



HEALTH IN PALESTINE AND THE MIDDLE EASTERN CONTEXT



Illustration, p. 313: The Wailing Wall, Jerusalem, 1929.
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Introduction: Health in Palestine, 1850-2000

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Health is about people's physical well-being. But at all times, and particularly in times of conflict, it is about a lot more than that. Health issues can translate into military strength or mythical national identity. They can divide groups into separate categories, or they can unite them in a common struggle against shared hardship. They determine what the individual can demand from society, and what society demands from the individual. In any case, the politics of health define the position of men and women in their relationships with their neighbours, both as individuals and groups (1). In the process, determinants of health, its organization and experience within societal groups become telling indicators of the state of this particular society. Spanning the period between the mid-nineteenth century to the recent past, the contributions of this volume explore the health issues in nineteenth and twentieth century Palestine in relation to its social and political realities.

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(1) See ALBRECHT, Gary L.; FITZPATRICK, Ray; SCRIMSHAW, Susan C. (eds.). *Handbook of social studies in health and medicine*, London, Sage Publications, 2000.

The focus is on interwar Palestine, which is covered by four out of six contributions. This choice was motivated by the fact that interwar Palestine seemed to offer the central theme of this volume most strongly. It was the time when foreign rule, international attention and competition between the Jewish and Arab communities as well as within the respective groups combined with lively developments on the medical scene to produce an exceptionally dense mixture. All the main problems of the area seemed to be contained in a nutshell within that relatively small period and place (2). For balance, this main body of papers is framed by one paper on both the preceding and subsequent period. Regardless of period, all authors had to confront two central elements: the specific natural and political circumstances which formed the background for the evolvement of public health in Palestine, and the diverse group of actors who took an active—or passive—role in these developments. Neither of these factors was conducive to an easy, harmonious public life.

Nineteenth century Palestine, then a part of the Ottoman Empire, was a good place for pathogens. On several levels, circumstances were conducive to illness and disease. The geography did not provide an easy living, comprising a relatively small area with both swamps and deserts. It was on the Islamic pilgrims' path on their way to and from Mecca, providing the opportunity for a steady influx of disease carriers. Poverty, backwardness, absenteeism of the local elite and the frequent incompetence and indifference of the central government and the resulting lack of effective social administration further prepared the ground for an easy spread of diseases. Thus, the region was frequently struck by epidemics, particularly malaria (3). The Ottoman public health system was influenced by increasing contact between the Ottoman Empire with European military, commerce and science,

(2) For detailed descriptions, see SEGEV, Tom. *One Palestine complete, Jews and Arabs under the British Mandate*, London, Abacus, 1999; SHEPHERD, Naomi. *Ploughing sand. British rule in Palestine 1917-1948*. London, John Murray, 1999; MEJCHER, Helmut (ed.). *Die Palästina-Frage 1917-1948*, 2nd edition, Paderborn, Schöningh, 1993.

(3) TESSLER, Mark. *A history of the Israeli-Palestinian conflict*, Bloomington and Indianapolis, Indiana University Press, 1994, pp. 123-124.

which triggered various reform movements (*Tanzimat*). While reforms regarding health care institutions were hardly felt in Palestine, the economy experienced a marked improvement. Growing integration in international European trade and foreign investments resulted in significant increases in agricultural production and export. Coastal towns, in particular, benefited from the increasing European influence and improved infrastructure and witnessed the emergence of a budding class of entrepreneurs (4). However, the overwhelming majority of Palestinians remained peasants, vulnerable to social and economic inadequacies. At the beginning of the twentieth century, the area was still a relatively underdeveloped area even within an Arab context (5). The European war of 1914-1919, which used Palestine as one of its battle grounds, disrupted local life. Ottoman authorities arrested both Arab and Jewish Zionist leaders, killing some, conscripted tens of thousands of Arab farmers, deforested large areas and commandeered crops and livestock. As a result, the population declined substantially (though temporarily). Those that had remained faced starvation and political chaos and were an easy prey to infectious diseases. The most immediate task of occupying British forces was to provide food and medical supplies and to restore social and economic order (6).

