants in addition suffered from high levels of poverty because cheaper agricultural products were dumped on the market, a problem the authors considered so "serious" it required immediate government remediation (GOP and Johnson and Crosbie et al. 1930, 49, 52, 54).¹²

Colonial sovereignty, argues Achille Mbembe, "means the capacity to define who matters and who does not, who is *disposable* and who is not" (Mbembe 2003, 27). He draws attention to racialization as the dividing line that "regulates the distribution of death" by sovereign powers (17).¹³ He coined the term *necropolitics* to describe sovereign

¹² The report concludes that the government should use "compulsory means" to continue to divide and privatize communally owned Palestinian farmland (*musha'*) that surrounded most village settlements, a process begun by nineteenth-century Ottoman land codes that were nevertheless ineffective in transforming peasant practices until British and Zionist colonization and passage of the 1921 Land Transfer Law (Zu'bi 1984, 92, 93, 94, 97; GOP and Johnson and Crosbie et al. 1930, 55–56).

¹³ Colonies, Mbembe argues, "are the locations par excellence where the controls and guarantees of judicial order can be suspended – the zone where the violence of the state of exception is deemed to operate in the service of 'civilization'" (Mbembe 2003, 24). For Mbembe, the "most accomplished form of necropower is the contemporary colonial occupation of Palestine. Here, the colonial state [of Israel] derives its fundamental claim of sovereignty and legitimacy from the

and non-sovereign forms of biopower that make “murder of the enemy its primary and absolute objective” using appeals to exception or emergency in the name of preserving the lives of the privileged group (12, 16, 21). British colonial necropolitics, I contend, was operative on a daily basis in Mandate Palestine but on quotidian levels that worked in tandem with periods of intensified military violence. The necropolitics of the Department of Health, which answered to the Colonial Office and the Treasury in London, was built on a logic of austerity and developmental extraction from a Palestinian population considered disposable.

As colonial powers, British authorities regularly reported to League of Nations offices on their “health and hygiene” responsibilities over the population in Palestine, which included venereal disease incidence and infant mortality rates, the latter “generally considered a prime indicator of the state of health of the population” (Bourmaud 2013, 13).¹⁴ As Philippe Bourmaud reminds us, however, while the health-care of the colonized “was one of the core concerns of the mandates, at least on paper,” the majority of the members of the Permanent Mandates Commission in Geneva “were former colonial officers themselves and unabashed colonialists” (12). Nevertheless, since the mandates were structured as a “civilizing mission,” it was imperative that British and French colonial governments “visibly represent the health improvements” with reports and statistics (15).

Few British-sponsored infant welfare centers were established in Palestine and when they did exist, they were similar to British government hospitals in offering no preventative services such as prenatal care (Kligler 1932, 173), which helps explain the comparatively high rates of Palestinian infant and child mortality. Research commissioned by

authority of its own particular narrative of history and identity” (Mbembe 2019, 80–83).

¹⁴ The infant mortality rate refers to the number of infant deaths per thousand births in a period of time, usually a calendar year. Infancy is the first year of life, composed of the “neonatal phase” of the first twenty-eight days after birth and the “post-neonatal phase that covers the eleven remaining months of the first year.” Each of these phases has patterns for causes of death. The “peak of mortality from nutritional deficiencies” is in infancy. A live birth is a fetus outside the mother and breathing, no matter how many gestational weeks old, while a “dead birth” is when a fetus is born after twenty-eight weeks of gestation but not breathing (Khalidi 1996, 10, 11, 12, 13).

US Zionist organizations reported that in 1925, 64 percent of all recorded deaths in Palestine were among children "before the age of five years," which the authors term "staggering" (Rosenau and Wilinsky 1928, 576, 577; also see Canaan 1927, 185; Granqvist 1947, 47, 49, 56–57, 60–66, 116; Granqvist 1950, 74, 80, 81, 83, 90, 110–114).

By 1929, 68.2 percent of recorded "Moslem" deaths (18,131) and 38 percent of recorded "Jewish" deaths (1,820) occurred among children younger than five years (Kligler 1932, 172). In 1930, the death percentages of children younger than five years by religion were 67.9 percent and 34.7 percent for Muslims and Jews, respectively (172). High mortality rates among infants and children continued in the 1930s and 1940s, with substantial gaps between Palestinians and Jews.

A five-year (1930–1934) table compiled from annual Department of Health reports on birth, death, and infant mortality rates, divided by columns for "Jews," "Christians," and "Moslems," offers another snapshot. For 1934, the infant mortality rate for Muslims was comparatively high (175.34), for Jews much lower (77.95), and for Christians closer to the Muslim than the Jewish rate (152.62) (MacLennan 1935, 6). In *Vital Statistics of Palestine Bulletin* No. 1 (1936), Director of Medical Services J. W. P. Harkness notes "the striking fact that nearly 32 per cent. of all deaths in Palestine in 1935 were of infants under one year of age" and half were of children younger than two and a half years old.¹⁵

Three years later, in 1939, infant mortality rates were once again broken down by religious category in a vital statistics report: "Median age of death for Moslems was between two and three years, while the median for Jewish deaths was a little over fifty years. The median age for deaths for Christians lay in the age group 25–29 years."¹⁶ Late in the Palestine Mandate, the Anglo-American Committee of Inquiry acknowledged that the "provision of infant welfare and maternity

¹⁵ GOP, Department of Health, Births, Deaths, Vaccinations and Inoculation – Regulations, 1932–1936. File location in catalog: 00071706.81.D7.1D.D5. Israel State Archives.

¹⁶ GOP, Report for Office of Statistics, Jerusalem: Vital Statistics. Includes quarterly reports for 1940 and totals for 1939 and 1940 and comparisons with earlier years, March 25, 1940–March 1941. File location in catalog: 00071706.81.D3.AA.55. Israel State Archives.

centres [for Palestinians] is admittedly inadequate in a country having a high infant mortality rate” (Anglo-American Committee of Inquiry 1946, 2:618).