Given the circumstances, this task was difficult, and it was further complicated by ethnic fragmentation. Palestine had always been multi-cultural, sometimes at the forefront of civilization and often a provincial corner of some large empire. The rising nationalism of the nineteenth century resulted in incompatible political ambitions and early ethnic hostility. The demise of the Ottoman Empire at the end

(4) SCHÖLCH, Alexander. European penetration and the economic development of Palestine, 1856-82. In: Roger Owen (ed.), *Studies in the economic and social history of Palestine in the nineteenth and twentieth centuries*, Oxford, Macmillan Press, 1982, pp. 10-87; KARK, Ruth. The rise and decline of coastal town in Palestine. In: Gad G. Gilbar (ed.), *Ottoman Palestine 1800-1914*, Leiden, E.J. Brill, 1990, pp. 69-89.

(5) See SHVARTS, Shifra. *The workers health fund in Eretz Israel. Kupat Holim, 1911-1937*, Rochester, University of Rochester Press, 2002, p. 8.

(6) TESSLER, note 3, p. 145; SMITH, Charles. *Palestine and the Arab-Israeli conflict*, 2nd edition, New York, St. Martin's Press, 1992, p. 68.

of the First World War produced a temporary power vacuum which attracted various groups interested in the area. Several colonial powers strove to extend their spheres of influence, the politically active class of the Arab population expected independence and an international Jewish community hoped to build a national home on the ground of the Jewish state of antiquity. Real power in 1920, rested with the British, whose army occupied the area during World War I and remained militarily in control. They had not made life easy for themselves or for anyone else in the Middle East. In a notorious and often-told sequence of war diplomacy the British government had negotiated with the French government, an Arab Sherif, and Zionist groups in England, resulting in mutually contradictory promises about post-war Palestine status (7). Predictably, the situation was confusing and fertile ground for antagonism. *De iure* responsibility of Palestine fell to the newly founded League of Nations. The League, in turn, granted Palestine to Great Britain under the status of a mandate, a decision dictated by English and French negotiations, that allocated the territory among themselves. British authorities proceeded to govern the area much like a regular colony, without, however, incorporating it fully into its empire. Meanwhile the Arab and the growing Jewish communities cooperated to some extent with British institutions but in parallel retained and built up internal quasi-governmental bodies. Interwar Palestine was one territory, inhabited by two ethnic communities of three religions, governed by four administrative structures.

As a result, it is not easy to find a suitable analytic framework for a socio-economic history. Roger Owen describes three possible models, which, in modified form, can be applied to socio-health analysis, each with its specific shortcomings (8). Health in Palestine was characterized first by its being a British colony. Like any colony, it was «expected to pay its own way financially as well as to support the cost of the local British garrison» (9), which drastically limited financial resources for the sanitation and health care system. This perspective, however,

(7) See TESSLER, note 3, pp. 146-150; SMITH, note 6, pp. 41-55.

(8) OWEN, Roger. Introduction. In: OWEN (ed.), note 4, pp. 4-8.

(9) OWEN, note 4, p. 4.

tends to obscure the heterogeneity of the Palestinian population. Secondly, Palestine can be seen as two societies whose duality determined dual health realities. This concept is true to some extent. The rise of a dynamic Jewish health care system which, though theoretically open to all members of society, in practice catered overwhelmingly to the Jewish community and resulted in different experiences of disease prevalence, treatment and prevention. The Jewish claim to a new nation with the highest possible living standard (an essential precondition to attracting more immigrants) and the refusal to adopt Middle Eastern living conditions effectively divided the society. At the same time, however, this view is simplistic. Public health was both more united, as some British sanitation measures benefited all parts of society, and more fragmented, as socio-economic diversity within the Jewish community and the existence of Christian hospitals and dispensaries established health-related sub-groups within the Jewish and the Arab communities. Third, health in Palestine was influenced by the clash between European-Western and Middle Eastern concepts of health and health care. Again, while supposedly true, this perceived dichotomy, if pushed too far, risks misinterpreting health differences which may have been not so much of cultural but of economic or political origin. And all of these models must take into account the changes in time: the rapid population increases, the rising tensions between Arabs and Jews resulting in repeated outbreaks of violence, and new concepts of medicine and health that added social medicine and racial hygiene to existing medical paradigms. Finally, health in nineteenth and twentieth century Palestine must take account the centuries of history in which it is embedded. Given the exceptionally long and multi-faceted history in this part of the world, which has witnessed human fate since pre-biblical times, health as a sub-plot of cross-cultural encounters is hardly a new phenomenon for Palestine. Involving pre-historic man, Canaanites, Philistines, Jews, Romans, Greeks, Arabs, European Crusaders, and Turks, to name but a few, all with their specific health agendas, the struggle for medical prerogative has been the rule rather than the exception (10). From this

(10) See WASERMAN, Manfred; KOTTEK, Samuel S. (eds.). *Health and disease in the DYNAMIS. Acta Hisp. Med. Sci. Hist. Illus.* 2005, 25, 315-327.

perspective, this collection of papers addresses a much larger story than «merely» health in interwar Palestine. It is the story of health in an ethnically diverse place. It is, if you will, a parable of health on this planet.

Within this framework, several themes emerge. The persistent parallel, of both «traditional» and «conventional» medicine, co-existing in a continuously changing relationship, is a thread that runs through several papers. Although a simplistic narrative of the rapid conquest of modern medicine over traditional medicine, is still one of the hardest fortresses in the historiography of medicine, nowadays various accounts have already demonstrated that traditional medicine has continued to thrive in Palestine as in all other parts of the world(11). It would also be a mistake to think that the rise in power of modern medicine and the Western bio-medical paradigm was smooth and linear. Constant friction, as well as stiff opposition, but also negotiations and various degrees of cooperation (open or hidden) between conventional medicine, many times allied with the state, and traditional healers with their strong roots within the local population, characterized the development of the medical system in Palestine.

The relationship between conventional and unconventional medical systems is deeply connected to the question of how health belief systems are connected to and influenced by broader cultural structures of which they are a part. How do people evaluate various therapeutic systems? What is the relationship between health-seeking behavior and the experience of sickness and healing in different situations? How do a person's values and norms and those of the society in which he or she lives affect this behaviour? These questions are important when it comes to analysing the phenomena of the use of various medical practices, conventional and unconventional. Miri Shefer's paper sets

holy land. Studies in the history and sociology of medicine from Ancient times to the present, Lampeter, The Edwin Mellen Press, 1996.

(11) For a recent analysis of the complexity of unconventional medicine histories, see: JÜTTE, Robert; EKLÖF, Motzi; NELSON, Marie C. (eds.). *Historical aspects of unconventional medicine: Approaches, concepts, case studies*, Sheffield, European Association for the History of Medicine and Health Publications [Network Series n.º 4], 2001, pp. 11-26.

the stage in her analysis of the circumstances and the consequences of the foundation of a new hospital in 1845 in Istanbul by Bezm-I Alem, the sultan's mother. This act exemplified fundamental changes within the state as well the medical scene. The structure of the new hospital reflected the increasing bureaucratization of state policy, including its increasing role in the medical sphere, as well as the changing perception of medicine. Responding to the influx of foreign ideas and the perceived need to modernize in order to withstand foreign pressure, this competition of concepts foreshadowed events in Palestine. A similar point is made in Aref Abu-Rabia's description of the health reality and traditional medical world of the Bedouins in Palestine. He lays out the background of health and medicine as it was experienced by a substantial part of the Palestinian population and against which the successive layers of health policies were played out. Using the example of trachoma, Abu-Rabia can show, how ethnic status coincided with social status and integration in a super-imposed foreign health administration, all of which had serious ramifications for individual and collective health.

While this is not to underestimate the tensions and controversies among the various healers: conventional vs. traditional, Jewish vs. Muslim or Christian, European or local, in general the «private» aspects of health —self help, networks of health and traditional healers— continued to exist and to have a strong influence on the everyday life, and still do today. The rise of the modern state no doubt reinforced processes of medicalization, blurring the lines between the private and public spheres. The rise of hospitals and clinics, the enactment of public health laws —all had a strong emphasis on «scientific» medicine which gradually but increasingly involved more aspects of the life circles between birth and death. Vaccination campaigns, with health officers working side by side to the police are just few examples of how the public entered the private.

The impact of this dichotomy of public vs. private in medical institutions is clearly shown in Iris Borowy's analysis of how different levels of public health care operated in interwar Palestine. Given the complicated mix of the population and the uneasy political framework, providing health care could hardly be easy or free of conflict, but

some policy decisions further exacerbated tensions. The British public health system was limited, deliberately leaving the majority of curative services to private institutions. This reliance on private initiative and funding increased social divisions, privileging the Jewish community that had relatively most access to private organizations, able and willing to sponsor medical institutions. Christian Arabs received outside support for health care institutions while Moslem Arabs were most dependent on the public health system. These divisions clearly impacted mortality and morbidity data, effectively leaving a society stratified in different health care casts. In addition, private initiatives supported the determined efforts of the Jewish community to set up an independent health system, which ultimately became the basis for the health system of the new Israeli state, gaining a quasi-public character.