Aziza Khalidi’s DSc dissertation on infant survival and death in Palestine between 1927 and 1944 finds that while poverty for Palestinian Muslims and Christians existed in both rural and urban areas, government, missionary, and private health services were concentrated in towns, as was infrastructure such as electricity, roads, sanitation, and water systems. Having health institutions and infrastructure was associated with better health outcomes and lower infant mortality rates (Khalidi 1996, v–vi, 197). She found that roads linking predominantly Christian villages to towns were associated with lower infant mortality rates *in those villages* (431). Death during infancy is socially rather than culturally or individually caused, she argues, since it depends on “resources” and their “patterns of allocation” (156).

Without the health infrastructure provided by missionary institutions in major towns, Palestinian infant and child death rates would have likely been higher during the British colonial period. In October 1941 Bertha Spafford Vester, the director of the relatively wealthy Anna Spafford Baby Home sponsored by the American Colony Aid Association (headquartered in New York), approached the British director of medical services to ask the government to take over the home because it was difficult to retain nurses during the war. When he replied, “we [are] not prepared to do so,” she asked if the government would take the six hundred babies they cared for if she closed it. If accurate, this was more babies than the number cared for by any other government-sponsored IWC with the possible exception of Watson House in the Old City. He likely refused. The home did close in October 1943 “on account of lack of trained nurses,” although it reopened at least by 1947 and continues to exist today.¹⁷

A 1933 report from the Colonial Office in London to the Permanent Mandates Commission illustrates the disavowal accomplished by rhetorical sleights of hand with respect to Palestinian death, in this case of postpartum women. A 1932 inquiry from the commission asked “whether there was any connection between the high mortality from

¹⁷ GOP, Department of Health, Infant Welfare – Anna Spafford Baby Home (American Colony Aid Association), Jerusalem, 1935–1948. File location in catalog: 00071706.81.D1.32.B6. Israel State Archives.

puerperal fever and the number of *dayas* [traditional midwives] permitted to practice midwifery."¹⁸ The official responded that the colonial government in Palestine only counted cause of death certified by government medical officers in towns. The town rate of puerperal deaths was not high, he contended, at 1.1 per 1,000. He assured the Permanent Mandates commissioner that since traditional midwives are no longer allowed to practice in "the majority of towns" after passage of the 1929 Midwives Ordinance, they could not be directly linked to "high mortality from puerperal fever." "If the *daya* is blameworthy, her name is removed from the register of persons permitted to practice midwifery." He explained that the cause of postpartum death was rather not seeking or delays in seeking professional medical help to assist with difficult births.¹⁹ The League of Nations query assumed that ignorant Palestinian midwives were primarily responsible for maternal death from puerperal fever. For its part, colonial response was contradictory on whether Palestinian postpartum death rates from puerperal fever were high and used a common (in the archive) passive-voice construct to evade addressing meta factors that increased the likelihood of death in difficult labor cases, such as lack of affordable medical care and transportation.²⁰

Using Science and Social Medicine to Make Healthy Jews

Zionist "aspirations to develop a national entity" were understood to require building "strong scientific foundations" that included research, education, and treatment institutions, as well as investing in technology

¹⁸ Puerperal fever is produced by a uterine bacterial infection that develops in the first few days after giving birth or miscarrying. In Palestine, forty-seven cases of puerperal fever with twenty-two deaths were reported for 1933 (towns only). In comparison, forty-one cases with eighteen deaths were reported for 1934, and fifty-four cases with twenty-nine deaths were reported for 1935. GOP, Department of Health, *Annual Report for the Year 1934*, 28. GOP, Department of Health, *Department of Health Report for the Year 1935*, 26.

¹⁹ "Report by His Majesty's Government in the United Kingdom of Great Britain and Northern Ireland to the Council of the League of Nations on the Administration of Palestine and Trans-Jordan for the Year 1932." London, 1933, Colonial No. 82, 58–82. In *Palestine and Transjordan Administration Reports 1932–1933, Vol. 4* (1995), 137–138.

²⁰ In British health reports active-voice prose typically accused the colonized of cultural and intellectual defects in healthcare practices while distancing and passive language skirted taking any responsibility.

to “civilize” and transform a “desert wasteland” (Davidovitch and Zalashik 2010, 402, 404). “Re-establishing the health of the country” was seen as a prerequisite for “re-populating” the land with Jews (406). Zionist health activists understood these Jewish bodies and subjectivities as plastic – that is, as highly amenable to social engineering that improves the quality of the population, an environmental eugenic approach that existed in the same welfare and health ecosystem as hereditary eugenic projects.

Health spending by Jewish organizations for Jews far exceeded that of the British government for many more Palestinians, and substantially focused on preventative care (Kligler 1932, 169). The 1920s saw annual reductions in Jewish infant and child mortality rates as a result of such investments (172, 171). Influenced by social medicine, Zionist health projects targeted entire Jewish communities in the multiple locations they lived and worked. The Zionist colonization of Palestine would not have been possible without this massive healthcare and medical infrastructure, facilitated by the British colonial policy of encouraging “private” and “voluntary” investment in “welfare.”

Social medicine, which emerged in mid-nineteenth-century Berlin, was concerned with the relationship between the health of individuals and communities and their socioeconomic situations. The field assumed that resolving health issues required treatment and “social work.” The public health field, in contrast, was historically more oriented to resolving communicable diseases. Both social medicine and public health have diffracted into multiple ideological and practical directions depending on context and historical moment, however. For example, Salvador Allende, the socialist president of Chile until he was overthrown in a US government-backed coup in 1973, was a public health physician and advocate for the poor who had first served as the minister of health. Che Guevara, who joined the Cuban revolution and became the minister of economy, was first an Argentinean physician (Horton 2013; Anderson et al. 2005). In comparison, British settler social medicine in First Nation communities in North America in the early twentieth century facilitated “the production of racial hierarchies,” influenced by the “broader concerns of social medicine – contagion, gender breakdown, racial characteristics,” and the “the pathological encounter” between colonists and indigenous people (Kelm 2005, 371, 372).

Examining the League of Nations Health Organisation in the inter-war period, Paul Weindling finds that although social medicine was

considered "objectively based in social or biomedical science, and benignly reformist," its practitioners had a "range of political interests," including "a prominent concern with eugenics that ranged from providing a rationale for positive welfare measures like maternity benefits to 'negative eugenics' measures such as compulsory sterilisation." In its "biologicistic formulations" at least, social medicine facilitated medicalization and support for professionals who created for themselves "new career opportunities in polyclinics and social administration," which functioned as "professional imperialism" in colonial settings (Weindling 1995, 135–136).

In contrast to the rather disinterested health policy of British colonial authorities in Palestine, US Zionist organizations commissioned the 1928 "Sanitary Survey of Palestine" to plan health investments for Jews in the following ten years and to push British authorities to provide increased funding for the Hadassah Medical Organization (the Women's Zionist Organization of America) and Jewish schools.²¹ The report challenged British refusal to disburse funds to "private" entities such as Hadassah (Rosenau and Wilinsky 1928, 539, 541, 542, 553–554, 561, 622). According to colonial government budget reports beginning in 1930, the Department of Health came to provide limited "grants-in-aid" to Zionist health organizations using the government's per-patient or per-bed formula for Palestinian patients in response to persistent applications for support by Jewish

²¹ Hadassah was established by Henrietta Szold (1860–1945) in 1912 in New York City after she joined a chapter of a Zionist women's group. Szold was a Jewish teacher, intellectual, and Zionist activist who grew up and spent much of her adult life in Baltimore as the beloved daughter of a rabbi. Szold and her mother visited Palestine in 1909 for a month, as Henrietta was suffering from heartbreak. Szold became overwhelmed by a need to offer practical help to Jews in Palestine, whom she perceived as backward and disease-ridden. In 1912, "philanthropist Nathan Straus offered [the women's Zionist group in NYC] partial funding to establish district nursing in Palestine" if they could raise the rest of the money and find "a skilled nurse able to depart for Palestine within a few weeks. Ultimately two nurses – Rose Kaplan and Rachel Landy – sailed with the Strauses on January 18 [1913]. In March 1913 they opened an office in a rented Jerusalem house identified by a Hebrew and English sign that read 'American Daughters of Zion, Nurses Settlement, Hadassah.' They saw 5000 patients in their first year . . . At the second [Daughters of Zion national] convention in 1914, the group [which included multiple chapters] formally adopted the name associated with the group's medical efforts in Palestine – Hadassah." "Women of Valor: Henrietta Szold," Jewish Women's Archive: <https://jwa.org/womenofvalor/szold>.

health institutions. British documents frequently complained of Jewish extravagance in healthcare provision, which did look generous in light of the government's absolutely minimal services and financial commitments to Palestinian healthcare.²²

Zionist health organizations continuously pushed the boundaries set by British colonial authorities in order to extract more money and authority and to improve health services for Jewish communities. The 1940 Public Health Ordinance, which amended rules regarding registration of births and deaths and consolidated circulars from previous years, was first published as a draft in the *Palestine Gazette* so as to solicit comments. The Jewish Medical Association of Palestine's deputy chairman, Dr. A. Wolwelski, wrote to Director of Medical Services John MacQueen seeking, among other things, more leeway for their physicians to make decisions regarding who must be hospitalized for infectious diseases. The organization also sought to make compulsory a second inoculation against smallpox and a first inoculation against diphtheria. Recognizing these were expenses British colonial authorities were unwilling to take responsibility for, Wolwelski assured MacQueen that Jewish localities and institutions would pay for diphtheria inoculations. MacQueen disagreed with both proposals, suggesting these were largely "administrative" rather than ordinance matters and the government had faced few difficulties quarantining infectious Palestinians and vaccinating Palestinian schoolchildren.²³

Zionist propaganda and fundraising campaigns showcased in documents and visual material the building of an advanced Jewish science and healthcare system of hospitals, research centers, medical schools, and clinics in order to solicit support from Jewish philanthropists and communities. Members of Hadassah continuously raised "Palestine Campaign" funds from the United States, and like British, Australian, and New Zealand Zionist women activists, deployed the ignorant indigenous Muslim or Jewish mother as a foil for its work, although the organization predominantly served Jews.²⁴ A letter from Bertha

²² For example, GOP, Department of Health, Public Health: Hospital Accommodation for Jewish Settlements, 1936–1945. File location in catalog: 00071706.81.D3.FB.89. Israel State Archives.

²³ GOP, Department of Health, Laws and Ordinances – Public Health Ordinance 1940, March 1940–1941. File location in catalog: 00071706.81.D08E.66. Israel State Archives.

²⁴ For example, as early as 1925, "Hadassah: The Women's Zionist Organization in NY" letterhead from the address at 114 Fifth Avenue included a footer:

Landesman (1882–1959), a settler who became the chief nurse of the Health Welfare Department of Hadassah, illustrated the organization's ecological approach to health.²⁵ Hadassah, she explained, took the Jewish "family as a unit, and not the Expectant mother or Infant." Home visits by nurses allowed them to "supervise the health of the entire family" through the vector of the expectant mother, who was monitored "six to seven months before the birth of her child" and then tracked until "the child finishes its school period."²⁶ In addition, Hadassah trained nurses in Jewish schools, where they were expected to work with physicians to identify and repair children's "defects." Landesman further explained to Hadassah's acting director, R. Katzenelson, in an October 12, 1925, letter: "The school nurse is to instruct in the home how to care for the school child physically, mentally and hygienically, as well as bring close contact between the school room and the home, the teacher and the mother." The nurse was also required to examine children between their annual physician visits so as to detect and resolve the emergence of "any new defects."²⁷

Landesman's correspondence cultivated material, ideological, and symbolic external support for Hadassah's settler-colonial medical and nursing projects in British-ruled Palestine. In a July 14, 1926, letter she wrote from Jerusalem's Hadassah office to Dr. I. M. Rubinow at the *Jewish Social Services Quarterly* in Philadelphia, she boasted that Hadassah had recently "saved every child" among "Yeminite Jews" ("100 families, 300 souls") in the colony of Rehobot despite "epidemics" of measles and whooping cough.²⁸ Hadassah's modern public

"United Palestine Appeal, \$5,000,000. Have you done your share?" Central Zionist Archives 1925, Folder J113/6738.