Implicitly, these issues describe boundaries, such as between the public and the private, scientific and non-scientific, between professional and non-professional, and also tangible physical as well as ethnic and social boundaries. Despite the fact that boundaries can be drawn in various periods, it is important to remember that these lines are not rigid, and transgressions and crossing of lines are common. The borders are in a constant process of flux, either through negotiation or through war. Indeed, the constant process of creating and erasing, erasing and re-creating, boundaries emerged as another central theme in several contributions (12).

Rakefet Zalashik's paper of the role played by psychiatry and psychiatrists in the formative period of the Jewish community can easily be read as a study on the negotiations of boundaries between the mentally healthy and the insane. Inevitably, these categorizations fed into the difficult construction of a national identity in a community composed overwhelmingly of immigrants of diverse backgrounds.

(12) Pierre Bourdieu's concept of cultural production circumscribed by boundaries can also be adopted for the medical discipline; see: BOURDIEU, Pierre. The field of cultural production, or, the economy world reversed. In: Randal Johnson (ed.), *The field of cultural production: Essays on art and literature*, New York, Columbia University Press, 1993, pp. 29-73.

Migration, always psychologically stressful, was particularly difficult for immigrants to interwar Palestine as it usually entailed leaving a life of very low social status to start one as a self-perceived a socially superior group, in an increasing hostile environment. At the same time, both practical and ideological exigencies of the Zionist immigrant society demanded a mentally fit society, effectively obstructing the arrival of the psychologically ill. It was thus the recent immigrant who suffered most: subjected most directly both to harsh stress of migration and to the harsh denial of their mental problems. At the same time, the existence in Palestine of native Jews whose existence approximated that of native Arabs created profound ambivalences for the conception of mental illness which could neither ignore nor build on ethnic lines.

Sandra Sufian's paper connects social and political with geographical boundaries. Her analysis shows how political borders as well as the physical landscape with its different interpretations can amplify differences in the treatment of malaria, a serious public health problem in Palestine. The emerging science surrounding malaria was eagerly adopted by the Zionist physicians as a way of both conducting their research and as an efficient way to transform the land and the bodies themselves, as part of Zionist ideology. As Sufian's analysis illustrates, the mapping process of malaria, apparently a scientific, professional process, was deeply involved in the political dispute between local Arabs and the Jewish community, was subjected to debates and negotiations. Maps, depicting high-risk areas for malaria, were effectively transformed into tools for the establishment of a new society as the political landscape followed a disease landscape. And in as much as anti-malaria activities changed the disease landscape, changes in the political landscape followed suit.

At the same time, the juxtaposition of Sufian's and Abu-Rabia's papers highlight the significance of malaria and eye-sight diseases as indicators of the social reality of health in Palestine. Malaria had been endemic to the area since biblical times (13). It continued to be regarded as making «many places (...) uninhabitable by Europeans

(13) WINKLE, Stefan. *Kulturgeschichte der Seuchen*, Düsseldorf-Zürich, Artemis & Winkler, 1997, pp. 707-781.

during a considerable part of the year» and as «the gravest obstacle to the development of the country» (14). The fight against malaria received enormous attention, supported not only by local health authorities, but also by various international initiatives, from humanitarian organisations (public and private) and research institutions. In the later part of the mandate, malaria was no longer a deadly threat to large parts of the population, but rather a disease of limited, local significance. The interpretation resembles a hen-and-egg paradox: To what extent did malaria decline because there was substantial health work, and to what extent did the anti-malaria work persist in spite of declining morbidity rates and remaining other acute health needs? Malaria was a high-reputation disease. It offered an attractive research field, in which careers could be made and reputations built, which may explain part of the international interest. In addition, as Sufian's paper demonstrates, malaria work was tied to land much more than most other diseases, and that was a major factor in a society focused on a struggle over land. Both «modern», Western science and political ambitions fed into efforts against malaria.