²⁵ Landesman was born in Ukraine and immigrated as a teenager with her family to New York City in 1896. She trained in nursing, graduating from Lebanon Hospital in NYC in 1913. From 1913 to 1920 she worked in the NYC public health department in child welfare and hygiene clinics that served public schools. She arrived in Palestine in 1920 and founded Hadassah's Public Health Nursing Services Department, where she worked until 1936. Nira Bartal, "Bertha Landsman [*sic*], 1882–1962." Jewish Women's Archive: <https://jwa.org/encyclopedia/article/landsman-bertha>.

²⁶ September 21, 1926, Landesman letter to Dr. Truby King. Central Zionist Archives 1925, Folder J113/6738.

²⁷ October 12, 1925, Landesman letter to Dr. R. Katzenelson. Central Zionist Archives 1925, Folder J113/6738.

²⁸ The letter references "Enclosure No. 5," a report from the Government of Palestine indicating that "1,508 Jewish babies" were born in 1925. Landesman glossed that Hadassah registered in its "Infant Welfare Clinics in Jerusalem"

health work was uniquely difficult and effective, she elaborated, given the backwardness of women in Palestine: “We are far more advanced than in America or European countries. That is, our work is more concentrated. It must be, because the mothers we teach are very primitive and our teaching must be more thorough, each detail demonstrated.” To reinforce her point, she explained that “when a baby was really seriously ill, they were rarely taken to the doctor, but all sorts of tortures [were] inflicted upon the poor little babies, such as burning underneath the tongue,²⁹ or making wounds on the temples hanging all sorts of amulets on their forehead, attached to the front hair, etc.³⁰ Now, at least they know we do not approve of these methods.”

In contrast to her deployment of “Yeminite Jews” as a population, Landesman used individual Palestinian or Muslim women as figures of the ignorant primitive. For example, she illustrated her case for external support by describing a thirty-eight-year-old “woman in the Old City Centre in Jerusalem, who had 24 children, 4 sets of twins, sixteen have died.” This prolific unlucky mother eagerly listened to Hadassah nurses’ advice to keep her youngest baby alive. Landesman also mentioned a “Moslem mother” who came in with a six-month-old ill baby but violated Hadassah advice on sterilization of rubber nipples and feeding. A visiting nurse had found “the nipple on the floor, with the rest of the family food,” maybe referring to trays and dishes from a communal family meal she interrupted. Hadassah nurses “managed to keep this baby alive until 11 months of age, it weighed 12 lbs., then got an attack of diarrhea: was instructed to stop the milk formula for a certain period. The next day mother returned with baby in a much worse condition.” The mother pleaded that while following instructions to stop milk feeding, she had given the “thirsty” child “some grapes to eat,” which the nurse determined to have “fatal” results.³¹

The ideological and rhetorical weight of these individual stories is indicated by their reuse in a similar letter from Landesman to

“926 new babies,” thus “about 60% of the Jewish babies born in Jerusalem” were under its health supervision.

²⁹ Arab healers frequently burned extra tissue tethering a baby’s tongue to the bottom of its mouth, which restricts the ability to nurse and a tongue’s range of motion, a condition scientifically termed *ankyloglossia*.

³⁰ The reference is to amulets or coins braided or tied into a baby or child’s bangs to reflect away the evil eye believed to lead to serious illness or death.

³¹ Central Zionist Archives 1925, Folder J113/6738.

Dr. F. Truby King about two months later (September 21). King (1858–1938), an iconoclastic and obsessive (described as “zealous” in a hagiographic account by R. M. Burdon) eugenicist physician who held many leadership positions over his long career, became by the early twentieth century a world-renowned infant welfare and “mothercraft” pedagogue. He insisted that white British bourgeoisie women follow “the laws of Nature” by fully devoting themselves to raising healthy children rather than seeking higher education or employment outside their homes (Burdon 1945, 49–53).³² He was particularly influential in his arguments for breastfeeding rather than artificial feeding, especially timed breastfeeding – or if necessary as a supplement, carefully formulated “humanised milk” – to lower infant mortality rates produced by “careless bottle-feeding . . . by the majority of women” (13–25, 25, 34, 35).

Summarizing Hadassah’s accomplishments in prenatal and infant care in her September 1926 letter to King, Landesman explained that many mothers in Palestine now understood the superiority of timed rather than at-request breastfeeding and were less likely to use methods informed by “old traditions and superstition” on ill babies. She described in familiar terms the lowered infant mortality rate among “Yeminite Jews” since Hadassah established its health center. She once again told the story of the woman who had twenty-four children (three sets of twins in this version, and eight babies remained alive). Given that the story of this unfortunate woman followed discussion of Yemeni Jewish mothers who previously had “eight, nine, and as many as seventeen births, with rarely more than one to three children living,” the “24 children” mother was probably a Muslim or Christian Palestinian rather than Jewish. Landesman now described the mother as thirty-seven years old when she attended the health center with the “24th child.”

As Warwick Anderson argues in his study of US medical authorities who colonized the Philippines in 1898, “Hygiene reform . . . was intrinsic to a ‘civilizing process,’ which was also an uneven and shallow process of Americanization” (Anderson 2006, 1). Dafna Hirsch

³² Although Frederick Truby King was born in the New Zealand colony of New Plymouth, his father had been a member of the British Parliament before he came to represent two districts in “the first and second New Zealand Parliaments” (Burdon 1945, 13). The younger King studied medicine at Edinburgh University before returning to New Zealand in 1888.

similarly connects hygiene to instilling manners and civilized behavior, not only health, for Zionist reformers in colonial Palestine. Hygiene science considered “almost everything . . . a potential factor of disease or health. The hygienic repertoire contained models for washing, sleeping, eating, dressing, working, organizing time, and much more” (Hirsch 2009, 579). While these hygiene concerns were certainly classed and raced, they were also gendered. Sherene Seikaly writes that British colonizers assumed that “most nutritional, health, and budgetary problems in 20th-century Palestine were a result of bad cooking, inadequate mothering, and ignorant housekeeping, whether Arab or Jewish” (Seikaly 2014, 785).

Consistent with the dominant Western supremacist sensibilities of civilizational superiority, Landesman explained to King in the September 1926 letter that if the mother “understands 1% of what the nurse is trying to convey, we feel satisfied, when one considered the element we have.” She retold the story of the “Moslem mother” with a “six months baby weighing 6½ pounds, starved almost to death” because the “mother had practically no milk.” Hadassah nurses, Landesman explained, “managed to keep the baby alive until it reached eleven months of age, weighing 12 pounds. The baby had an attack of diarrhea; mother was instructed to stop the [formula] milk for a certain period, the next day mother returned with baby in a much worse condition, but pleading that she followed instructions, not giving milk, etc. but baby seemed thirsty so she gave it some grapes. The result, fatal.”³³ In this account, the mother is responsible for the baby’s initial low weight because she had no breast milk, the baby’s diarrhea at eleven months, and the baby’s death.

Zionists understood Jewish science and health institutions to prove the worth of a Jewish homeland to the British colonial overseers of Palestine, but they also made that separatist demographic project a reality on the ground. Israel Kligler, professor of hygiene and bacteriology at the Hebrew University, director of Hadassah’s Nathan and Lina Straus Health Centre, and former associate of the Rockefeller Institute in New York City, described the Zionist sense of demographic urgency in the following way: “The Jewish people are in a hurry. They are anxious to improve health conditions with the utmost speed in order to facilitate reconstruction [of a Jewish homeland] and resettlement [Jewish settler-colonialism] with a minimum loss of life and

³³ Central Zionist Archives 1925, Folder J113/6738.

health" (Kligler 1932, 167). Demographic transformation of the land was the sine qua non of settler-colonial dominance, even as Zionists struggled with low Jewish fertility rates.

The goal was to bring in and reproduce as many Jewish bodies as possible and cultivate what US Zionists called "Jewish genius" by assuring the health of indigenous Jews and Jewish settlers (Rosenau and Wilinsky 1928, 741). Jewish scientific, hygiene, and health projects aimed to "regenerate" the "health of the nation" (Sufian 2007, esp. 240–287). Sandra M. Sufian shows how Zionist antimalarial campaigns, for example, worked to transform in tandem "the physical topography of Palestine" and "its Jewish inhabitants and their bodies." Zionists considered inculcating "hygienic principles and health habits" necessary for reshaping "an unhealthy, passive people in the Diaspora" into a "renewed and vibrant" Jewish body politic (239–240). Medical and health research, investments, and propaganda were vital to this project (242).

Zionist organizations came at these goals from different ideological perspectives shaped by their leaders, members, and the support and fundraising of Jewish communities in Europe, the United States, and white colonial settlements in places such as New Zealand and Canada.³⁴ Hadassah nurses in Palestine, who were predominantly settlers from Central and Eastern Europe, followed a hygiene framework that assigned them to be civilizing agents of "social and cultural mediation," a project shaped by early twentieth-century US Progressive ideals (Hirsch 2008, 232, 231, 240) in cities such as New York, Boston, Baltimore, and Philadelphia. Following a gendered model of medicine, Hadassah subordinated Jewish midwives to "public health nurses" and "physicians, who benefited through the outcome of increased hospital birth rates" (Katvan and Bartal 2010, 170). Sick Funds (Kupat Holim) were initially established in 1912 as health care mutual aid systems by socialist Jewish male settlers who were agricultural workers in Palestine. The sick funds were integrated into the General Federation of Labor (Histadrut) health insurance system when the Zionist labor organization was established in 1920. The Histadrut worked closely with Hadassah through the late 1920s to provide healthcare to its members and their dependents until it established its own institutions (Cohen 1987, 144–152).

³⁴ New Zealand became independent of Britain in 1947 and Canada became independent in 1919.

Primary documents illustrate inter-Zionist competition and conflict, as well as coordination, for example between Hadassah and the British-based Women's International Zionist Organization (WIZO), which primarily sponsored Jewish schools run by the "locally" founded (1920) Hebrew Women's Organization in "Eretz Israel/Palestine." The WIZO also established IWCs, and its volunteers and workers conducted tens of thousands of "home visits" to Jewish families.³⁵ Hadassah additionally competed with socialist and labor Zionist organizations such as Histadrut's Nashim Ibriot women's committees (funded by Jewish women in New Zealand), whose members canvassed Jewish neighborhoods for pregnant women and accompanied them to hospitals to be examined by a gynecologist in the 1920s, leaving them with a ticket that allowed them to be delivered at home or in a Zionist hospital by a nurse-midwife. Another organization, Ezer Leyoldos (Children in Need) served Ultra-Orthodox Jews.³⁶ Despite their differences Zionist health activists were feverishly oriented toward Judaizing Palestine by populating it with as many Jewish bodies as possible and assuring their survival and health. The final section of this chapter uses examples from an early and late moment in British colonial rule to explore Palestinian elite responses to British and Zionist health projects and priorities.