Eye-diseases were likewise a serious public health problem. In 1922, the incidence of trachoma, in Europe at that time already confined to marginalized and under-privileged groups, ranged from 15% in the north to 69% around Nablus and an incredible 97% in Southern Palestine (15). Between a third and half of school children were estimated to have trachoma during the interwar period, with decreasing incidence and a distinctly higher infection rate among Arab than Jewish children (16). Eye-diseases were social diseases that thrived on poor, unhygienic living conditions and lack of water. Public and private efforts to fight the disease were substantial. The Order of St. John kept a specialized hospital for eye diseases in Jerusalem

(14) *REPORT of the High Commissioner on the Administration of Palestine 1920-1925*, London, 1925, p.10.

(15) *REPORT of the High Commissioner on the Administration of Palestine*, 1922, p. 36.

(16) REISS, Nira. British public health policy in Palestine, 1918-1947. In: WASER-MAN; KOTTEK (eds.), note 10, pp. 319-320.

which treated thousands of patients (17). In 1935, ophthalmic clinics and village first aid ophthalmic posts of the British Health Department treated 65,315 new cases and had a total attendance of 750,225 (i.e. statistically half of the entire population) (18). But eye-diseases never commanded Western scientific clout comparable to malaria. As Abu-Rabia's paper demonstrates, traditional, «non-scientific» therapies retained an important role in the Arab society. And unlike malaria, eye-sight diseases remained a local and low-status concern. There were no foreign Eye Survey Units, and no organization of the stature of the Rockefeller Foundation ever became interested. And apparently eye-diseases did not decline to the same extent as malaria. To some degree, the differences reflect the characteristic approach of a colonial power of the time, favouring areas deemed vital to the functioning of the colony, urban rather than rural, and emphasizing curative rather than preventive medicine (19). Thus, such differences of disease construction may have been just usual procedure. But in the tense circumstances of inter-ethnic rivalry, these boundaries of scientific and social prestige contributed to the power struggle that culminated in a war that gave birth to the state of Israel.

From a public health point of view, the creation of Israel simplified matters. Instead of having overlapping layers of health systems that had characterized the interwar years, the responsibility for the health system now rested with the new Israeli state. However, the continued tense relations between different groups in that country as well as between Israel and its Arab neighbours kept health on the agenda of political and social life. Tamara Awerbuch-Friedlander's paper studies an example of post-independence health management in Israel. Rabies, although claiming only relatively few victims, form an interesting case study on how socio-political, demographical and environmental changes have affected the epidemiology of a given

(17) *REPORT of the High Commissioner on the Administration of Palestine*, 1925, p. 1.

(18) *REPORT of the High Commissioner on the Administration of Palestine*, 1935, p. 155.

(19) ARNOLD, David. Introduction: disease, medicine and empire. In: *Imperial medicine and indigenous societies*, Manchester, UP, 1988, p. 15.

disease. The number and geographical distribution of rabid animals were subject to fluctuations. While some of these changes appear erratic, some of them could be attributed to political events like the Gulf War which induced urban-rural migrations involving the abandonment of dogs, the main vector for the infection of humans. Likewise, the incidence of rabies on different sides of political frontiers seems inversely correlated, strongly calling for regional cooperation. Though it is a truism that «disease has no borders», the paper exemplifies how borders are negotiable and can affect our health. Health and disease, though deeply based on social and political foundations, can sometimes serve as a tool to erase political and social borders (20).

Thus, the last paper almost symbolically exemplifies another repeated theme of the papers of this collection: boundaries divide, but they also form the connection of both sides of the divide. In different ways, health has served as a vehicle of contact. It mediated controversy and conflict as well as cooperation, both between different peoples in the area and between the area and the outside world. Health served as a means to introduce modern European methods of administration and new concepts of disease to the Ottoman Empire. Health served as a means by which Jews, Christians and Moslems played out their respective claims to land and statehood. Health helped immigrants take control over the land but also gave expression to their difficulties making a home on it. Health both united individuals in their search for relief from suffering, and it separated them as their search took them to different places. Finally, health has been a means to retain contact across political divides and to call for cooperation. In short, health appears as the perfect indicator of how members of a society interact and how the society interacts with the rest of the world.

(20) On this theme, specifically related to Palestine, see: BARNEA, Tamara; HUSSEINI, Rafiq (eds.). *Separate and cooperate, cooperate and separate: The disengagement of the Palestine health care system from Israel and its emergence as an independent system*, London, Praeger, 2002.

For the Middle East, these issues have not been widely explored. While there is an abundance of literature on the political and, to a lesser extent, the economic history of the area, studies on its history of health are less frequent. It is hoped that the present volume may stimulate others to get interested in the field and ask questions that have not occurred to us this time as editors and authors.