Palestinian Elites and the Politics of Health

Palestinian elites realized that the heart of Zionist settler-colonialism was transforming the demography of Palestine by populating it with healthy Jewish bodies and that this project was vitalized by investments in science and medicine and a colonial civilizational discourse. A telling early example of conflict involving Palestinian, British, and Zionist leaders centered on Health Week 1924, held in the third week of November. Initiated by Hadassah and led by its director, Dr. Simon Tannenbaum, this massive educational campaign run by "local committees" was aimed

³⁵ July 27, 1926, Landesman letter to Rose Slutzkin in London. Central Zionist Archives 1925, Folder J113/6738. Also see "WIZO: Who We Are": www.wizo.org/who-we-are/our-history.html. In 1931 the WIZO Congress moved the Palestine office from Jerusalem to Tel Aviv because of mass immigration to the municipality from Germany. Central Zionist Archives 1933, Folder A217/29.

³⁶ *Report of the Central Committee for Maternity and Infant Welfare in Palestine*. This committee was an unfunded British project founded in 1922 by Lady Samuel and largely composed of representatives from Zionist women's health organizations. Central Zionist Archives 1925, Folder J113/6738.

at schoolchildren and their parents. It included posters, "Cinematograph and Magic Lantern exhibitions," essay contests, health propaganda newspaper stories, and a Hebrew curriculum translated into Arabic pamphlets. Health Week was designed to "spread the light of health" by targeting the "person" or "individual" rather than the "environment," according to a Department of Health statement.³⁷

British officials made clear to Tannenbaum that their support was conditional on inclusion of Palestinians ("Christians, Moslems"), although the meetings were organized by the secretary of the Health Week Committee, Hadassah's Nellie Mochenson (Straus), and were usually held at the Hadassah office or the Jewish "Lemel" School. The executive committee, whose appointed figurehead chair was British director of health Rupert Briercliffe, expanded over three months but remained composed of Zionist health and education representatives, British colonial officials from the departments of health, education, and public works, wives of high-ranking colonial officials (e.g., Lady Samuel Bentwich, Lady Gilbert Clayton, and Lady Ronald Storrs), and a few representatives from private Christian religious schools serving Palestinian children.³⁸

The elephant in the room was the lack of high-level Palestinian participation. "Dr. Canaan" and "Dr. Khalidi," who were mentioned occasionally and expected to write stories for publication "in each of the Arabic newspapers," did not continue to participate in the planning for political reasons despite attempts to frame the Health Week campaign as apolitical. The minutes of a September 10, 1924, meeting of the executive committee, at which only Briercliffe and Hadassah and other Zionist representatives were present, included a section on "Participation of [the] Arab Population": "Dr. Tannenbaum stated that it is very doubtful whether it would be possible to secure the active participation of the Moslem Supreme Council. It was decided that an effort should be made to persuade the Moslem Supreme Council that there is no political significance attached to this plan." A September 10 handwritten note by Briercliffe summarized a meeting with Dr. Tannenbaum:

³⁷ Environmental campaigns, the focus of the British colonial government, focused on anti-malaria projects, food inspections, and regulations related to sanitation, health, and hygiene.

³⁸ GOP, Department of Health, Hygiene and Health – Health Week – Hadassah Med. Organization, August–November 1924. File location in catalog: 00071706.81.D0.97.4B. Israel State Archives.

Impressed Dr. Tannenbaum that a meeting which, apart from myself, represented only the Jewish section of the Community, was going to limit Government participation in the Health Week, considerably. Dr. Dajani's resignation at the instigation of the Supreme Moslem Council must be regarded as very serious. One of the conditions of Government cooperation was that the Health Week was on for the whole of the people of Palestine and that it really was backed by Jewish Christian & Moslem public opinion. I had obtained Chief Secretary's approval to take part in the movement because it was presented to him that all communities were willing to help. RB.

A September 12 handwritten note by Briercliffe summarized a meeting with the British civil secretary of the Mandate government: "Asked Col. [George S.] Symes (CS) his opinion of the situation. He considers the movement should proceed purely as a Jewish matter and that at a different time a Health Week should be held for Moslem schools too. I thought this would not be in keeping with the Health Week idea. RB."

A September 16 handwritten note by Briercliffe summarized a meeting with the mufti of Jerusalem:

Asked Mufti reason for Dr. Dajani's non-participation. Mufti most desirous of helping the Government in health work and is not opposed to Health Week. Considers however that as at present organized it is mainly a Jewish affair and that if a Moslem representative takes part in it the Jewish press will make political capital out of the incident and put it forward in light of a rapprochement between Arabs and Jews which would be most undesirable. He will lend his support to the Government but not with Health Week Committee which is predominantly Jewish. RB.³⁹

The Health Week events went forward in 1924 without Palestinian participation. I fleshed out this example from the archival records in order to impress that all major players in the political field recognized the implications of health and healthcare in Mandate Palestine: British officials worried about optics and costs; Zionist leaders had demographic, material, and ideological agendas; and Palestinian leaders realized all of these dimensions but had few cards to play, politically or in terms of capital.

Palestinian physicians, exemplified by Tawfik Canaan, invested substantial time and energy appealing to British colonizers for healthcare

³⁹ GOP, Department of Health, Hygiene and Health – Health Week – Hadassah Med. Organization, August–November 1924. File location in catalog: 00071706.81.D0.97.4B. Israel State Archives.

services, often participated in British-sponsored public health projects, and were enamored of the modern as hygienic, "steady development and progress" (Canaan 1946, 1), enlightenment, and rationality. Canaan, born in the Bethlehem-area Ottoman village of Beit Jala to a poor family of Lutheran religious affiliation, trained as an ethnologist in Germany and as a physician at the Syrian Protestant College for Medicine (established 1867, later renamed American University of Beirut), from where he graduated with honors in 1905 (Nashef 2002). He was involved in multiple scientific, health, and medical research projects and institutions, as well as ethnographic scholarship, over sixty years in Palestine, beginning from early in the twentieth century in Ottoman Greater Syria.⁴⁰ Salim Tamari, who writes of Canaan's successful work to eradicate leprosy in Palestine, calls him a "nativist ethnographer" who was part of "the attempt to establish sources of legitimation for Palestinian cultural patrimony (and implicitly for a Palestinian national identity that began to distance itself from greater Syrian and Arab frameworks)." Canaan turned to "primordial sources of identity" in response to British superiority frames and "Zionist attempts at establishing their own putative claims to the Israelite and biblical heritage" (Tamari 2009, 95, 99). Canaan's textured folkloric work "contested Zionist claims to biblical patrimonies by stressing present-day continuities between the biblical heritage (and occasionally pre-biblical roots) and Palestinian popular beliefs and practices" (99). Tarif Khalidi similarly argues that Palestinian intellectuals such as Canaan and Omar al-Barghouthi were "striving to show the Semitic roots of the Palestinian peasant as an ancient and continuous occupier of the land" (Khalidi 1981, 65).

⁴⁰ Canaan wrote for and participated in the editorial board of the *British Journal of the Palestine Oriental Society*, established in Jerusalem in the early 1920s, directed a number of medical and research institutions before and after 1948, including Augusta Victoria Hospital, and cofounded the Palestine Arab Medical Association and its medical journal in the mid-1940s. The society came to be responsible for a number of nongovernment hospitals serving Palestinians until 1948. British colonial authorities arrested Canaan in September 1939 (he was held for nine weeks), the day Britain and France declared war on Germany. His wife, a German national, was arrested the same day and imprisoned for nine months, as was his sister Badra, held for an astounding four years. Accused "of inciting Arab women against Britain," Badra and her mother had indeed been involved in the 1936–1939 Revolt. See "Palestine Information with Provenance Database": <http://cosmos.ucc.ie/cs1064/jabowen/IPSC/php/event.php?eid=4237>.

While not interested in using Jewish resources to provide for Palestinian health, Zionist political propaganda in the 1940s apparently took credit for lowering Palestinian infant mortality rates. This galled the anti-Zionist Canaan, who acknowledged the lower “general and infantile” death rate in Palestine for multiple reasons over time during the Mandate period but argued it “is a fundamental mistake to attribute it only to one cause, as the Zionists say, i.e. to their influence” (Canaan 1946, 10). He repeatedly pointed to structural conditions that produced high infant mortality, such as lack of roads in Palestinian villages and hamlets and Palestinian physicians settling in towns rather than villages (1).

In a section of a 1946 report titled *The Hygienic and Sanitary Conditions of the Arabs of Palestine*, Canaan dismantled the Zionist argument of hygienic superiority by looking at Jewish and Palestinian infant mortality rates separately. He used British data (provided by Zionist health institutions) to argue that “despite the vast sums of Jewish money poured into the country during the 18 years and which were used for Jewish interest, not least for the sanitation of the [Jewish] colonies and the general standard of health of the Jews, [they] were not always able to decrease the mortality among their [own] infants.” He showed that “Jewish total infant mortality was higher in 1938 than in any previous year, except 1935 and 1936, while the total infantile mortality among the Arabs was in 1938 the lowest since 1923.”

Canaan realized that counting often tells an ideological story. The report I analyzed at the US National Library of Medicine includes Canaan’s taped-in handwritten table showing “Infantile Mortality in Places far from Jewish Influence per 1000 Live Births” (see Figure 1.2). The table lists Palestinian infant mortality rates from 1938 to 1944 for Khan Yunis, Hebron, “Hebron Villages,” Bethlehem, “Bet Djala” (Beit Jala), and “Jericho Villages,” showing their variability over time and across space despite all of them being “far from Jewish influence” in terms of geographic access to Zionist health institutions (Canaan 1946).⁴¹

Palestinian elites recognized that the Zionist movement sought to advance the project of a Jewish state in historic Palestine by “proving” its civilizational superiority in economic, health, and scientific development before Western powers. Given that British colonial authorities

⁴¹ This report is not paginated sequentially.

... among their ...
... in any previous year, except 1935 and 1936, while the total infantile ...
... among the Arabs was in 1938 the lowest since 1923.¹
... Several villages, lying far from Jewish colonies and thus not influenced ...
... any Zionist influence had a marked decrease in infantile mortality as the ...
... Table 8 will show:

TABLE 8

Infantile Mortality in places far from Jewish Influence
Per 1000 Live Births

Village or City	1938	1940	1941	1942	1943	1944
Khan Yunis	130	90	98	38	27	36
Helwan	178	161	172	180	133	112
• Nablus	102	80	92	81	63	66
Totlakhun	303	206	184	229	184	173
Port Safa	140	129	94	92	72	44
Fridia Village	200	68	61	52		

... taken from official lists ...

Figure 1.2 Handwritten taped-in Table 8 by Tawfik Canaan calculating “Infantile Mortality in Places far from Jewish Influence per 1000 Live Births” (Canaan 1946). Photo by author. Courtesy of Army Medical Library/National Library of Medicine, Bethesda

and the League of Nations connected a population’s “civilization” level to its health, “Jews and Arabs would be at odds to link the contrasting levels of infantile mortality among the national population groups in Palestine with their respective contribution to the territory’s development” (Bourmaud 2013, 14). Palestinian medical professionals, including the Palestine Arab Medical Association established in 1945, persistently requested an increase in the Public Health Department budget and additional health facilities to address “the real needs of the country for more thorough sanitation and more medical help.”⁴²

Palestinian physicians also advocated for their professional and economic interests. A July 15, 1945, letter from the Palestine Arab Medical Association signed by Dr. M. T. [Mahmud Taher] Dajani (general secretary) and Dr. Canaan (president) to the director of

⁴² The first “Medical Non-Jewish Association” of physicians was established in Jerusalem in 1912, likely initiated by Canaan (Canaan 1946, 4).

medical services in Jerusalem, John MacQueen, included requests for investment in sanitation infrastructure and healthcare as two of five demands from the Arab Medical Congress held in Jerusalem. The third demand was that “one or more young Arab doctors should be sent yearly to British Universities for specialization . . . No real scientific work and no real service can ever be done to the country without a backbone of specialists.” MacQueen responded they were “endeavouring to send two of our [government-employed Palestinian] doctors this year.” The fourth demand was for the Palestine Arab Medical Association to be involved at the decision-making level in any “basic changes . . . contemplated” in relation to “sanitation, health or medical services.”

The fifth demand, for a “radical change of the present regulations for licensing physicians,” took up most of the letter. It noted the high “number of licensed and practicing Jewish physicians,” which the Arab Medical Congress expected would increase after the war. It demanded protection of “the vital interests of Palestinian Arab physicians.”⁴³ The association complained that Jewish physicians actively drew away Arab patients from the small number of Arab physicians, with significant impact on their livelihoods, “as (1) the Arab population as a whole is poorer than the Jewish one, as (2) it does not seek the help of the doctors as often as the others, and as (3) practically no Jew will come to an Arab physician for treatment – following the fundamental Jewish National Principle viz., Jewish work only for Jewish workers; non-Jewish work for all.” While the phrasing is confusing, the message is clear. Zionist settler-colonial principles considered Palestinians fair and appropriate game for extraction in all realms in order to maintain their livelihoods and cultivate a Jewish National Home. Zionist health institutions had a policy of charging Palestinian patients fees that were “high and at times exorbitant” (Canaan 1946, 14).

MacQueen met with Dajani and Canaan on July 29, 1945, after receipt of the letter. In a September 5 confidential memo to the “Acting Chief Secretary,” he summarized the content of the meeting, dismissing the Arab physicians’ criticism of the quota system that determined the

⁴³ The letter states there were 2,247 “licensed Jewish physicians” for “600,000 inhabitants [who] are Jews,” a ratio of “1 physician for every 267 persons,” which it compared to the high ratio of 1 physician per “1067” Norwegians.

number of Jewish physicians allowed to immigrate to and be licensed in Palestine: there was "no need for a new law," although he agreed that "numerically we had more than enough doctors at present." He reported encouraging the physicians "again" to develop a "rural medical service," an idea they "were fostering . . . amongst Arab doctors."⁴⁴

In his testimony to the Anglo-American Committee of Inquiry in 1946 about the health of the Palestinian population, Canaan challenged Jewish Agency testimony claiming that lower Arab mortality rates in Palestine were caused by the treatment of Palestinian outpatients in Jewish institutions (Sufian 2015, 133–134). The published Jewish Agency memorandum to the Anglo-American Committee (Jewish Agency 1946) had made a non-zero-sum case for Zionism that was crucial at that historical juncture before a Western international audience: Zionists had "common interests" with "Arabs" and had worked with them in "cooperation" and offered "help" and "friendship," including healthcare services, during the Mandate. The Jewish Agency memo recommended that the Anglo-American Committee support a "Jewish commonwealth" with "a Jewish majority" because of "common economic and social interests" between the Zionist movement and Palestinians, including "cooperation" between Arab and Jewish "orange growers," "certain Arab trade unions established with the help of the Histadrut," and coordination between Jewish and Arab politicians in the municipality of Haifa (33). Zionists had advanced the knowledge of "Arab farmers," the memo claimed, and "Valuable pioneer service in the cause of Jewish-Arab friendship has been rendered by the Hadassah Medical Organisation whose hospitals have always been open to Arab patients and have also been frequented by Arabs from the neighboring countries" (34).

⁴⁴ Health and Vital Statistics. "The Palestinian Arab Medical Association Requests for more medical health by provision of Clinics, Hospitals, Laboratories, Etc." File location in catalog: 00071706.81.CF.FD.59. Israel State Archives. These demands may have influenced the 1946 Department of Health investment of "Approximately £P.5,000 . . . for the development of [Arab Palestinian] Village Clinics," a modest influx that should be understood in comparison to the £P.81,000 in grants provided for "Jewish health services" in the same year, excluding additional government investments in bed strength at the Government Hospital, Tel Aviv, which served Jews, and "staff increases" at the Mental Hospital, Jaffa, which was more likely to serve Palestinians. GOP, Department of Health, Health and Vital Statistics, Annual Reports – Annual Report for the Year 1946. File location in catalog: 00071706.81.CF.FC.FA. Israel State Archives.

The 1946 “Evidence” document submitted to the Anglo-American Committee by the Arab Office in Jerusalem insisted, to the contrary, that “there are no benefits obtained or to be expected from Zionism commensurate with its evils and its dangers.” Responding to claims that Zionist health institutions and knowledge had reduced Palestinian mortality rates, it stated: “The increase in the Arab population is not primarily due to Zionist immigration, and in any case would not necessarily be a sign of prosperity . . . The Zionist contention that their social organizations provide health and social services for the Arab population is exaggerated; only a minute proportion of Arabs, for example, are looked after by Jewish health organizations . . . Arab voluntary social organizations have grown up independently of Jewish bodies and without help from them” (Arab Office 1946, 4–5). The document emphatically challenged Zionists’ claims that they were “mediators of Western civilization to the Middle East . . . the Arab world has been in direct touch with the West for a hundred years, and has its own reawakened cultural movement, and thus it has no need of a mediator” (5).



Despite the extractive political economies that are the very definition of imperial and colonial relations, health and science nevertheless remain especially amenable to civilizational discourse that posits the colonizer as an advanced purveyor of the good to the benighted colonized. The putative “silver lining” of the stark power differentials of colonialism is an improved lot for the colonized in the arena of health, but that was not the case for Palestinians. Chapter 2 uses archival material to consider the health impact of British “efficiencies and economies” logic in Palestine. It draws links between hunger and poverty on one side and disproportionate morbidity and early death on the other and explores the multiple ways in which Palestinian traditional healers and midwives were situated in relation to the Mandate government. The chapter tracks the material dimensions and embodied outcomes of British healthcare austerity, as well as the persistent rhetorical mythology of Western cultural and racial superiority.